April 2024
Report

Dr Rosemary Crosse,
Dr Patricia O'Connor
& Professor Caroline McGregor

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Profiles, Trends and Decision-Making in Private Residential Care in Two Regions in Ireland

AN EXPLORATORY STUDY

Ollscoil na Gaillimhe
University of Galway

unesco Chair

tusla.ie

Profiles, Trends and Decision-Making in Private Residential Care in Two Regions in Ireland: An Exploratory Study

Dr Rosemary Crosse, Dr Patricia O'Connor & Professor Caroline McGregor

UNESCO Child and Family Research Centre, University of Galway

April 2024

The authors of this report are Dr Rosemary Crosse, Dr Patricia O'Connor & Professor Caroline McGregor.

Any citation of this report should use the following reference:

Crosse, R., O'Connor. P, & McGregor, C. (2024). Profiles, Trends and Decision-Making in Private

Residential Care in Two Regions in Ireland: An Exploratory Study. Galway, Ireland: UNESCO Child and Family Research Centre.

ISBN: 978-1-911702-13-9

For further information, please contact:
UNESCO Child and Family Research Centre
Institute for Lifecourse and Society
Upper Newcastle Road
University of Galway
Galway, Ireland
T: +353 91 495 398
E: cfrc@universityofgalway.ie
W: https://www.universityofgalway.ie/cfrc/

DOI: 10.52516/HYYX5837

About the UNESCO Child and Family Centre

The UNESCO Child and Family Research Centre (UCFRC) is part of the Institute for Lifecourse and Society at the University of Galway. It was founded in 2007, through support from The Atlantic Philanthropies, Ireland and the Health Services Executive (HSE), with a base in the School of Political Science and Sociology. The mission of the Centre is to help create the conditions for excellent policies, services and practices that improve the lives of children, youth and families, it is uniquely positioned to advance theory and practice and to

facilitate knowledge transfer across the worlds of research, policy and practice. Recurring themes of interest across the work programme are prevention and early intervention as a strategic orientation for policy and practice; family support as a policy and service paradigm; interventions that enable youth agency and development and, across all areas, a strong commitment to engaged research emphasising voice and participation.

Institute for Lifecourse and Society,

University of Galway, Ireland.

Telephone: +353 91 495 398

Email: cfrc@universityofgalway.ie

Web: https://www.universityofgalway.ie/cfrc/

Twitter: @UNESCO_CFRC

Foreword

I'm delighted to welcome this report as it provides us with a window into the experience of vulnerable children and families who are being helped in an innovative way through the Creative Community Alternatives (CCA) programme in Tusla and Private Residential provision. The CCA programme takes account of the individual needs of families and children and tailors a support to meet this need with local initiative. This report makes an important contribution to the developing knowledge base in Ireland and specifically in Tusla in relation to the services provided for children and families. University of Galway has contributed to increasing our understanding over the last decade with other insightful papers on how child protection services compare with other English-speaking countries, evaluation of the Meitheal programme, and other research over the course of the last 10 years since Tusla came into existence.

These authors have contributed to an increased understanding how child protection is conducted in Ireland. This helps Tusla to reflect on the current challenges it is facing and prepare better for the challenges to come. As the name 'Tusla' reflects 'new day', there is a new challenge and opportunity with each new generation of children and the services that support children and family's needs to be able to change and respond to that changing dynamic. This report also reflects the participation of children and families as experts in their own lives and service provision with significant input into the analysis.

In this report we see that neglect, drug abuse and domestic violence as the three most common concerns in the families of origin of the children interviewed. If we have a good network of supports for these problems we could avoid much later trauma for children. This underlies a common theme in the report that early intervention remains an important pillar in protecting children and maintaining positive family relationships that can maintain safety over the lifetime of a person. Indeed, as in much other literature regarding services for children and families, relationships themselves again feature as one of the most significant building blocks to a positive experience for the child or their parents. Geography is also recognised as a significant factor in influencing the child's experience of residential care with increased difficulties for building relationships due to distance and creating blockages for availing of aftercare support in some instances.

An important aspect of the findings for CCA in this report is that the literature and research tell us it's never too late to intervene early. Even for a child at home on the verge of care, support provided at home could keep a child safe and protected with their family building positive relationships. At

every moment in a child's life, we can take opportunities to provide wraparound support to them or their network. At the same time the report highlights the importance of having a positive approach to residential care. When it is required it important to have a positive understanding and approach to what residential care can provide as this can accentuate positive outcomes.

Lastly this report points us to the importance of decision making and adopting a comprehensive approach to making decisions for children who are need of these services. Each child is unique, and each family have different strengths and challenges but if we have more integrated decision-making involving parents and children and using more ecological frameworks, we can make better decisions for children. This is complicated work that requires skilful use of knowledge and application in a way that builds trust, empowers families and children, but keeps the child at the centre giving them the opportunities they deserve to become the best people they can be.

Gerard Brophy

Chief Social Worker, Tusla.

Contents

Figures

Tables

Acknowledgements

We wish to extend our sincere thanks to all participants who contributed to this research study. Firstly, to the children and young people who met with us and shared their stories and experiences of living in private residential care. We hope this research shows that we heard what you said and that we have highlighted the issues you shared with us which will most certainly contribute to better understanding and learning based on your very personal experiences and your valuable insights.

To the Private Residential Care Managers, Key Workers and staff in the Centres which we visited and spoke with, thank you all so very much for allowing us to meet with you and for taking the time to accommodate us when interviewing the children and young people you take care of. Thank you also for taking the time to participate in online interviews during your busy days of work. Your contributions have been insightful, honest and detailed and have greatly enriched this research project.

Thank you to the Social Workers whose experiences and input into this research have been extremely important and necessary to inform this report. We thank you for your time and expertise in contributing to this research. Many thanks to our organisational stakeholders who gave us great insight into the many benefits and challenges relating to use of private residential care from both regional and national perspectives.

Thank you to the two Regional Service Directors (now Regional Chief Officers) in Tusla West and Dublin Mid-Leinster who commissioned the research. We extend our thanks also to Tusla's Children's Services Director, Senior Manager and Regional Service Directors who were instrumental to the production of this research and expansion of the project to cover the two regions. In addition, your roles as gatekeepers, you ensured the complex process of accessing data and recruiting participants was efficient and professional at all times.

Thank you most sincerely to the Tusla Placement Team Managers and staff who worked so hard to provide the information from case files in accordance with the template agreed based on the information to hand. Many thanks also to the National Tusla Research Office for ongoing support during the project.

Thanks also to colleagues at the UNESCO Child and family research centre, in particular, Professor John Canavan and Dr Carmel Devaney for their ongoing support and leadership regarding this project.

Abstract

The objectives of this research were:

1. To describe the current usage of private residential care placements for children and young people in Tusla in the two regions (West, North-west (previously West) and Dublin Mid-Leinster)
2. To identify any relevant trends or patterns in this usage from 2015 to commencement date of research (March 2022), with an emphasis on understanding the decision-making process leading to the use of private placements
3. To provide a profile of the cohort of children and young people being provided with private placements.
4. To identify any trends or patterns in the case histories of this cohort of children and young people.
5. To identify any missed opportunities for the provision of prevention and early intervention services to this cohort.
6. To summarise what is known about international best practice in supporting permanency for this cohort of children and young people.
7. Explore the experiences of children, young people, parents/Guardians, staff social care and social workers, aftercare workers. Tusla management, PRC management and policy actors with responsibility for alternative care will also be consulted for their views.
8. To make recommendations for improving the approach of Tusla to providing the best possible care and support to and outcomes for this cohort.
9. To recommend a framework for ensuring the decision-making process on the use of private placements is as robust as possible
10. To inform the implementation of the Creative Community Alternatives and Tusla Therapeutic Services as these relate to this cohort. In order to give them an insight into the experiences of PRC and the decision-making processes involved, which is directly related to the work of the CCA as well as the Therapeutic Services.

The study involved a detailed international literature review, an analysis of data from 127 case files and qualitative interviews with 16 people including children and young people, key workers, private residential care managers, social workers and management representatives from regional and national perspectives.

The international literature shows that there is considerable agreement on the ingredients that contribute to best practice in residential care service provision. These include: a family oriented, preventative approach; developmentally appropriate care; emphasis on services to address behavioural issues, mental health and trauma related issues; participatory approaches and attention to diversity. However, the way this is achieved is a result of a complex interplay of factors across ecological systems from macro level historical, legal and social processes to micro- and meso-levels of quality of practice, relationships, service, support and continuity. Too great an emphasis on family-oriented practices and family reunification can prevent awareness that for some children and young people, other routes to permanence and stability during and after care are in their best interests.

The main findings from the research identified the need for more extensive prevention and early intervention services for children and young people in Residential Care from pre-care to the placement of children in private residential care. Specific recommendations were made regarding Tusla's ongoing development of its Therapeutic services and Creative Community

Alternatives as important elements to achieve better prevention and early intervention. The need to address attitudes to value and appropriateness of residential care for children and young people and promote better public and professional understandings of this form of provision was highlighted. A number of recommendations regarding the use of private residential care within overall provision emerged many of which reinforced the recommendations of the Strategic Plan for Residential Care Services 2022-2025. Particular emphasis was placed on the need to prioritise ring-fencing of places geographically to reduce distancing of young people from their networks and communities of origin. Recommendations also emerged regarding the provision, governance, management and ongoing monitoring of private residential care. Another important theme emerging from the findings was the need to enhance and continue to develop the scope for meaningful and effective involvement of young people in decision making. The research reinforced the importance of relationships across the ecological system. It also highlighted the importance of planning for and providing after care supports as an integral part of service provision. Also, it was recommended that in order to track important decision-making processes that help understand the pathways that led to the PRC, a more robust and detailed recording process is needed.

Another important outcome of the research is a recommended framework for ensuring decision making on the use of private residential care is as robust as possible. This framework needs to align with ongoing developments of integrated service delivery and to take into account an ecological relational model that captures the complexity of decision making in this area.

This research reinforces many of the recommendations made by the Strategy for Residential Care Services and related developments in Tusla since the timing of the research. It amplifies key messages to inform service delivery and shows that for some young people, PRC may be the best option but for others, the placement was a result of missed opportunities to intervene earlier. It is evident from this research, and evidence from elsewhere, that the provision of care for children and young people is necessarily complex and there is no one answer or solution. The research findings and recommendations aim to complement current ongoing developments within Tusla to improve outcomes for children and young people and to make the best use of private residential care as one of a suite of options available. The research has shown: the importance of a relational ecological approach to decision making to capture the complexity of factors involved; the need for improvements in how data is collated and made available to provide more robust evidence to inform decision making and; the urgency of ongoing commitment to enhancing the use of private residential care, as part of the overall continuum of services provided by Tusla, to better meet the outcomes of the cohort of children placed in these settings.

Glossary of Acronyms

CAMHS	Child and Adolescent Mental Health Services
CP	Child Protection
CCA	Creative Community Alternatives
CPD	Continuous Professional Development
CRS	Children's Residential Services
CYP	Children and Young People
DCYA	Department of Children and Youth Affairs
DML	Dublin Mid-Leinster
DNE	Dublin North East
DPIA	Data Protection Impact Assessment
EPIC	Empowering Young People In Care
GDPR	General Data Protection Regulation
ICT	Information and Communication Technology
IFCA	Irish Foster Care Association
MW	Mid-West
NPPT	National Private Placement Team
NUI	National University of Ireland
PPCT	Person, Process, Context and Time
PRC	Private Residential Care
TCM	Tusla Case Management System
TTS	Tusla Therapeutic Services
SE	South East
SEN	Significant Event Notification
SOS	Signs of Safety
SW	South West
UNCRC	UNESCO Child and Family Research Centre
UNESCO	United Nations Education, Scientific and Cultural Organization
WNW	West North West
YP	Young Person

Chapter 1: Introduction

Opening Comments

Over a million children grow up in care across Europe and hundreds of thousands are confined to institutions for children. Between 5 million and 6 million children (aged 0–18 years) worldwide are estimated to live in institutions rather than in family-based care settings (Opening Doors for Europe's Children, 2017). A UN General Assembly Resolution on the Promotion and Protection of the Rights of Children recognises that a child should grow up in a family environment to allow full and harmonious development of her or his personality and potential. It urges member states to take actions to progressively replace institutionalisation with quality alternative care and to redirect resources to family and community-based services (Goldman et al. 2020).

A number of countries have been progressively dismantling their institutional care systems and re-integrating children into their families and communities. However, residential care continues to be a preferred or dominant option in some jurisdictions. Whittaker et al. (2022) in their 16-country study on residential care included countries with high, medium and low usage of residential care, ranging from 7% in Ireland and Australia to 97% in Portugal. Countries in the low-usage category (England, Scotland, Ireland, Canada, Australia and the United States) had undertaken recent legislative initiatives that changed out-of-home care services and reduced residential care rates. In medium-usage countries (Denmark, France, Italy, Finland, Spain, Netherlands and Germany), reforms focused more on improving and strengthening the quality of residential care combined with higher levels of cultural acceptance for the use of residential care. In higher-usage countries (Argentina, Portugal, Israel), reforms and policy development are oriented towards the quality and delivery of residential care, with a focus on deinstitutionalisation and some focus on building of services oriented towards family support and family care.

Ireland is in the low-usage category regarding use of residential care within its overall alternative care provision. There has been a sustained process of dismantling institutional care as a main form of alternative care for children and young people since the 1970s in Irish policy and practice (Devaney and McGregor 2017). Progressively, institutional care for children has been replaced with the provision of smaller residential units that aim to provide a family environment. When residential care services are used in Ireland, a range of residential care is provided by statutory (Tusla), voluntary and private services. Privatisation of residential care is a growing trend globally with the emergence of what Meagher et al. (2016) call a 'care market'. While it is recognised that this form of care may be ideal for a small number of children and young people with specific needs, some children and young people in residential settings find themselves placed in such settings following the exhaustion of a range of other options. Presently in Ireland, private residential care is the dominant form of provision used, as discussed in more detail in Chapter 2.

Regardless of the type of care arrangement put in place, a variety of factors influence critical decision-making from the point of original referral to decisions about alternative care placements. Child protection decisions are not single events, but the result of complex processes embedded in the social activities and practices that make up the work (Crea 2010; Munro 2005; Saltiel 2016; Taylor 2012, 2017). Decision-making processes from the early stages of intervention are extremely difficult to establish (Spratt 2000; Benbenishty et al. 2015). The number of factors that lead to decision-making throughout a young person's care journey is immense, as discussed in more detail in Chapter 3. As McCafferty and Taylor (2020, 107) argue, decision making in child welfare and protection involves 'weighing the potential gains against possible losses incurred' and 'necessitates a level of extrapolation

from current events to help calculate future outcomes. As discussed below, decision making is complex and does not lend itself well to linear approaches or solutions. Care must be taken in decision making to balance between risk assessment and meeting needs (McCafferty and Taylor, 2020) especially when decision making to support the needs and interests of 'complex youth' (Monson, 2020).

This research was commissioned to establish a profile of the young people placed in private residential care in two locations. The intention was to better understand the decision-making processes based on professional judgements and organisational arrangements that led to these placements due to individual and wider ecological factors (McCormack et al, 2020). It was also to seek to understand, in hindsight, whether there are specific trends and patterns to note in this process, and to explore any missed opportunities for earlier intervention and prevention. While it is acknowledged that for some children and young people, residential care is the most suitable form of care, the problems informing this commissioned research were multifaceted. Firstly, the cost of private residential care on a weekly basis is significantly greater than the cost of alternative forms of care. Secondly, for reasons of availability of residential centres, many children were being placed outside of their own localities and thus losing contact with crucial systems and relationships. Thirdly, there was a lack of evidence of clear alternatives and an interest in exploring what opportunities may have been missed in the profile of young people included in the research. Overall, the intention was to explore whether better outcomes could have been achieved for the young people profiled and to inform ongoing policy and practice developments within Tusla as part of its suite of universal and targeted services As indicated in the objectives listed below, the views of young people and families were deemed crucial to this study and a mixed methods approach was applied to ensure learning from both quantitative case file data and qualitative data from children and families, practitioners and policy actors at regional and national level.

Within this context, the research objectives were agreed with representatives from the two designated regions and the National Office for Children's Residential Services. The overall gatekeeper for the research was the Director of Children's Residential Services. The contact point and designated gatekeeper for Phase one was the Senior Manager, NPPT, Children's Residential Service.

Research Objectives

The agreed objectives of this research were as follows:

1. To describe the current usage of private residential care placements for children and young people in Tusla in the two regions: West–Northwest and Dublin Mid-Leinster.
2. To identify any relevant trends or patterns in this usage from 2015 to commencement date of research (March 2022), with an emphasis on understanding the decision-making process leading to the use of private placements.
3. To provide a profile of the cohort of children and young people being provided with private placements.
4. To identify any trends or patterns in the case histories of this cohort of children and young people.
5. To identify any missed opportunities for the provision of prevention and early intervention services to this cohort.
6. To summarise what is known about international best practice in supporting permanency for this cohort of children and young people.

7. To explore the experiences of children, young people, parents/guardians, staff social care and social workers and aftercare workers. Tusla management, Private Residential Care (PRC) management and policy actors with responsibility for alternative care will also be consulted for their views.
8. To make recommendations for improving the approach of Tusla to providing the best possible care, support and outcomes for this cohort.
9. To recommend a framework for ensuring the decision-making process on the use of private placements is as robust as possible. The type of framework will emerge from the data analysis, findings and literature reviewed.
10. To inform the implementation of the Creative Community Alternatives (CCA) and Tusla Therapeutic Services (TTS) as these relate to this cohort to give them an insight into the experiences of PRC and the decision-making processes involved, which are directly related to the work of the CCA and the Therapeutic Services.

As explained in more detail in Chapter 3, which details the methodology employed, this study was made possible by excellent cooperation with Tusla representatives and the support of the office of the National Private Placement Team (NPPT), especially relating to Phase One of the study. However, it was also adversely affected by a number of significant delays, particularly the Covid-19 pandemic and the cyberattack on Tusla and related organisations, which occurred during the course of the study. This impacted negatively on capacity within the system to engage with the research process and to extract the necessary data to inform the study questions. This time delay also meant that other national developments have occurred that superseded the intentions of this research to inform national policy – most notably the publication of the Strategic Plans for Residential and Foster Care Services 2022–2025. The discussion and conclusions of the research take into account the Strategic Plans to contribute to their enhancement. Another major limitation of this study was the extremely low response rate to the qualitative aspect of the study from centres willing to participate and practitioners from Tusla being available to engage with the work. Despite significant efforts to recruit, we had a very disappointing response for the qualitative aspect of this study. Given the complexity of the issues, and the importance of gaining a better understanding of decision-making processes to inform future practice, this has limited the potential value and richness of the study. Participation in research such as this is extremely challenging for busy organisations and professionals, and for future studies, greater attention could be paid to how to ensure engagement with commissioned research so that the significant investment and commitment given to this study by those leading it from within Tusla pays dividends with regard to the results provided.

The remainder of this introduction provides a glossary of terms and definitions relating to different care arrangements. Following this, Chapter 2 outlines the context of private residential care in Ireland, setting it alongside international trends. Chapter 3 outlines the methodology of the study, which was carried out in two phases: a quantitative analysis of case file data and a qualitative study involving young people, residential care workers, social workers and relevant Tusla management personnel. Chapter 4 provides an overview of international research relevant to this study. Chapters 5 and 6 report the findings from Phases One and Two, respectively. Chapter 7 discusses the implications of the findings for the objectives, and outlines recommendations from the research.

Definitions of Terms

A number of terms used throughout this report require definition and are outlined here. While there is considerable variation in both living conditions and caregiving environments across different care settings, in line with the UN definitions there are generally two main

types of alternative care setting. These are referred to in the literature as 'family-based' care, and care that is 'not in the home of a family'. The two main forms of 'family-based' care are kinship care and foster care. In terms of care settings that are not family-based, two of the main types are residential/institutional care and supervised independent living arrangements (Petrowski, Cappa, and Gross 2017).

As indicated below, within this differentiation, there are many different ways to describe care practices pertaining to children who require protection by state systems: alternative care, out-of-home care and looked-after children. In addition, definitions of types of alternative care are generally categorised as formal or informal, family-based arrangements and non-family-based arrangements. The differing definitions in terms of the types of care placement make comparisons difficult. For example, the UN Guidelines do not define clearly the terms related to alternative care (Lerch and Nordenmark Severinsson 2019). The terms *residential care* and *institutional care* for example are used interchangeably in many countries. In some languages, there is no difference between these two terms. The term 'alternative care' is used in some countries as meaning 'alternative to institutional care', whereas in others it refers to the full provision of care placements.

Conceptualising 'alternative care' is somewhat challenging (Roby 2011). A review of pertinent literature in this area suggests that across the globe, there is variation in the use of language to denote 'care', and differing constructions of care (Courtney and Thoburn 2017). In addition, variations exist within countries. In Canada for example child welfare services fall under the jurisdiction of provincial and territorial authorities (Mulcahy & Trocmé 2010) and there are notable variations in the definition of what they term 'out-of-home care'. Overall, the terminology and typology of care placements are often not harmonised nationally and certainly not at European level (p. 15) or internationally. Thoburn (2022) highlights the complexity of comparison between countries given the many, sometimes subtle, differentiations between different concepts and how they are applied to data gathering and analysis, referring to it as the 'complex jigsaw of context' (2022, 16).

In general, alternative care is divided along two lines: formal care and informal care arrangements. Bearing this in mind, the terms below are indicative and subject to further scrutiny and clarification.

Definitions of 'Care'

The UN Guidelines for Alternative Care defines formal care as:

> all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures (2010, p. 6).

Informal care is defined by the Guidelines as:

> Any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body (2010, p. 6).

UNICEF (2020) categorises these definitions further; with respect to the environment where the care is provided, alternative care maybe one of the following.

Special Care

Special Care is short-term, stabilising and safe care in a secure therapeutic environment. In Ireland, young people referred to Special Care Services are between 11 and 17 years and usually have complex psychological and sociological profiles. Many will have had high numbers of previous placements which have broken down. The aim of the Special Care intervention is to provide an individualised programme of support and skilled therapeutic intervention which will enable the child/young person to stabilise and then move to a less secure placement based on the assessed needs of that child/young person. Given the restriction on the child/young person's liberty, a placement in Special Care can only be made pursuant to an Order of the High Court (Tusla, n.d. a, 2002). Special Care Units differ from general residential care in a number of ways: the units are secure, the child is detained, the units offer higher staff-to-young person ratios, education is on-site and there is specialised input such as psychology services. The child is not detained as a result of criminal offences, but for their own safety and welfare (DCYA 2019).

Residential Care

Residential care is a form of group care for children who are looked after, where care is provided by teams of paid staff. This may be arranged under a Care Order or a voluntary agreement. Children's Residential Services aim to provide a physically, emotionally and psychologically safe space for children and young people.

The majority of children and young people placed in children's residential services are there because of family problems, adverse experiences or some other form of abuse or behavioural management. Children's residential centres are staffed on a 24-hour basis by social care workers, Leaders and Managers. Centres are supported in their efforts to look after the children and young people in their care by external managers, Social Work Services, Inspectors, Monitoring Officers and others, including An Garda Síochána (Tusla, n.d. b, 2020).

Residential care services take into account the needs and wishes of the individual, weighed against the resources and policies of statutory agencies. There are various residential care options available, depending on the needs of the individual.

Residential care institution

A residential care institution is a collective living arrangement where children are looked after by adults who are paid to undertake this function.

Children in public institutional care broadly refers to children under the full-time care of the State either on a permanent or temporary basis. Children in ***non-public institutional care*** are children in and other NGO-run services, financed in total or in part by non-state sources.

Public residential care

Public residential care includes infant homes for children aged 0–3 years, children's homes for children without parental care, institutions for children who are physically/mentally disabled, and family-type homes where caregivers live with children who do not have parental care. Public residential care also encompasses general boarding schools that are fully state funded. This refers to children who are under full state support. Temporary placement centres/shelters are institutions that provide emergency care and short-term accommodation for children without parental care. Children in these structures will either be returned to their family or referred to social services.

Private residential care

Tusla funds private residential care through contracts and/or service level agreement. Private residential services offer placements to young people whose needs cannot be met within Tusla or voluntary services. These placements offer higher staffing levels, lower occupancy, enhanced on-site clinical supports and education, and specialised services designed to meet the needs of children and young people.

Private Care

Foster care is full-time or part-time substitute care of children outside their own home by people other than their biological or adoptive parents or legal guardians. Foster care can be provided by the State (i.e. Tusla – the Child and Family Agency) or by non-statutory, voluntary or private fostering agencies. All foster carers, regardless of the method of recruitment, must be approved by Tusla – the Child and Family Agency prior to any child being placed with them (IFCA, n.d.).

The literature suggests that foster care can also refer to placement settings such as group homes, residential care facilities, emergency shelters, and supervised independent living. However, for the purposes of this study foster care refers to a temporary service provided by the State for children who cannot live with their families. Children in foster care may live with relatives or with unrelated foster parents (Child Welfare Information Gateway 2020).

Family-based Care

Foster care: Provision of parental care to children not related through legal or blood ties. The term 'foster care' refers to formal, temporary placements made by the State with families that are trained and supervised by social services. Foster parents normally receive a special fee or allowance.

Guardian care: care provided by a guardian who is the legally appointed adult representative for a child. Guardians in most cases are relatives. However, the nature, process and duties associated with guardianship vary from case to case and from country to country. Decisions on guardianship are made by a family court, guided by family law. As the State has no duty to finance guardians, special fees or allowances are, in many cases, not available for guardians.

Other types of family-based care include informal kinship care, which is full-time care of a child by a relative or another member of the extended family (this type of arrangement is typically made without formal legal proceedings and is unregulated by the State), or other types of care arrangements where children live in a family setting. In the context section that follows, the terminology and definitions relating to this study are explained further as they pertain to Ireland specifically.

Chapter 2: Context of Private Residential Care in Ireland

Introduction

In Ireland, Tusla has a statutory responsibility to provide alternative care arrangements under the provision of the Child Care Act 1991, the Children Act 2001 and the Child Care (Amendment) Act 2007. Alternative care is defined by the UN as 'all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment' (UN Guidelines for Alternative Care 2010, 6). This chapter provides the context for the study. Data is mostly based on the period of the study, circa 2021–2022. For further updated statistics, please see Tusla Performance and Activity Reporting Site Tusla – Child and Family Agency.

In 2022, over 89% of children in alternative care were in foster care settings (Tusla 2022b). In May 2023, 6.9% (386) were in residential care and 2.9% (162) in 'other' care placements. Of the 386 children in residential placements, 2.8% were in 'Special Care' (Tusla 2023, May Performance Data). In January 2023, 223 children were in private residential placements, down from 269 in January 2022 (Tusla 2023, May Performance Data).

Ireland's current child welfare system reflects many trends with systems in other jurisdictions. This includes an emphasis on preventing children coming into care, through increased emphasis within policy and practice on family support, partnership, and solution-focused and family-centred practices (O'Brien and Cregan 2015). Where alternative care is required, there is a recognition that children can have complex needs that warrant a range of responses. While there is no set definition of what a 'complex need' is, it usually refers to situations where two or more specific needs are present and interacting. These may include needs relating directly to a child (e.g. because of behavioural, psychological or trauma related issues), their carers or guardians (like family violence, substance abuse, poverty) and the wider context (e.g. lack of suitable services to respond). According to Gilligan (2019), Ireland, along with Australia, has one of the highest rates of family placement (foster family care and formal relative or kinship care) in child welfare and protection systems globally. This high rate of family placement makes Ireland an interesting case study for global policy in this area in terms of Ireland's move from high use of institutional care historically to high rates of family placement in the present day (Gilligan 2019).

Worldwide, different historical trajectories and societal views have influenced the development of current models of alternative care (Petrowski et al. 2017; Beard et al. 2022; Van Ijzendoorn et al. 2020; Goldman et al. 2020). More information about these trends is provided in Chapter 4. In Ireland, the focus has been firmly on deinstitutionalisation from the 1970s onwards, following the 'Kennedy report' on the industrial and reformatory schools in 1970 and the commencement of the Health Act 1970, which led to the expansion of statutory community care services, including child and family support. While slow at first to embed as reflected in the Task Force on Child Care (1980), a clear and deliberate shift in policy and practice relating to modes of family-based care in Ireland can be traced from the 1970s to the present (Devaney and McGregor 2017; Skehill 2004). This trend preceded the revelations of widespread abuse that occurred within the industrial and reformatory schools in Ireland (Raferty and O Sullivan 1999). However, the disclosure of systematic and enduring abuse and neglect of children in Ireland's institutional care homes, mostly industrial schools and a smaller number of reformatory schools, as reflected in the Ryan Report (2009), has led to huge reputational damage to the very nature of residential care that affects those still delivering such services in the present day. Despite the development of new standards and scrutiny within residential care, it still occupies a 'contested space' in Ireland (Brown et al. 2018). This history has contributed in the present to a culture of fear and continued negative

perceptions about 'residential care' that can cause challenges within the current system to recognition of its value and suitability for certain cohorts of children and young people. As Gilligan (2022, 109) argues '(T)he Ryan Commission's report dealt a decisive further blow to the reputation and prospects of residential care as a field of provision within child welfare. The passage of time may eventually serve to reduce this, but for now, the tainted view of residential care in the public mind is firmly embedded' (p. 109). Brown et al. (2018) and Cahill et al. (2016) consider the implications for residential care work in Ireland, and as discussed further in Chapter 4, identify the challenges to and opportunities for improving relationships and decision-making in the sector in the present day.

Issues about the specific use of private care have been of particular concern within Irish services in recent years. In 2021, Tusla's then Chief Executive Mr Bernard Gloster agreed that there was a concern around reliance on private providers, with specific concern about the ability of private providers to withdraw from the residential care sector and the challenges that that would pose:

> if that private provider left the market, the state has only one option and that is for us to take over that provision there and then, and you are into very complex matters of employment law and transfer undertaking and lots of other things (Gloster, as cited by Baker 2021).

In 2022, Gloster also argued that the way private residential care was regulated needed to be reviewed, stating that:

> I do not agree that we should be the regulator for private residential care, because we also provide it. It is one of the greatest possible contradictions of governance … We are the provider of public residential care, the funder of all residential care, the overseer of the placement of children in all residential care, the commissioner of private residential care, and the regulator and inspection and registration service for private services. It is a fundamental contradiction, and it is problematic (Gloster 2022).

This concern about over-emphasis on the use of private residential care has led the organisation to set targets to reduce reliance on private care by at least 50% by 2025 and 40% by 2027.

Tusla's current Strategic Plan for Residential Care Services for Children and Young People (2022–2025) establishes the agency's position regarding residential care in general and the use of private residential care in particular for Irish services. It summarises 15 main challenges regarding the current provision of residential care which resonate with international literature and with many of the findings of this research as discussed later. These include the fact that, while overall numbers of children in care are decreasing, the numbers in residential care are increasing and so too is the duration of time spent in care. Another challenge is the increased cost of service provision, especially the rising and substantial cost of private residential care. Increased reliance on the private sector was a related concern as was the lack of a sufficient supply of placements and increased demand for emergency placements, respite places and residential placements for young people at the age of 18. The increase in the complexity of need among young people requiring residential care, inconsistent models of care, variations in regulation processes, fragmented referral processes, difficulty tracking occupancy capacity and lack of Therapeutic Services are also identified as challenges. Inadequacy of permanency planning and issues relating to staff recruitment and retention were also noted (Strategic Plan for Residential Care Services for Children and Young People (2022–2025) pp. 29–36).

In her foreword to the strategy, Kate Duggan, then National Director of Service and Integration, outlined that:

> The evidence is increasingly clear that for a small but increasing cohort of young people we are not adequately meeting their needs, with more reactive approaches, an overreliance on private residential placements and a significant increase in the number of local, non-procured, emergency residential care arrangements. It is clear from our data, that to better respond to the needs of these children and young people, we must increase our preventative and early intervention services, strengthen our foster care and residential care services, and better support young people as they transition to aftercare services (Duggan 2022, p. 2)

Duggan goes onto acknowledge 'that private provision in alternative care, like other care groups in health and social care services, will continue to be part of the Agency's response into the future. However, it is evident that our current dependency on private residential care, 60:40 private: public provision, is unsustainable and carries several risks. Our ambition over the next three years, as detailed in this plan is to incrementally reverse our disproportionate dependency on private residential care, increasing our public residential capacity by an additional 104 beds, to achieve 50:50 private: public provision by 2025' (Duggan 2022, p. 2).

In sum, Tusla recognises that it continues to require residential care services for certain cohorts of young people in some instances, but for the most part, preventative, early intervention or family-based care arrangements are deemed more appropriate. Where residential care is needed, the position is that there should be a reduction in the use of private residential care and an increase in public capacity. Moreover, the model of care recommended is one focused firmly on return to family care. As set out in the Strategic Plan for Residential Care Services, 'the first day in Residential Care should be the first day of the plan to get the child to transition to a family structure, either parents, extended family, or foster/adoptive family, thus enabling every child to grow and flourish in the safety of a family environment and experience the sense of belonging that comes with being part of a family' (2022, 37).

Relevant Data and Statistics

Section 8 of the Child Care Act 1991 (as amended by the Child and Family Agency Act 2013) requires Tusla – the Child and Family Agency to prepare an annual report on the adequacy of childcare and family support services available and submit it to the Minister for Children and Youth Affairs (Tusla 2016). For the purposes of this section, data is taken from Tusla's Quarterly Service Performance and Activity Report from September 2022 (Tusla 2022c) and Tusla's Strategic Plan for Foster Care Services 2022–2025 (Tusla 2022b).

Children in Care September 2022

Data on children in care available from Tusla – Ireland's Child and Family Agency, is contained in the agency's monthly performance data.

- There were 5,810 children in the care of the State at the end of September 2022, 1% (31) fewer than the same period last year (5,841).
- Sixty-three per cent (63%) (3,690) of children were in general foster care; 26% (1,481) were in relative foster care; 7% (432) were in general residential care; 1% (14) were in special residential care; and 3% (193) were in 'other' care placements.
- 14.8% (858) of children in care at the end of September 2022 were in placements with private providers, 2% (14) more than the same period last year. 59% (506) of those

(858) children were in foster care placement with private providers and 29% (246) were in private residential care, the categories of care which are the focus of this study.

Residential Care

According to Tusla (2022b) there are currently 177 residential care centres, comprising Tusla-owned centres, community and voluntary centres and private centres, which account for 11% of overall alternative care placement provision. Of the 177 residential care centres in Ireland there are: 37 Tusla Mainstream Centres; 3 Tusla Special Care Centres; 25 voluntary centres; and 112 private residential care centres. Private centres make up 63% of all residential care providers (Tusla 2022). These centres are a mix of domestic-style homes in housing estates, villages, towns, cities and rural areas across Ireland. The centres typically have between two and six children/young people being cared for. Where possible they attend local schools and are supported to take part in local sporting and community activities. Services aim to provide a physically, emotionally and psychologically safe space in which children and young people can heal, develop and move forward in their lives.

The requirements for placing a child in a children's residential centre and for the running of these centres are laid out in the Child Care (Placement of Children in Residential Care) Regulations 1995. The Child and Family Agency both registers and inspects voluntary and private (for-profit) children's residential centres (Devaney and Rooney 2018). Service providers are also guided by the Good Governance Framework (Tusla 2019), which includes financial, budgetary and ethical issues, and by Tusla's Commissioning Strategy 2019–2023, which includes a Commissioning Decision-Making Tool (Tusla 2019).

Private residential care

At the end of Q4 2022 there were 251 children in residential placements with private providers (Tusla 2022). Tusla funds private residential care through contracts and/or service level agreement. In 2014, Tusla established a dedicated National Private Placement Team (NPPT) to commission private residential services in response to demand. According to Tusla, private residential services offer placements to young people whose needs cannot be met within Tusla or voluntary services. Tusla has suggested that private residential services can offer higher staffing levels, lower occupancy, enhanced on-site clinical supports and education, and specialised services designed to meet the needs of children and young people (Branigan and Madden 2020, 20–21).

Even though it represents a relatively smaller proportion of overall placements, residential care costs represented approximately 25% (214.10m) of the total expenditure by Tusla in 2021 (867.10m). From 2015, the cost of private provision has risen by 21% (an increase of 15.36 million). Special care services and Tusla provision have also increased by 17% (an increase of 2.17 million) and 25% (an increase of 10.23 million), respectively. Gilligan (2022) highlighted Tusla's overreliance on the use of private residential centres, which has been described by Tusla's Chief Executive as a risk for the care system should any of those providers fail financially. The increasing reliance on the private sector is influenced by an ongoing lack of availability of suitable placements to meet the complexity of need. It is also associated with difficulties in recruiting non-relative foster carers to ensure sufficient supply of alternative options (Gilligan 2022). The most recent Strategic Plan for Residential Care Services 2022–2025 makes a commitment to reduce reliance on private residential care to 50% by 2025.

Special care

As noted earlier, 'Special Care' part of a continuum of state residential care available to children and young people. The aim of the Special Care intervention provision is to provide

an individualised programme of support and skilled therapeutic intervention which will enable the child/young person to stabilise. Subsequently they may be moved to a less secure placement based on their assessed needs (Devaney and Rooney 2018). Given the restriction on the child/young person's liberty, a placement in Special Care can only be made pursuant to an Order of the High Court. Tusla, – the Child and Family Agency operates and maintains three Special Care Units, two of which are situated in Dublin and one which is situated in Limerick (DCYA 2019). Special Care Units differ from general residential care in a number of ways: the units are secure, the child is detained, they the units offer higher staff staff-to to-young person ratios, education is on-site and there is specialised input such as psychology services. The child is not detained as a result of criminal offences, but for their own safety and welfare.

At the end of Quarter 1 2020, Tusla reported that 13 children were resident in Special Care Units in Ireland, representing 0.2% of the 5,968 children in care (Tusla 2020). At the end of Quarter 4 2022, 5,759 children were in the care of the State (compared with 5,862 at the end of 2021). Of these, at the end of Quarter 4 2022, 5,112 (89%) were in foster care (general and relative foster care) and 874 (15%) were in private residential care placements (Tusla 2022d).

Placement abroad

Aside from residential and Special Care Units, children in state care in Ireland can be placed abroad in out-of-state placements depending on their needs and circumstances. Tusla (2018) maintains that 'children placed abroad are generally those requiring placement with relatives who happen to live abroad and those requiring highly specialised care currently not available in Ireland, e.g., specialist, secure, forensic mental health services and therapeutic residential services addressing specific needs identified in the child's care plan'. In seeking such specialist placements, the needs of children are prioritised over the location of placement (2018, 58).

At the end of May 2020 there were 20 children in a placement outside of Ireland. Children in placements abroad account for 0.3% of the total number of children in care (Tusla 2020b). In Q2 2023, 12 children were in out of state placements account for 0.2% of overall figures for children in care (Tusla, 2023).

Service for Separated Children Seeking International Protection

In some countries, as discussed in Chapter 4, residential care services have expanded or been targeted to respond specifically to the need for care of separated children seeking international protection. In Ireland, the data and context discussed here *excludes* Tusla services for separate children seeking international protection. Most care arrangements offered for separate children include foster care or supported lodgings, although use of registered residential care settings is also a stated option (Separated Children Seeking International Protection Tusla – Child and Family Agency)

Conclusion

Over a five-and-a-half-year period, 2017 to Quarter 2 2022, the number of children in care has decreased, with 6% (360) fewer children in care in 2022 than in 2017. The same period also shows a decrease in the number of children in foster care by 9% (490). However, the number of children in residential care during that period has risen by 20% (71) while the number in other care placements has also risen, with 46% (59) more children in those placements. Tusla's Strategic Plan for Residential Care Services for Children and Young People 2022–2025 notes this trend: 'while the total number of children in care is decreasing,

the total of children entering residential care is increasing and the distance children are from their family/community is increasing' (2022, 5). Moreover, the increased reliance on private providers increases risk from the perspective of value for money, but also sustainability. There is a risk that private providers will exit the market, causing significant disruption to children and young people and leaving major capacity gaps. Tusla, through its Strategy for Residential Care Services, has set a target to reduce the use of private residential care to 50% of overall provision by 2025 and 40% by 2027. However, even if this is reduced, and even if progress continues to be made in early intervention and prevention of admission to care, residential care will continue to be an important part of the alternative care continuum. The challenge is to consider how this can be delivered to young people in a way that best meets their needs for protection and support. This project, as set out in Chapter 3, aimed to contribute to informing policy and practice based on learning from international contexts, selected quantitative data and qualitative interviews. Since this project was carried out, there have been further developments within Tusla of the following services referred to further in recommendations relevant to the outcomes of this study:

- There is a process of planned reform under the Local integrated Service Delivery Programme which is seeking to move towards more integrated working across the existing response pathways through the greater integration of practice, processes, teams and other available community network resources. Any recommendations from this study should take account of this current development.
- Tusla Therapy: Tusla now provides therapeutic services relating to the psychological welfare for children in care and their families as per Section 8(3)(c) of the Child and Family Agency Act 2013. Area based teams are being developed with six learning sites now established. A standard operating procedure developed and agreed, and a seven-step process is undertaken by area-based therapy team in conjunction with the team around the child. An integrated framework has been drafted for consultation to capture Tusla's approach to provision of therapeutic services, including its aims of providing clear coordinated pathways for children based on their assessed need, along with consistent, quality and integrated service delivery.

Services are provided across four strands:

1. ACTS (Assessment Consultation Therapy Service) provide a multidisciplinary the approach for children in or at risk of special care or detention.
2. NIAP (National Inter Agency Project) provides assessment and interventions to children who display harmful sexual behaviour.
3. Area Based Therapy Teams - a new initiative for 2023 whereby multidisciplinary input into care planning takes place on admission to care for all children in six learning sites across the country.
4. Local area provision – a mix of Tusla provided, Tusla funded and privately procured service provision to meet the needs of children in care and their families. This includes a wide range of provision from psychology, speech and language therapy, occupational therapy and various modalities of counselling/psychotherapy.

Creative Community Alternatives established in 2017 aimed at providing alternative responses to young people at risk of placement in care or already in care has continued to develop. As outlined in the Creative Community Alternatives Report (2022) it is a holistic service, designed to meet the identified needs of children, young people, caregivers, and siblings and to address a range of life areas through the team-based planning and implementation process, within the community. CCA also aims to develop the problem-

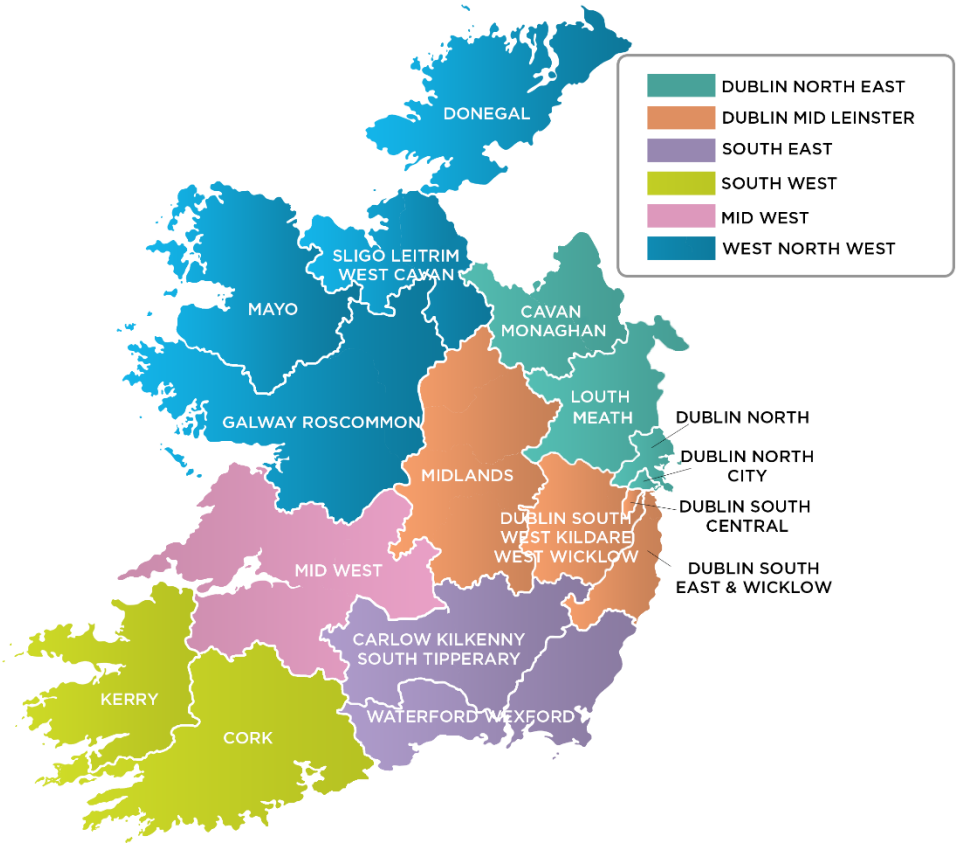
solving skills, coping skills, and self-efficacy of the young people and family members. There is an emphasis on integrating the youth into the community and building the family's social support network. CCA has been sustained throughout all Tusla regions since its inception in 2017.

The First Five Implementation Plan 2023-2025 (Government of Ireland, 2023) outlines the First 5 Big Steps Vision for early childhood reflecting an advancement of the commitment to early intervention, prevention and family support. As part of the development of a model for Parenting support, a national approach to publicly funded home visiting has been developed and is funded through the Children's Fund (https://www.gov.ie/pdf/?file=https://assets.gov.ie/262344/76abc825-1685-4ccc-a392-e00bd283dbbf.pdf#page=null). Other important steps include a package of measures to tackle early childhood poverty. See gov.ie - First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028 (www.gov.ie)

Chapter 3: Methodology

This is an exploratory study of the use of private residential care in two regions in Tusla: The West–Northwest region and the Dublin Mid-Leinster region.

Figure 1: Tusla regions



Private residential care relates to use of care 'contracted out' by Tusla. The intention of this study is an in-depth exploration of the issues that will inform national and regional policy and practice in this area. The desired outcome from the review is to produce findings that can inform a clear framework for Tusla national and regional management teams to enable the best possible decision-making at national, area and regional level in relation to the care of this specific cohort of children and young people.

The study was commissioned by Tusla, and the objectives and methodology were agreed in partnership with the lead representatives from Tusla including the office of the Director of Children's Residential Services, the National Private Placement Team and the Regional Chief Officers/Area Managers from the two areas. The study was approved by the University of Galway and Tusla, and, as detailed below, required careful consideration in relation to all phases of the research. The approval process included DPIA (Data Protection Impact Assessment). In the section to follow we outline the details of Phase One and Phase Two, and throughout highlight the ethical considerations that were considered in the process of research design, strategy and process.

The study took a broad systemic approach to looking at the issues from micro to macro level. It began with Objective 6: 'To summarise what is known about international best practice in supporting permanency for this cohort of children and young people'. The approach to the literature review and overview of literature is provided in Chapter 4. The main part of the

study consisted of two empirical phases. Phase One involved collation of quantitative data and Phase Two involved a follow-up qualitative phase, as detailed below.

Phase One: Quantitative Study

Aim of Phase One

The aim of Phase One was to establish and collate internal Tusla data already available and accessible to the Director of Children's Residential Services which provided a profile of young people in private residential care. This internal data refers to the National Private Placement Team referral files. These files provided point in time data regarding usage of PRC in the two regions (for 127 children and young people) and background information about each person that was used to identify trends or patterns in the usage of PRC and decision-making that led to this. The data was also used to help identify patterns in case histories and any missed opportunities. This data related to children and young people in Private Residential Care as of February 2022 which the NPPT selected as being in PRC in the 2 regions at that time. Given the sensitive nature of the data and in consideration of ethics and the General Data Protection Regulation (GDPR), a template of information required by the research team was forwarded to the Senior Manager for Children's Services to be completed internally. Appendix 1 provides details of the information sought from the referral files. This template was informed by the literature review and sought to capture as much relevant data as possible to address the research questions for the study in line with the objectives below. In total, 127 anonymised templates were returned to the research team between June and October 2022. Appendix 2 provides a summary of templates received.

Objectives of Phase One

The objectives of Phase One were to contribute to the first five research objectives as follows:

1. To describe the current usage of private residential care placements for children and young people in Tusla in the two regions (Tusla's West–Northwest Region – Galway/Roscommon, Mayo/Sligo/Leitrim and Donegal, and Dublin Mid-Leinster – Dublin South, West Kildare, West Wicklow and the Midlands).
2. To identify any relevant trends or patterns in this usage, with an emphasis on understanding the decision-making process leading to the use of private placements.
3. To provide a profile of the cohort of children and young people being provided with private placements.
4. To identify any trends or patterns in the case histories of this cohort of children and young people.
5. To identify any missed opportunities for the provision of prevention and early intervention services to this cohort.

Data Preparation – Phase One

In order to safeguard the data received from Tusla, the UNESCO Child and Family Research Centre (UCFRC) received ethical approval from both Tusla National Research Office and the University of Galway following a comprehensive process of consideration that involved the UCFRC, the University of Galway's research office and Tusla's research office, and which took sixteen months to complete. In addition to these ethical approvals the UCFRC completed a Data Protection Impact Assessment (DPIA). The General Data Protection Regulation requires assessment of the impact of a study on the protection of personal data (4(1)). The DPIA was required to ensure that all risks arising from the processing of the data were identified, assessed and mitigated. The DPIA for this study was reviewed and approved

by Tusla's Data Protection Officer. Overall, the approval processes for the study took approximately two years to complete.

The information required for this phase of the research was provided by Tusla under the supervision of the Senior Manager, NPPT, and Children's Residential Service. This person was also responsible for the anonymisation of the data. In consideration of both the ethical and GDPR requirements the UCFRC developed a template of the information needed to meet Objectives 2 and 3 of the research. The template was piloted with the NPPT and was amended to include further information to meet the objectives. It was then populated by the NPPT staff and returned to the researchers over the course of 5 months (June 2022 to October 2022) in fully anonymised, encrypted files. A total of 127 files were received by the research team.

Data Analysis – Phase One

The 127 case files were collated into one Excel spreadsheet and then further analysed in order to:

- Develop a profile of young people currently in PRC in Dublin Mid-Leinster (DML) and West–Northwest.
- Identify trends/patterns in order to understand the decision-making processes for placement in PRC.
- Identify trends/patterns in case histories; identify any missed opportunities for prevention/early intervention.

Analysis of the templates utilised in this study mainly focused on frequency distributions and response patterns, with some qualitative analysis. 'To protect the identity of the children and young people, only general patterns are reported. Cross-tabulation of data with individual case histories was not carried out to avoid any risk of identification of individual pathways. It is noted that while important for ethical reasons, this did limit the scope for making cross-tabulation for more in-depth analysis. Also, the overall dataset, while useful to illustrate trends and patterns, was limited in relation to our ability to provide a full picture of the whole history of decision making in relation to the child. The results of Phase One are reported in Chapter 5.

Phase Two: Qualitative Phase

Aim of Phase Two

The aim of Phase Two was to interview key stakeholders to a) provide further findings for Objectives 4 and 5 set out above, b) To explore the experiences of children, young people, parents/guardians, staff social care and social workers, aftercare workers and consult with Tusla management, PRC management and policy actors (objective 7). Overall, the findings then informed Objectives 8–10 below.

8. To make recommendations for improving the approach of Tusla to providing the best possible care, support and outcomes for this cohort.

9. To recommend a framework for ensuring the decision-making process on the use of private placements is as robust as possible. The type of framework will emerge from the data analysis, findings and literature reviewed.

10. To inform the implementation of the Creative Community Alternatives and Tusla Therapeutic Services as these relate to this cohort. To give those services an insight into the

experiences of PRC and the decision-making processes involved, as this is directly related to the work of the CCA as well as the Therapeutic Services.

Phase Two – Recruitment

The office of the NPPT, under the direction of the office of the Director of Children's Residential Services, issued an email from the UCFRC detailing the study. Recruitment was carried out through a gatekeeping process in line with the agreed ethical approval. When service providers expressed an interest, they did so through e-mail directly to the researchers (or gatekeeper which was then shared with the researchers). The researchers then discussed any queries directly with the service providers. All queries and any concerns were discussed directly with the service providers.

Seventy-eight emails were issued to 78 PRC centres from 23 organisations/service providers with some having residences in different areas. Those interested in participating in the study were asked to contact the researchers directly.

Sixteen PRCs responded, and an additional call for participation by the NPPT (due to the limited response rate) resulted in a further six responses. In total 22 PRC centres expressed interest in participating in the study.

Researchers in the UCFRC designed information packs to be distributed to the 22 PRC centres that responded to the call for participation. Each information pack contained:

- An age-appropriate flyer outlining the study and detailing our ask for the participants.
- An age-appropriate, accessible information leaflet detailing our ask for the study.
- Consent forms for all participants, with an extra consent form for parents to fill out to give permission for their children and young people to participate (see Appendix 5 for details on information packs).

Despite the concerted recruitment effort of the UCFRC research team and the office of the NPPT, only two different providers of PRC centres agreed to participate, one from each region. There were various reasons as to why centres could not participate. These reasons are detailed in Table 1 below.

Table 1: Reasons for non-participation

Children and Young people from either region had left the PRC centre at the time of data collection	Children and young people did not want to participate
PRC centre not operational	No consent from social worker
Family dynamics a barrier to participation	Time shortages

Tusla Gatekeepers also indicated via email to the researchers that "some" service providers had contacted them stating they were unable to take part due to staff shortages.

The details of those who did agree to participate are contained in Table 2 below by region.

Table 2: Professional participants by region

Director of Children's Services	
Senior Manager for Private Residential Care Placement Team	
DML	**WEST**
1 Service Director	1 Service Director
2 children (aged 13 and 11)	2 young people (aged 17 and 14)
1 Residential Centre Manager	1 Residential Care Manager
2 Residential Care Key Workers	2 Key Residential Care Workers
2 Social Workers, Child Welfare Service	2 Social Workers, Child Welfare Service

The purposely designed, age-appropriate information sheets were distributed by the PRC centre managers to the different cohorts who met the criteria set out, namely the children, young people, parents, key workers and social workers. The PRC centre managers assisted with selection of the children and young people based on the criteria. The keyworkers facilitated the children's and young people's participation by distributing the project information and being available to discuss this with them. The information sheets were designed to be accessible and informative (see Appendix 5).

Data Collection – Phase Two

Interviews with young people took place face to face in the young person's residential unit at a day and time that they identified as suitable. Gatekeepers were asked to distribute Parental Information Sheets and Consent Forms to parents as prepared by the Researchers. This was done where deemed appropriate. No parent approached agreed to participate. Also, due to the circumstances of the children's and young people's cases in the interested PRC centres, the appointed social workers deemed it inappropriate to contact the parents in some contexts. Moreover, consent for the interviews was given by the children and young people themselves and their respective social workers (in their role as guardian). This was agreed following consultation with the Tusla National Research Office.

Interviews were also held with the following stakeholders: (a) Director of Children's Residential Services (b) Senior Manager of PRC Placement Team (c) Service Director in the West and (d) Service Director in DML. Interviews took place at a day and time selected by them. Interviews with professional stakeholders were conducted using an online meeting platform as this was the method preferred by participants. This included key workers from the PRC centres and social workers.

Data Analysis – Phase Two

All qualitative data was inputted into the NVivo software package for the analysis of qualitative data. Data was analysed using Thematic Analysis (Braun and Clarke 2006), which is a method to identify, analyse and report patterns (themes) in data and reveal core consistencies and meanings in a text (Buetow 2010). It organises and describes elements of the research data but can also be used for interpretation.

Ethics

There were a number of ethical issues to consider in this study given that we were accessing data relating to young people and making contact with parents and children. As professional researchers, we were very aware throughout of our important duty of care towards all participants in this study.

The study was subject to Tusla and University of Galway ethical approval. A number of meetings were held with Tusla National Research Office to agree the ethical arrangements, in particular collection of data and access to participants.

Access to Personal Information

In order to fully adhere to the GDPR and ethical guidance on access to personal data, the researchers had no access to the personal information of young people and received anonymised data based on a designed template (Appendix 1). Phase One data collection was carried out independently by Tusla so that researchers were not involved in the data collection phase. Information in the database for Phase One analysis could not be traced back to individual participants, therefore no risk for participants or researchers was envisaged at this stage. Likewise, in Phase Two, all of the recruitment and contact with young people and families was carried out by Tusla staff. Minimal information, e.g., first name and location of centre, was made available to the researchers to enable them to conduct the interviews.

Consent

The information sheets (Appendix 4) provide details of how consent was sought. Consent was required from parents, if possible, for all children. Consent for children in care was given by Tusla social workers as 'statutory' guardians but best practice is that parents give consent and young people provide their assent. As stated previously the social workers deemed it inappropriate to obtain consent from the parents due to the circumstances of the children and young people's cases. We consider the issue of informed consent to be important in the context of this study. Seeking the informed consent or assent of the children and young people is particularly important, given their personal experiences are being sought.

We were very aware that participants may have felt discomfort about sharing the reasons for being referred to the care system in the first instance. Participants were informed that taking part was voluntary and that they could opt out of any of the phases of the study if they experienced distress or wished to do so. Anonymity and confidentiality were guaranteed. We recognised also that some young people may not want the parent/guardian involved in the study. We addressed this by ensuring that the young person would give consent to their parent/guardian being contacted in the first instance. However, no parents participated in the study; therefore, this did not occur. Assent from the children and consent from the young people was sought first. Where assent/consent was not given by the children and young people, the researchers did not pursue participation from those centres. Specific assent/consent was required from children and young people for the centre to participate.

Data Storage and Confidentiality

To ensure confidentiality, data was stored securely, and participants were informed that only the researchers had access to this. The data was held under the control of the main researchers, with hard copy data in locked filing cabinets and electronic data in password-protected computers stored on Office 365 OneDrive, with access only available to members of the research team. Interview recordings were the only data shared with a third-party transcriber. The transcriber for this project is known to and has worked for the UCFRC on

many occasions. In addition, all of those contracted by NUI Galway/University of Galway to provide data-processing services are contractually bound by NUI Galway/University of Galway GDPR Terms and Conditions, which are applicable to all suppliers/contractors/agencies/temporary workers/external examiners who process in any way personal data on behalf of NUI Galway/University of Galway. Moreover, all audio files were transferred to the contracted transcriber via a secure platform (HEAnet FileSender) provided by the University, which is only accessible via a password-protected university account. All apparatus utilised to fulfil our organisation's security obligations in the case of working from home was provided by NUI Galway/University of Galway. In regard to securing the data, databases were encrypted with passwords shared only between the Tusla data manager and researchers from the UCFRC. In terms of reporting, all participants were assigned identifier codes and all identifying information was changed. Data will be retained for five years after the end of the study in accordance with NUI Galway/University of Galway's Data Protection Policy and with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 (Article Five). After five years, the data will be removed from databases. Hard copies will be shredded by the professional services currently in use by the UNESCO Child and Family Research Centre. While we did not envisage any limits to confidentiality, under GDPR individuals have a number of rights, which include:

- The right of access
- The right to rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- Rights in relation to automated decision-making and profiling
- The right to be informed.

While no such requests pertaining to these rights have been received, participant information sheets contained details of two particular contact points for handling requests or queries from individuals, which is deemed the most efficient way for an individual to have their request responded to promptly. If the issue had arisen, researchers would have responded to an individual's request in the same way in which the request was made, or in the way in which the requester specifically asked for a response. Researchers would respond without undue delay and at the latest within 40 days of receiving the request, giving due regard to the data protection rights of other individuals who have participated in the study. Researchers would update individuals on the progress of their request and give them sufficient notice in advance of any potential delays or requests for clarification.

Potential for Distress

This study is about experiences of being in residential care and it is assumed that for young people it could certainly cause distress. In Phase Two, young people were asked to voluntarily provide details of their experiences. This could entail descriptions of challenges and difficult experiences, but it was for the participant to decide what they wished to speak about. It was recognised that participants may become distressed as they shared the difficulties they experienced at the time. The NUI Galway/University of Galway Protocol for Distressed Participants was in place to provide appropriate help and support for participants at any stage of this research study. There was also a support person available (e.g. social worker, residential worker) to provide additional supports.

Relevant staff were asked to provide accounts of their experiences and views of the Residential Care Process. Participation was voluntary, and data was fully anonymised. Participants were guaranteed that their participation or refusal to take part in the study would not have repercussions in their roles. Opinions and views were only reported as themes and the individual experiences of participants were not reported in any traceable way.

It was not envisaged that Tusla participants would experience distress during the research process; however, participants were informed that they could stop their participation at any time if they became distressed by the issues being discussed in the interviews. The distressed participant protocol was in place to respond to the needs of participants. This provided staff with information on public and institutional supports available to them.

Risks for Providers

We also recognised that there may be risks for Tusla and providers of residential care that must be acknowledged. There may be a negative impact for the organisation should a young person, family or practitioner imply that organisational factors in the residential care system directly impacted the stability and permanency of outcomes for them or their families.

Limitations

Phase One data gives a picture of the trends and profile of 127 young people in private residential care in the two regions. While this is very useful, we note there would be greater scope with more data linkages within the system and more comprehensive and consistent data to allow more in-depth analysis and cross-tabulation of data to determine specific pathways of decision-making and missed opportunities. This is an important issue to note for the future., Buckley (2012, 64) maintains that one of the key components of child protection intelligence is basic statistical information about the number of children in the care system, the needs of the children and the adversities that they face within a particular context. It is of benefit to compare this data internationally. However, the process of data linkage between sectors such as education, health and social services varies between Ireland and other countries, so direct comparisons can be limited. Traditionally, Ireland has been noted to lag behind in the processes of providing effective data linkages in two respects according to Buckley (2012). Firstly, Irish child protection data has been shown to be inadequate and inconsistent. Secondly, there is a problem concerning the 'disconnectedness' of information held by the various organisations that work with children and families (pp. 64–65). Such challenges have been noted in other Irish research; see Furey and Canavan (2019) and Devaney et al. (2020). Ongoing updates of the information systems, which were not in place at the time of this study, should lead to improvements regarding the opportunity to systematically connect and analyse data sets for further research and policy and practice development purposes.

Phase Two data provides very rich information in relation to the research topic. A major limit however was the low participation rate for Phase Two. Significant efforts were made with the PRCs to distribute and recruit for the study yet only four children and young people were included in the end. The lack of inclusion of parents is a major limitation to note. This then limited the number of social workers and key workers as the sample for inclusion was based on the number of children and young people who participated. Generally, the low numbers of other stakeholders engaged in the research limited the opportunity to collect more wide-ranging perspectives and contributions to inform the study. This indicates a need for future research commissioned by Tusla to consider how those involved could be supported and encouraged to participate more, as discussed in Chapter 1. Given the low numbers who participated in the qualitative study (16 respondents in total), the findings are not

generalisable but rather should be seen as illustrative based on the perspectives of those who participated.

Another limitation to note relates to the interviews with young people. While providing important data, it was not always appropriate or possible to discuss difficult subjects like entry to care and decision-making during care. Researchers ensured they would only discuss what the young people wished to talk about. Also, one of the children and young people had a significant learning disability and found it difficult to communicate their views effectively. The researchers were unaware of this prior to the interview taking place, and, in addition, the keyworker felt it was appropriate to stay with the child/young person during the interview. Other centres that also had children and young people with additional needs and difficulties around communication expressed an interest in participating in the study. While the researchers were fully willing to include these centres by utilising appropriate interview methods with the children and young people, the request for participation came after the deadline for data collection had passed. More generally, a limitation of this study was that it was not designed as a participatory study to include children, young people and families more actively. Centre managers or staff were not directly involved either. More active involvement in the design and set up of the research may have resulted in more active and involved participation in the research itself.

Another limitation of the study was the timeline and delays that occurred during the project. Covid-19 and the cyberattack in Tusla occurred during this study. This, with other factors, led to long delays in progressing this project.

Chapter 4: Learning from International Best Practice to Support Permanency and Decision-Making for Children and Young People in Residential Care

Introduction

One of the objectives of Phase One was to provide a summary of what is known about international best practice in supporting permanency for children and young people in residential care. A scoping literature review approach (Munn et al. 2018) was used for this study. The review focused on literature relating to the use of different types of care including cost of care and models of care. Search terms included residential, special residential, private care services and private residential care services for children and young people. The review also explored decision-making in children's residential care settings, and the processes, policies and procedures for decision-making and other supports for same. Research relating to alternative models of care for children and young people was also reviewed. Search terms included alternatives to residential (special) care, alternatives to institutional care, community models of care, foster care models and family placement models. A number of related themes relevant to decision-making in relation to residential care placements were explored including policies and legislation regarding the use of residential care, philosophies and principles informing use of residential care, and factors that ensure permanence and stability within a residential care process.

The research included the literature review in recognition of the importance of looking to international practices, in particular seeking out 'best practices. Generally, the purpose of looking at practices in other countries is to gain an understanding of what might help to reform the policies, systems and practices at home (Gilbert et al. 2011; Parton 2017; Furey and Canavan 2019; Merkel-Holguin et al. 2019; Berrick et al. 2022). Cross-national comparison is complex given the range of contextual, socio-historical and cultural differences that inform and shape child welfare institutional systems worldwide (Whittaker et al, 2022, b, Thoburn, 2022). For this literature review, direct comparisons are not made. Instead, a range of illustrative examples are discussed that help to inform our understanding of developing best practice relating to decision-making, support and permanency planning with children in residential care in general, and private residential care in particular.

Overall, the research evidence is compelling in its messaging regarding use of residential care that a 'one size fits all' approach is simply not possible (Whittaker et al, 2022a). There are complex reasons why different types of residential care are used and the range of residential care 'options' is varied and difficult to summarise given the variations across countries and time (Whittaker et al, 2022a). The range of purposes evolves over time, and in line with major factors influenced by economics, politics, history, social context, philosophy of care and societal context (ibid). As Thoburn (2022) suggests, this complexity should not discourage practitioners and policy makers from learning from other countries, but in learning from them, practitioners should realise there is no single country that has the 'right answer' (p. 24). The bottom line, she argues, is that 'there is no "right size" for the residential care sector' and that

> an overarching policy of keeping children out of residential care (residential care as a 'last resort') is no more appropriate than a blanket policy of routinely placing children in residential care when they first enter 'out-of-home' care (2022, 24).

While there is no single right answer, the research evidence reviewed is convincing that largescale institutional care should not generally be used. Where institutional care is in use, a clear deinstitutionalisation process should be in place. Where residential care is the

dominant form of care, it should be provided in smaller group and family-based units and usually alongside the dedicated development of a welfare system based on prevention and early intervention. This system should be focused towards reducing the need for alternative care in the first instance, and then, where care is inevitably needed in certain circumstances, decision-making about the placement should be informed by the needs and best interests of the child or young person. However, evidence shows that often decisions are driven by other external factors such as lack of available alternatives, poor training and support for those providing family-based care, lack of suitable policies to address wider socio-economic factors that increase risk of entry to care, failure to transform services proven to be unsuitable and detrimental to wellbeing for those accommodated in this way, and so on.

It is also clear that in many jurisdictions worldwide, private residential care has become a norm. The care may be part of a package of services also delivered by state or third sector/voluntary organisations as the main provider. This reflects a wider global trend towards the marketisation of care, and while the contradictions of providing care for profit need to be to the forefront in our critical appraisal of services, the major concern is to ensure that such services are delivered in line with what is known about the best possible practice. Providers must also be appropriately regulated, supported and integrated into the national and regional alternative care and child welfare and protection systems. While we cannot establish one model of 'best practice', there are many key principles and practices to learn from that can inform our goal of 'best' practice to achieve best outcomes for children, young people and their families. To capture the complexity, we set out discussion in the context of a systems approach. We use Uri Bronfenbrenner's ecological model, which has been applied to a range of relevant contexts relating to child protection and welfare services in general, and practice and policy relating to alternative care specifically (see for example Moran et al. 2017a). This includes reference to his original presentation of the ecological model to understand context (Bronfenbrenner 1979) in terms of micro-, meso-, exo- and macro-levels. In this context, micro refers to individual characteristics and experiences, meso refers to immediate interactions and relationships, exo refers to wider organisational relationships and processes, and macro refers to legislation, policy and procedures. In later work, chrono was added; this relates to changing trends over time such as changes in demand for care for children and young people and growth in the private residential care sector. Another important aspect of the ecological model, later developed as the bio-ecological model (Bronfenbrenner and Morris 1998, 2006), is the PPCT, relating to Person, Process, Context (as above) and Time. This aspect allows greater focus on interactions at different levels of the system: focus on the person and the process, for example, a young person and their key worker or social worker, and a focus on time, which helps with recognition of the relevance of past and present. In this chapter, we will draw attention to specific aspects of the ecological context in particular as relevant. For example, it is clear from key messages from research outlined below that issues to consider are:

- micro- and meso-focused issues regarding the child, young person and their immediate environment,
- exo issues associated with organisational polices and services,
- macro issues regarding law, policy and procedure and
- chrono issues regarding changing trends over time.

However, it is important not to simplistically 'split' these between micro and macro for example, as in many instances the issues are interconnected. For example, policies and procedures at exo level impact on the capacity of an individual social worker to build relationships at the meso level with young people. Or, micro factors affecting a person, like their behaviour, often result from relationships with family (meso) or inadequacies of

services (exo). In the discussion, we consider the application and adaptation of an ecological model in more detail and return to other aspects of the ecological system and related literature to demonstrate how it can be used to inform a decision-making framework based on the learning from this research.

The chapter is presented in two inter-related main sections to inform the research objectives. In each section, attention is paid to issues arising across the eco-system as relevant throughout. The two sections are:

- Overview of models and approaches to residential care
- Decision-making processes and practices to support permanency and stability for children in residential care.

Section 1: Overview of Models and Approaches to Residential Care

This overview is presented in four sections as follows:

- Key messages from research
- Overview of usage of residential care in selected international contexts
- Use of residential care for specific identified purposes and needs
- Specific issues relating to the use of private residential care.

Key Messages from Research

Residential care is frequently referred to in international literature as a last-resort placement when problems are so severe that other options have failed or are unavailable. However, there are a variety of rationales for the use of residential care that are supported internationally. For example, the UN Guidelines for the Alternative Care of Children (UN 2010) asserts that

> (t)he use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests (2010, 5).

Recognising that 'residential care facilities and family-based care complement each other in meeting the needs of children', the guidance asserts that 'where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall deinstitutionalisation strategy, with precise goals and objectives, which will allow for their progressive elimination' (2010, 5). This means that, internationally, use of large institutions should be eliminated, and smaller-scale group care and/or family-based foster and kinship care prioritised.

The 'Stockholm Declaration on Children and Residential Care', established by representatives from 80 countries in 2003, has been influential in establishing principles for provision of residential care in international contexts. The Declaration recognised the negative consequences of residential care, and called for community-based alternatives, reduction in the use of institutional care and the setting of standards for group care (Courtney and Iwaneic 2009 xi). In their introduction to an international overview of use of residential care, Courtney and Iwaniec (2009) suggested a reader of this Declaration may conclude that there is consensus on this matter, but they argue for recognition of the greater complexities involved. Concluding this volume, Courtney, Dolev and Gilligan (2009) reinforce this point showing how residential care, despite its critics, is 'alive and well' and remains a dominant form of care for many jurisdictions in the world. They make a compelling argument to support ongoing research into and understanding of why different types of care should be provided and for which children and young people. The underlying

message, resonating in the more recent research discussed below, is the fallacy of seeking out simple assessments relating to use of residential care and the benefit of learning from practices globally to ascertain, within specific ecological contexts, when how and for whom group care should be provided (Thoburn 2022).

Notwithstanding the diversity of provision, there is consensus that this method of care must meet the developmental needs of children and young people holistically (e.g. emotional, practical, educational, social and civic). Some core principles are common across systems and modes of residential care provision. For example, Whittaker et al. (2015) use the principles of Therapeutic Residential Care as a guide. These are: safety first, partnership with families, contextually grounded, culture of learning through living and a continuing search for evidence (see also, Whittaker et al. 2022a).

The diversity of reasons for persons coming into care is clearly articulated in the research (see Whittaker et al. 2022a). While many reasons are cited, the most common reasons for use of residential care across many countries are abuse, neglect and lack of parental care, followed by behavioural reasons and foster care placement breakdown. Other factors relating to educational needs, developmental issues, and wider family (substance abuse and mental health issues) and socio-economic issues also feature. Many reasons for placement are from within the child's micro- and meso-level context, especially their lives, care, support and safety within their families. As demonstrated in Whittaker et al. (2022a), wider exo- (organisational) and macro-level factors include lack of services and resources, lack of regulation, overreliance on outsourcing and the private sector, over-representation of Indigenous communities and ethnic minorities, staff recruitment and shortages, and lack of care on leaving services.

Overview of Usage of Residential Care in Selected International Contexts

Whittaker et al. (2022a) provide a current international profile of residential care. Their book reported on residential care use in 16 countries. They include countries where use of residential care ranges from 7% (Ireland and Australia) to 97% (Portugal). Countries in the low-usage category (England, Scotland, Ireland, Canada, Australia and the United States) have various legislative initiatives to reduce residential care rates. Medium to high usage countries (Argentina, Denmark, France, Italy, Finland, Spain, Netherlands, Israel, Portugal and Germany) have been engaged in reforms towards improving and strengthening the quality of residential care combined with refocusing towards more family-based care options. It is important to recognise from the outset that decision-making is influenced in the first instance by the legislative and policy drivers that determine the amount, nature and orientation of alternative care provision.

Throughout most child welfare and protection systems, the development of family foster care and community-based programmes is a common response for reducing the use of residential care (Courtney and Iwaniec 2009; Whittaker et al. 2015, 2022). For countries with low usage of residential care, the emphasis is specifically on delivering prevention, early intervention and family-based foster and kinship care as the primary form of alternative care (see for example Scottish Government 2022). In these contexts, residential care is recognised as necessary for certain cohorts. For example, referring to England, where 11% of children are in residential placements, a residential placement may be used for children with complex needs, (emotional and behavioural) who require larger and more specialised teams to support them. The young person may choose to be placed in residential care as they no longer wish to live in their family environment, or children are placed in residential care when other placements have been unsuccessful (MacAlister 2022; Holmes et al. 2022).

In the United States, similarly, the philosophy is towards family-based care, and where residential care is used, an emphasis is placed on therapeutic foster care models (Fisher and Gilliam 2012). The role of residential care in the United States child welfare system is shaped by federal legislation and its use varies across states. Under the Family First Prevention Services Act (FFPSA) 2018, funding was moved towards family-based care to try to prevent overuse of residential facilities. Residential care placements for young people have become more and more uncommon in the US with emphasis being placed more on community-based services, evidence-based interventions and family support services in order to reduce the need for out-of-home placements.

In Australia, the emphasis is also on family-based care; in 2020, 91% of children in care were in home-based placements such as with relatives or kinship carers (54%) or in foster care (37%). Seven per cent of children and young people placed in out-of-home care in Australia are placed in residential care (AIHW 2021). These settings are funded by the state and territorial government departments and are delivered mostly by non-governmental community service organisations with a few centres which are privately resourced (McPherson et al. 2021). Policy states that children entering residential care should be at least 12 years, but some may be as young as 8 years, with most staying for approximately two years but some remaining up to five years or more or until they leave care (McNamara and Wall 2022).

For countries with heavier reliance on residential care, a clear commitment to prevention and early intervention is evident in many policies and related legislation. For example, in the Netherlands, half of children in care by December 2020 were in residential care. Following the Youth Act of 2015, there has been an increasing focus on preventative care, strengths-based care and customised care. If out-of-home care is required, it must now be small-scale, and family based. This has led to a significant decrease in secure residential care placements and the creation of more family foster care placements. A shortage of residential care services for child with more complex needs, due to the costs involved for municipalities, has been reported (Knorth and Harder 2022). In Denmark, there has also been a large shift from the use of residential care to family foster care; it decreased from 56% in 1982 to 32% in 2020 (Lausten 2022). A major strength of Danish residential care units was the establishment of a Social Supervisory Authority in 2014 whereby all units were re-evaluated, leading to the closure of several units that did not meet the required standards. All residential care units in Denmark are supervised and re-evaluated regularly (Palsson et al. 2022).

Some countries with a very high level of residential care usage are under pressure to strengthen family-based care and reduce residential care, especially units that accommodate relatively larger numbers of children and young people. In Portugal, for example, 97% of children in out-of-home care are in residential care (Instituto de Seguranca Social 2021). Care facilities are relatively large, ranging between 15 and 40 children, and most children aged under 6 are placed in larger residential care centres averaging 30 children per home. As asserted by Barbosa-Ducharne and Soares (2022) ‘the whole child and youth care system in Portugal needs to undergo an overall and profound renovation’ (p. 261). In the last decade, because Portugal has had an increase in the use of residential care, the Committee on the Rights of the Child (2014) warned of the need to strengthen family-based care and progressively eliminate institutions. Decision-making has come under particular scrutiny in Portugal. For example, Delgado, Pinto and Carvalho (2017) conducted research to understand what influences and determines the decision-making process among 200 professionals responsible for providing care assessments and recommendations for interventions in the Portuguese child protection system, to verify if they contribute to decisions that privilege foster or residential care. They found that decision-making within

the child protection system is influenced by factors such as case characteristics, professional team size, training, resources, guidelines, experience, legal framework, critical events and community involvement. One of the most significant issues arising in this and related research was the need for children's participation, which professionals supported, but noted needed to be developed with regard to both child and parental participation. Indeed, as discussed later, this aspect of decision-making is central across all systems.

Israel is another country that relies heavily on residential care and children are accommodated from age 0 up to the age of 17 for care and educational purposes. Of the 12,439 children and young people in out-of-home care in Israel in 2018, 63% stayed in a residential placement, 23.6% in family foster care and the remainder (13.2%) in emergency centres or other settings such as a shelter or transition apartment (NCC 2019). Care includes needs-based support programmes based on mental and behavioural requirements, comprised of: rehabilitation programmes (for children with learning disabilities, learning gaps or emotional difficulties); therapeutic programmes (for children with behavioural dysfunction or mental health impairments); post-psychiatric hospitalisation programmes (for children following psychiatric hospitalisation with severe behavioural disorders and complex problems) and educational residential facilities and youth villages. Some of the main challenges in Israel's residential care system are the absence of a national database; placements based on professional decision-making procedures (with or without a Court Order); and the need for greater organisation and coordination between governmental offices of the welfare and educational systems (Zeira and Grupper 2022).

For all countries, how systems develop aftercare for those in residential care is complex and challenging. There is long-established international research on the nature, diversity and challenges of supporting young people through care into adulthood (see Stein and Munro 2008). The risks of social exclusion, the need for stability in care placements to support transition, the importance of preparation, the need to focus on identity and identity formation and education are evident (e.g. Stein 2008). Recognition of the diversity of responses by young people to leaving care is important. Stein's three classifications of those who 'move on' (thrive), 'survive' or struggle remain current (Stein 2008). While micro factors, like a person's resilience and psychological readiness for leaving care, are significant, how a person transitions are highly influenced by the extent of stability and support available to them. Those who struggle most, and who are most disadvantaged, are those who have had the most damaging pre-care experiences and the least stable experience of care (e.g. multiple moves) (Stein 2008). Medes and Snow (2016) pay particular attention to the needs of those who are particularly disadvantaged leaving care, including those involved in the youth/criminal justice system and young people with disabilities. Pinkerton (2021) demonstrates the value of Bronfenbrenner's ecological model in relation to understanding and responding to the needs of persons leaving care. He reinforces the importance of focusing on changing historical influences at the 'chrono level' and reminds us that:

> (t)he chronosystem also directs attention to biographical change at the micro level—both normative and non-normative. The changes in a care-experienced young person's life are not historically determined. Those changes cannot be accounted for without considering the young person's own particular starting point precare, the care pathway followed, and the aftercare experiences and the dynamic for change within that journey (Pinkerton 2021, 227).

Generally, aftercare services have been much slower to develop globally and continue to be a major deficit even in the most well-developed child welfare and protection systems (see Medes and Snow 2016; Medes and McCurdy 2019). Van Breda et al. (2020) summarise the two main messages from research. The first is that 'care-leavers experience a range of

outcomes, with some but not all experiencing serious difficulty in adjusting to the transition from the care system at age 18, especially in the absence of needed supports' (2020, 2). The second is that there is a 'need for a range of innovative support measures tailored to the specific and varied needs of care-leavers and which go above and beyond any supports that may be provided to the general population of youth of the same age', reflecting the State's responsibility as 'corporate parent' (2020, 2). However, as Van Breda et al. (2020) and others acknowledge, the answer to how best to support remains elusive, complicated, context driven and constrained and challenging. While the importance of a systemic and global perspective has long been argued for (e.g. Pinkerton 2006) with an emphasis on social ecology (e.g. Pinkerton 2011), it seems that aftercare, 'post-care' and transition from care remain particularly underdeveloped aspects of the care system in general and residential care systems in particular, even though research and evidence in relation to this has flourished, influenced in particular by the work of the INTRAC network (INTRAC n.d.).

Indeed, in many countries it is only in recent years that governments have been required to develop services for those reaching the age of 18 years, such as economic support, accommodation, study resources, and psychological and legal advice on leaving residential care (e.g. Van Breda et al. 2020; Stein 2019). This is not universal, and there is very limited or no legal or policy provision for leaving care in a number of jurisdictions. There are however examples of good practice as summarised by Stein (2019) regarding support for leaving residential care. Stein (2019) describes approaches in Germany, Switzerland and the Netherlands, all of which have a high dependency on residential care provision. For example, in Germany, residential homes continue to be provided after young people leave care. Residential workers visit and support young people to secure follow-on accommodation in order to maintain stability and security of place and relationships (see also Cameron et al. 2018). Stein (2019) also describes how in Switzerland young people are gradually moved to accommodation where they can start by spending a few evenings before moving on to become tenants in independent living arrangements. Telephone contact, counselling and coaching are also provided. Another example from Stein (2019) is the Netherlands, where individual mentoring is provided for young people aged 18–24 who are returning home after care. While reinforcing the message of the complexity of translating approaches across different contexts, Stein (2019) emphasises the importance of a life course perspective with a view to pre-care experiences and personal characteristics, gender, ethnicity and needs. He identifies five key messages to inform best practice regarding supports for young people leaving care. These are:

- recognise the importance of stability for promoting resilience and achieving positive adult outcomes in physical and mental health, education and employment,
- support educational opportunity and success, which are so closely correlated with resilience,
- involve people actively in decision-making about their own lives and wider policy issues, including engagement in peer research,
- offer support with preparation for leaving care, and
- recognise the costs and consequences of not supporting people given the high level of mental health needs among care populations.

Van Breda et al. (2020) discuss practices like those described here as 'extended care' and argue that this concept is gaining increasing interest although it needs further conceptualisation and differentiation from 'aftercare' internationally. Extended care has been a theme driven by many advocates for change and highlighted by INTRAC in 2003 (Van Breda et al. 2020). Extended care 'allows eligible groups of care-leavers to voluntarily opt to remain in their care placement under certain conditions, until a later age, often 21'. (Van

Breda et al, 2020, 2). However, as argued by Van Breda et al (2020), 'the conceptualisation and operationalisation of extended care (and its differentiation from aftercare) appears lacking in many countries' (ibid). The authors identify ten examples of where extended care arrangements are in place and provided detailed outlines of what this involves and how it is funded and organised. These include Canada, England, Ireland, Israel, Netherlands, Norway, Romania, South Africa and Switzerland. While many challenges exist regarding definitional ambiguity, diversity of practice, balance of formal and informal arrangements, financial issues and lack of research, Van Breda et al. (2020) demonstrate the value of considering 'extended care' as part of the path to transition to 'aftercare'. The authors show that the practice has become established in many contexts, although it is not sufficiently defined or applied as yet.

There are three main 'pathways' to leaving care discussed in the literature: reunification, adoption, and 'aging out', which can involve a range of options (Courtney and Thoburn 2009). Developing the transitional concept of 'extended care' adds to this set of options for young people especially in residential care who do not have the option of family reunification. Reflecting on the overall principle of family-oriented approaches and the focus on reunification, the unsuitability or desirability of this option for some young people (for example, those who came into care due to family violence and abuse) requires a range of other clear pathways to 'age out' in a way that promotes stability, security, identity, a sense of belonging and connection. This reinforces the need for an eco-system lens to capture the many factors and to ensure respect for and attention to each person's unique biography, characteristics and abilities. There is a need for greater leadership in approaches that focus on supporting a young person to achieve their dreams and ambitions. A focus on the psychological as well as the social impact of transition from care is essential (Dima and Skehill 2011).

So far, the focus has been on general trends and developments in residential care in selected countries, which have a direct impact on decisions to use residential care, showing the distinction in particular between low-, medium- and high-usage engagement. We have also discussed relevant issues regarding leaving care. The following section looks in more detail at the use of residential care for specific identified purposes to give further depth of insight into when, how and why residential care services are used in different contexts.

Use of Residential Care for Specific Identified Purposes and Needs

It is well established that out-of-home care placements are varied and usually consist of intensive support services for children whose needs have been identified as requiring higher level intervention/treatment. Many pragmatic reasons affect decisions relating to the 'need' for ongoing use of residential care even when in principle it is viewed as a 'last resort' or final option within a planned welfare system. In Ireland, for example, Gilligan (2022) attributes some usage of residential care to difficulties recruiting foster carers and providing care for children with complex needs including mental health and behavioural needs. He argues that residential care placements are still relevant for some children in conjunction with a vision to expand formal kinship care. To provide high-quality residential care for those children, the system needs a skilled workforce to serve those high needs. Staff need to be provided with a range of evidence-based practices and policies. There should also be ongoing development of earlier intervention and prevention approaches.

While the general trend has been to reduce use of residential care in many countries, it has actually increased because of changing demands and needs for out-of-home care. For example, in Finland, alternative care has increased steadily over the last ten years particularly in emergency placements of teenagers, despite the strong prevention-focused

child welfare system and universal social welfare services (Statistics Report 2021; Timonen-Kallio 2022). Likewise, in Italy, a similar trend of increasing usage of residential care is seen, particularly for unaccompanied minor migrants who represent 40% of the total number placed in specialised units in 2022 (Palareti et al. 2022). This is also the case in France, where the number of children in care has generally increased over the last 20 years due to increased social problems in families as well as demands for accommodation of unaccompanied minors (Tillard and Join-Lambert 2022). A major challenge for residential care services in Germany (James et al. 2022) also relates to the high numbers of unaccompanied minor refugees who require specialised supports. Likewise, in Spain, for example, over half of all young people in residential care (55%) are from a migrant background and 88% of those are unaccompanied migrant children, predominantly boys (Martín et al. 2020).

In other countries, residential care is used mostly for therapeutic purposes. 'Therapeutic residential care' while comprising a range of approaches, philosophies and practices, is a specialised model of care, although its principles are applicable across the spectrum of residential care services (Whittaker et al. 2015, 2016, 2022a). For example, in Germany, non-public organisations run over 95% of residential care programmes, which are guided by specific pedagogical concepts with an emphasis on learning through a 'life-space' perspective focusing on participatory and relationship-based approaches (Grietens 2015). In Spain, legal changes in 2015 led to specific centres for adolescents who had behavioural problems and needed more intensive Therapeutic Residential Care (TRC) (Bravo et al. 2022, see also Observatorio de la Infancia 2020). Residential care is the US is generally considered a restrictive placement intended only for treatment purposes and is closely regulated (Lee and Bellonci 2022). Child welfare agencies can only receive maintenance payments if care is provided in certain types of care institutions such as a Qualified Residential Treatment Programme (QRTP), which is a stricter form of residential care.

In reviewing the range of developments in residential care in recent years (e.g. in Whittaker et al. 2022a), a common recurring theme is the fact that many young people in residential care services – especially in countries where it is used selectively and for specialist purposes – have significant 'behavioural problems', 'challenging behaviour' or 'problematic behaviour' caused by many factors including trauma, developmental delays, mental and physical health needs, and personal and family reasons. These challenges can result in young people not being placed at the optimal level of care from the outset (Chor 2013). For example, Henriksen's (2022) research with young people found that most of them were aware of how their behaviour impacted their cases and understood that contesting the rules could result in more restrictive measures being imposed while good behaviour could increase their voice in decision-making regarding future care plans. Case managers were aware that over-focus on behaviour management represented a non-developmental approach and instead wanted to be facilitators of change not controllers, whereby young people should be motivated to change rather than be governed by threats of restrictive measures.

Common across most systems, as argued by Ward (2022, xix), are the complexities of psychological need for many children and young people in residential care, with many 'struggling with the consequences of childhood trauma'. Specific trauma-informed residential care services have been developed in countries including Scotland, Canada and the USA (e.g. trauma-informed CARE model, Holden et al. 2022). As research in this field develops, emphasis is put on the importance of a trauma-informed approach which refocuses attention away from 'what is wrong' (e.g. behaviour) to 'what happened' (e.g. childhood trauma). This is informed by the significant advancement of research on the impact of adverse childhood experiences (ACEs) and their correlation with trauma (Spratt and Kennedy 2021). A trauma-informed or trauma-aware approach (see Spratt and Kennedy

2021) in working with children in care refocuses attention away from what can be seen as a deficit emphasis on 'problem behaviour' towards an emphasis on the experiences of children and young people who have had adversity leading to the need for care, and the impact of this adversity. Strong arguments are made for the importance of greater critical focus on practice developments with a mind to ACEs, their potentially traumatic impact and how this affects relationships and engagement at organisational levels (e.g. Spratt et al. 2019).

Children who have been born into and grow up coping with developmental trauma can appear to be self-sufficient or independent but could have poor ability to emotionally self-regulate and may resort to communicating through actions instead of words. Mental health professionals can have difficulty diagnosing the child's behaviours and often state that they have no mental disorder or might offer various diagnoses such as post-traumatic stress disorder, attention deficit hyperactivity disorder, depression or autistic spectrum disorder. On the other hand, parents, social workers, teachers and social care staff may not realise the presence of underlying developmental and mental health problems (Brown 2016). Emphasis on trauma-informed care that integrates research around neurobiology, trauma, resilience and attachment features in many current system developments regarding foster and residential services. With regard to Ireland, Lotty et al. (2021) examined the experiences, beliefs and perspectives of foster carers, foster care trainers and practitioners working with foster carers on factors informing the implementation of TIC (Trauma Informed Care) for foster carers. Findings revealed there was a need for TIC training so that foster carers could be fully equipped and prepared to provide adequate care. Similar considerations are important for residential care settings.

In terms of considering other 'specialist' needs for support where residential care is used, it is important to take a critical view from an ecological perspective, to ensure that individual or family issues (micro–meso) are not over-emphasised with under-recognition of the many wider factors that were more influential in children being in residential care (exo–macro). Acknowledged factors that influence use of residential care include lack of support earlier on, limited support at home or in foster care, lack of sufficient resource investment and lack of continuity of support (Whittaker et al. 2022a; Courtney and Iwaniec 2009).

In much of the literature, the factors and issues arising are common whether the residential care placement is provided by a third sector/voluntary, statutory or private provider. But there are particular issues to note focused on private residential care, as discussed in the following section.

Specific Issues Relating to the Use of Private Residential Care

Already, some of the specific challenges of private care have been mentioned. A clear trend in many child welfare and protection systems in recent years has been a significant increase in the use of private, for-profit care services, although this varies between contexts. Some countries rely almost exclusively on private, for-profit care, such as Australia, Finland and the Netherlands. In others, it makes up a significant aspect of service delivery, such as in Ireland, the UK and Argentina. Other nations like Portugal, Israel, Spain and France have little or no private residential care and rely mainly on private charity or non-profit organisations and/or state provision (see also Bravo et al. 2022; Tillard and Join-Lambert 2022; Valencia, Lopez and Armenta 2021).

Like debates about residential care in general, it is clear that for any country, it is not a simple matter of arguing 'for' or 'against' such provision but more about how, when using this provision, it is delivered in line with core principles of the best interests of children, young people and their families. As Meagher et al. (2016) articulate in relation to the use of private care for children and young people in Sweden, the movement towards private care

needs to be understood within the wider context of the emergence of New Public Management since the 1980s. Marketisation, neo-liberalism, the rolling back of 'welfare state' ideologies, regressive measures for the care and control of populations of children, youth and families, and the impact of the New Right are well-known factors that have affected many 'public' service sectors including child welfare and protection, and family support. For-profit care has been analysed in-depth in many sectors where it is normative, including healthcare (see Waitzkin et al. 2018), adult social care (see Bayliss and Gideon 2020) and early years provision (O'Sullivan and Sakr 2022). While well established for many decades in some contexts, a clear global trend in current chrono (time) conditions is the increased use of private for-profit services for a vast range of 'welfare' and 'care' services that historically and traditionally have been more associated with welfare systems, voluntary not-for-profits and charities. In this expansion, the importance of social leadership and responsibility in relation to for-profit services are emphasised across sectors (e.g. O'Sullivan Sakr 2022).

Private residential care facilities range from small-scale family-owned and -run services to increasingly large businesses running many services across a region or nationally. Private care organisations can often be more flexible than state services and have greater capacity to be responsive regarding delivery of certain types of supports needed in individual cases. In some instances, private residential services are specialised, employ a wide range of different professionals and may offer specific therapeutic models of care. But the provision of private residential care brings with it particular challenges too. The issue of regulation of private contractors comes up in many contexts. For example, in Finland, 80% of residential services are provided by the private sector, which has led to competitiveness without sufficient quality monitoring as well as a variety of competing programmes (Porko et al. 2018). Barillas (2011), referring to the US, argues that for privatisation to be successful governments must have the necessary fiscal and institutional resources, or state capacity, to properly select and monitor private contracts. The author also notes however that, like many other countries, one of the reasons for privatisation is to address the limited capacity of governments to achieve positive results in child welfare and protection systems. While regulatory systems have become more robust, this remains a major area for development in many jurisdictions.

How decisions are made regarding use of private care is also a matter of concern. For example, in the review *Financial Stability, Cost Charge And Value For Money In The Children's Residential Care Market* commissioned by the English Department of Education, concern was expressed that there was 'a hierarchy of placement provision that assumed in-house fostering was first choice through to private external residential care at the end of the chain' (Institute of Public Care 2015, 74). They also expressed concern 'at the suggestion that some providers seemed to turn down children with complex problems or move them on, because of anxiety about forthcoming inspections' (ibid). They argued that '(f)ailing to be clear about who residential care is for when and why means inevitably you end up with a reactive, last resort, service which is often seen as [a] failure by social workers and children alike. Such a system automatically starts by being seen as low value. Obviously, these are issues that should concern the regulator as much as commissioners' (ibid).

An Irish review of costs of private residential care by Brannigan and Madden (2020, 35) described residential care as a 'key cost pressure' for the child welfare and protection services. They showed how private services accounted for the greatest increase on costs for residential services from 2016-2019. Between 2016 and 2019, the spend on private residential care, as a proportion of overall spend on residential care services, increased from 46% to 57% of total costs. In reviewing the three main delivery mechanisms for residential care services in Ireland (statutory, voluntary and private), most of the cost increase for provision between 2016 and 2019 was in the private sector. The Spending review went onto

consider how the increased reliance on private residential care was impacting on overall cost and capacity to deliver residential care services. While not in a position to make specific recommendations regarding 'cost containment' based on the data available, a number of suggestions for further analysis were made by the Spending review. These included a review of the 'costs, benefits and risks associated with each of the existing delivery mechanisms: Tusla-owned, voluntary and private services)' (2020, 82). Analysis of the effectiveness of different deliver methods and the benefits of alternative prevention methods such as Creative Community Alternatives was also recommended. Attention to the increased number of overall children in residential care during the time period in question and the governance structures for placements was also proposed.

Meagher et al. observe how in Sweden 'a regionally coordinated, public social service system was transformed into a thin, but highly profitable, national spot market in which large corporations have a growing presence' (2016, 8180). In the UK, with the exception of Northern Ireland, the Competition and Markets Authority (CMA) studied the children's residential and foster care market, where over 83% of the residential care market was owned by the private sector and within that most homes were owned by a few large providers (CMA 2022). They expressed similar concerns about the emphasis on profit-making. Their report highlighted the rising profits being made by private residential children's home providers and stated this is due to high demand for placement from local authorities, poor planning, and low wages. They believe for-profit sector growth to be concerning, given the quality of care being provided (Holmes et al. 2022). Mulkeen (2016, 15) states that 'the international evidence points to serious shortcomings in for-profit provision of care, with rising costs, varying quality of care and an inability to meet policy goals for children in state care'. Her examination of the literature on the marketisation of children's residential care shows that in the UK there are related deficiencies in information about quality, greater use of out-of-area placements, increasing demand for specialist services and concentration of ownership (see also Kirkpatrick et al. 2001; Department for Education 2012). Canadian research also shows that the financial interests of private providers of children's residential care often took precedence over the needs of children (Gharabaghi 2009). Indeed, in this work, there was concern over 'practices of filling the beds and allowing minimum time for children to adapt to the departure of a peer or to prepare for the arrival of a new child' (2009, 171).

In the literature, other challenges to the use of private contracted care in the children's residential care system include: the impact of withdrawal of private contractors from the market; the quality of care provided; the relative cost of provision; challenges with integration of services and achievement of minimum standards; and ensuring the care needs of children and young people are met. Other critical findings regarding use of private care, for example in Finland, include concerns about competitiveness, insufficient quality monitoring and competition between programmes and providers (Porko et al. 2018).

Overall, the research evidence clearly indicates the need to maintain a balance of provision between the non-profit, for-profit and public sectors. According to Mulkeen, this ensures a range of provision is available to meet children's needs at sustainable cost levels (2016, 19). The evidence discussed above indicates many challenges to consider that can negatively affect provision of quality care when delivered in the for-profit context. It also indicates the benefits of private services; they can be more flexible, diverse and responsive. The ecological context of the use of PRC brings in additional macro factors of markets, competition and international investment. But, as Meagher et al. (2016) suggest, in many ways, the specific challenges of the private care sector are 'predictable, significant and well-documented' (2016, 805). While the situation is complex, Meagher et al. suggest a few core actions that could be significant: increased audit and regulation of quality of care, legal restrictions on the levels of profit allowed and how surplus funds can be used when providing 'care for-profit' services,

and ensuring it is evidenced that the service achieves its overall aim, which 'must be to fulfil the needs of the end users – vulnerable children in need of care' (2016, 819).

The brief overview of themes within the literature relating to specific issues for use of private care highlights the important considerations in decision-making at an exo (organisational) and macro (policy) level regarding whether PRC is used, and if so, under what conditions and for what purposes. In the discussion, we will return to strategic decision-making concerns arising from the use of PRC that impact on processes and outcomes for children and young people. Other issues will relate to the use of residential care generally. Likewise, in the next section, some of the issues pertain to decision-making more generally and others may be more pertinent specifically to use of private care.

Section 2: Decision-Making Processes and Practices to Support Permanency and Stability for Children in Residential Care

This section considers the literature and research under two main headings:

- Decision-making processes for and with children and young people in relation to residential care
- Participation of young people in decision-making.

Decision-Making Processes For and With Children and Young People in Relation to Residential Care

Section 1 has considered many of the challenges associated with many aspects of decision making such as finding the correct type of out-of-home placement regarding use of residential care generally and private care specifically. Decision making in this context refers to making choices about the best response to offer solutions for what are often complex needs of a young person and/or their family. The nature of provision, types, purpose and availability of service all influence decision-making about placements. For example, at macro level, decision-making depends on trends in and usage of residential care. At exo level, it includes organisational factors such as staff capacity; heavy caseloads; unavailability of less restrictive settings (non-residential); availability of prevention, early intervention and specialist support services; and issues of integration and coordination between various aspects of the child protection and welfare system, areas or teams. Then at the micro and meso levels there are multiple considerations with regard to the individual needs of the young person, their relationships with family and with support workers, and the specific experiences that have led them to need alternative care placement in the first instance. In this section, we focus specifically on processes and guidance relating to decision-making processes and frameworks including a focused discussion on the nature and complexity of decision making.

It is evident that factors affecting decision-making within and across different contexts in residential care are manifold (see Whittaker et al. 2022a). It is also established that decision-making must involve a combination of data-informed practices and reflective and relational practices. Decision-making should take place in partnership with young people and their families. The historical and current trends for institutional care significantly influence decision-making about use of this form of care and about which children and young people it should be provided for. Thoburn (2022) suggests four themes that can be compared to understand decision-making regarding out-of-home care in different contexts: economics, political economy, societal values and predominant understandings of child development (2022, 17). Whittaker et al. (2022a, b) demonstrate the different emphasis across systems on individualised and system-led decision-making. They highlight the importance of context to understanding the complex set of factors that influence how decisions are made in relation to the pathway towards and decision-making during periods of residential care. Following our

consideration of some of these complex factors in Section 1, we focus here on specific literature informing decision-making for placements of young people in residential, especially private, placements. These are presented under four headings:

- Decision-making to achieve stability and permanence
- Complexity of decision-making tools and approaches – towards a systems approach
- Examples of specific decision-making practices within residential care
- Involvement of young people in decision-making.

Decision-Making to Achieve Stability and Permanence

The achievement of permanent and stable (i.e. for as long as is needed before reintegration or reunification) alternative care for children and young people is the overarching goal of decision-making within any care system. The broad range of factors impacting on permanence and stability are well established in the literature. For example, Devaney et al. (2019), reporting on research by Moran et al. (2017a), highlighted both intrinsic and extrinsic factors; many have been referred to earlier specifically regarding residential care. Intrinsic factors include mental health and wellbeing, behavioural and emotional development, levels of confidence and positive self-identity, pre-care experience and age of entry to care. Extrinsic factors include family relations, number of moves, quality of support and relationships with carers and social workers (Devaney et al. 2019).

Figure 2: Moran et al (2017) Socio-ecological Framework relating to Permanence and Stability for Children and Young People in Long Term care

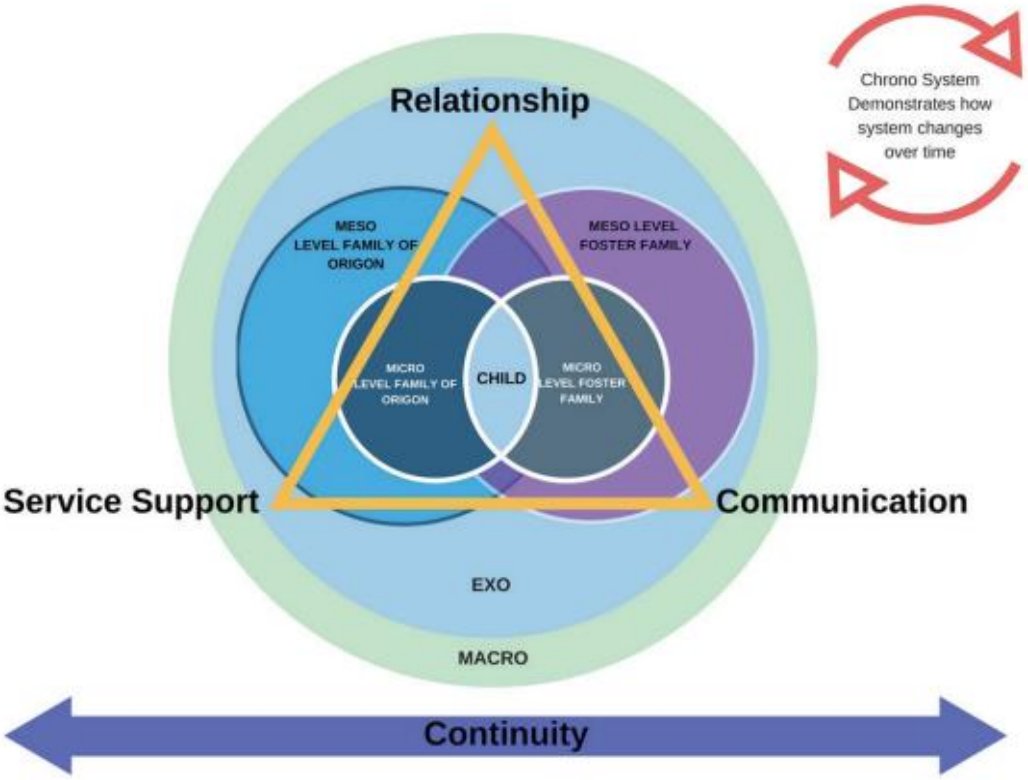


Figure 2 (b): Developed Socio-ecological framework

While interconnected, the difference between permanence and stability is important to note, especially when considering residential care. Stability in a residential care context is associated with 'feelings of family and belonging, more commonly associated with permanence in family placements, when close relationships with staff and continuity of care into early adulthood are available' (Thoburn 2016, 27). 'Stability' within one setting might be over a short or longer period of time. Even when the planned placement may be short term, all children in alternative care require a 'permanence plan' towards achieving and maintaining stability (see Woodall et al. 2023). In such planning, residential care placement may be a part of a permanence plan involving a period of transition from home, from a foster placement or towards a return to home or community, or it may be the permanent, stable home for a child or young person for a longer period of time through to adulthood. Permanence and stability are complex involving both objective (a stable place to live, to put down roots and be connected) and subjective (a feeling of identity, security, safety) elements (see Moran et al. 2017; Woodall et al. 2023).

As shown in Figure 2, from Moran et al. (2017a), three interconnected features are central to achieving stability and permanence for children and young people in care. These are Relationships, Communication and Support. These need to be underpinned throughout the ecological system with a focus on continuity. Specifically for residential care, the quality and consistency of relationships between child welfare personnel, children and parents are key.

For example, research by Cahill et al. (2016), with reference to Ireland, demonstrates the importance of building positive, supportive relationships with young people. Care workers highlighted as significant the importance of time spent, the residential centre's environment, and professionals' skills, knowledge, personalities and levels of genuineness. But there can be many challenges for young people to engage in partnership and to build relationships, including difficulties trusting staff, staff turnover and sense of lack of voice in relation to decision-making. Child and youth participation is discussed more later where the theme of the importance of relationships continues to resonate.

There are also many factors affecting parental participation in decision-making towards stability and permanence including issues they may be dealing with themselves (such as difficulties relating to substance use or mental health), complex relationships with the system especially in cases of abuse and neglect, past experiences of engagement with services, and quality of relationships with their child and with those working with them. Issues of contact and access can be contested and challenging (Sen and Broadhurst 2011; Bullen et al. 2016; Roe and O Brien 2019). Distance from placements, lack of regular access and lack of involvement in care planning and decision-making, especially where children are on Care Orders, are further barriers to parental participation and relationship building. As Tillard and Join-Lambert (2002) explain, some residential centres are developing practices that allow parents to take part in the upbringing of their children even if reunification is not a realistic option. For example, in France, even though most out-of-home measures (82%) are court ordered due to parents' reluctance to accept protection services and their mistrust of practitioners (Kertudo et al. 2015), when children/young people are in care, involving parents and maintaining family ties is viewed as paramount in decision-making. In Denmark, socio-pedagogical homes are provided where staff and families live together at the care facility (Palsson et al. 2022). Greater attention to parental participation is noted in the literature but remains uneven and varies greatly (James et al. 2022). Taplin et al. (2021) also noted that there is relatively limited research with parents, suggesting this is 'partly because they are challenging to directly engage in research and partly because of limited engagement and outreach strategies used by researchers' (2021, 2).

As discussed further in the following sections, relationships also need to be considered within the wider ecological context. For example, Devaney et al. (2019) argued:

> it is important to focus on the interactions and dynamic interplay between the levels of a child's eco system at any one time (chrono), seeing it as a moving and evolving space. Because children in care have moved at least once in their lives, and often more frequently during their care experience, special effort is required to help them to build, sustain, rebuild and develop continuities in their social system, which effectively becomes their social network as they age out of care and into adulthood (2019, 645).

Likewise, Woodall et al. (2023), building on the adaptation of Bronfenbrenner's ecological model in Moran et al. (2017), states that

> young people's outcomes emerge through the continuous interplay between factors that are close to the child in their immediate systems, and contexts that work at the wider systems, which shape young people's and families' everyday lives. This insight can help professionals recognise young people's individual experiences and relationships within their wider socio-ecological networks and contexts and address them at multiple levels (787–788).

The ecological model has similarities to a relational model of practice which also emphasises the importance of relational networking towards networking and societal practices (see

Folgheraiter 2004). Discussing the relational model of practice in Scotland, the emphasis is on building safe and trusting relationships delivered through 'pockets of' (rather than comprehensive) high-quality residential care (Johnson & Steckley 2022, 65; see also Scottish Government 2022). Overall, connecting with the theme of continuity and support, the research is clear regarding the importance of relationships that promote continuity of care and provision of support with the 'whole system' in mind and the interests and wellbeing of the young person at the centre. However, as discussed in the next section, by the very nature of this need for a holistic systemic perspective, decision-making is a complex matter no matter how many guides or frameworks are available.

Complexity of Decision-Making

The complexity of decision-making processes in child welfare is well established (e.g. Taylor 2012; Benbenishty et al. 2015). It includes use of decision-making tools and threshold frameworks (see for example Platt & Turney 2014; Devaney 2019; Munro 2011). Complex algorithms and detailed risk assessment tools have been developed to improve the 'science' of risk assessment (Keddell 2019). No matter what amount of guidance is provided, discretion, professional judgement and individual/team practices play an important role (Taylor 2017). McCormack et al. (2020) summarise a number of decision-making approaches that balance 'intuitive and analytical decision-making models' (p. 149). Devaney et al. (2020), with reference to Hammond (1996), argue that rather than seeing these as two opposite approaches, they represent 'the two poles of a continuum of approaches to decision-making' (2020, 13) between the practice-experienced model and the empirical decision-making model (ibid). Heuristic decision-making (Taylor 2017) takes into account the number of factors that need to be considered and the role of the decision-maker in that process. Moving from a dualistic to a cyclical and dynamic frame, a systems approach (e.g. Munro 2005) is particularly influential as it ensures holistic consideration of the range of elements. For example, in Irish research on decision-making, McCormack et al. (2020) demonstrated how a systems approach informed by an ecological model has relevant use in a range of decision-making contexts (Bronfenbrenner 1979; Benbenishty et al. 2015; Helm and Roesch-Marsh 2017; Dickens et al. 2017). McCormack et al. (2020) focused on decision-making at the referral point to the child welfare system. They found that it was organisational factors such as decision-making tools and guidance and organisational processes which were most influential. Devaney et al. (2020) consider the decision-making ecology model (Baumann et al. 2011), which also promotes a holistic approach in order to capture the complex interplay of systemic factors that influence how child protection and welfare decisions are made.

While 'best practice' is well established with regard to the factors that can enhance stability and security in care placements, a myriad of other factors, often at exo and macro level, negatively impact achievement of better outcomes. Decision-making processes or outcomes can be influenced by many other issues. For example, the negative impact of distant relationships between residential care workers and decision-makers in Irish residential care was highlighted by Brown et al. (2018). Reference is made, for example, to this leading to 'a lot of pointing fingers as to who's to blame for a decision made' (p. 661). Fear connected with the 'legacy' of residential care in Ireland was shown to have a big impact (Brown et al. 2018). Lack of availability of permanent and stable placement also impacts decision-making and outcomes significantly. As Woodall (2023) puts it: 'although young people's experiences of early adversity contribute to poorer outcome, their experiences within care can exacerbate issues and even cause new ones, especially due to lack of permanency' (2023, 772). Many of these factors have already been discussed regarding issues about availability, supply and type of care support within residential care. The particular challenges of monitoring, governance and access to decision-making with private providers were also highlighted. Echoed across

research studies (many of which include the views and experiences of young people themselves and their own care experiences) is evidence strongly reinforcing the need for a 'cross-system' approach, from ground-level practice to macro legal decision-making in order to prioritise achievement of stability for young people in care. In the following section, some examples of further specific decision-making practices relating to residential care are discussed.

Examples of Specific Decision-Making Practices Within Residential Care

As with decision-making across child welfare and protection systems, decision-making processes for placing a child in residential care often involves use of an algorithm such as risk–need–responsivity assessments specifically to inform the treatment model developed (Andrews et al. 2010). Chor et al. (2022) developed a predictive risk model using administrative data collected by child welfare agencies and predictors of residential care placement informed by the literature. They argued that this model of predicting placement using historical data could directly inform decision-making on placing young people in residential care and alternative care settings. This preventative approach of mapping existing practice of residential care placement could potentially inform caseworkers' decisions around placement planning. Another study, by Forkby and Höjer (2011), analysed the decision-making processes involving the institutional placement of teenagers, focusing particularly on factors affecting the choice of residential centre. Finding the right combination of residential centre factors and the needs of the young person being placed in that centre were key aspects in successful placements. So too was a focus on security, continuity and permanency, which, as discussed earlier, needs to begin at a much earlier stage for the young person at early stages of entry to care. However, even though the many factors affecting placement are well established, there can be a tendency to focus on the problems with the child or young person, rather than the wider system issues. For example, Brown (2016), focusing on admission of children to a secure setting in the UK, is critical of an over-emphasis on a young person's behaviour as the reason for the need for the placement*:* 'As if all would be well if only young people would just behave themselves' (p. 102). Too often professionals respond to risk and disturbing behaviour without thinking about what caused the behaviour. The author goes on to state that only when those behaviours are understood by adults to be the young person's way of communicating worries, memories and feelings that they cannot put into words, will any lasting type of stability be achieved. Trauma-informed approaches are increasingly being introduced in residential care programmes in order to inform decision-making and to meet the needs of young people who have experienced trauma (e.g. Gahleitner 2012). This reinforces findings regarding the need to shift from behaviour-focused to trauma-focused assessments, as discussed earlier (see also Whittaker et al. 2022; Courtney and Iwaniec 2009).

Better Care Network (2015) outline how an effective gatekeeping system is essential to improve decision-making to ensure children in care receive the most appropriate support, while respecting their rights. As indicated in some examples discussed earlier, each jurisdiction usually has a complex interplay of factors affecting their gatekeeping processes that informs decision-making about how a child or young person is placed and supported through residential care. As part of this gatekeeping process, various efforts have been made to develop risk–need–responsivity models to support decision-making processes for children with multiple needs and risks in order to improve the system (Chor et al. 2012; Leloux-Opmeer et al. 2017).

The importance of attention to behavioural issues and complex needs for support in decision-making in residential care resonates through much of the literature already discussed (see also Leloux-Opmeer et al. 2017; Johnson and Steckley 2022). The decision for

placement can often be determined by issues relating to availability rather than specific needs analysis. One of the major consequences of this is young people being placed far from their home. While there are often specific reasons for this, such as complex needs of the young person or for safeguarding, this is acknowledged in some systems as a necessity because of lack of alternatives (Clarke et al, 2019). When children are placed outside of their local areas in an effort to ensure their immediate safety, other fundamental rights can be neglected such as their right to education, health care, and a stable home (MacAlister 2022).

In order to understand the barriers, enablers, successes and challenges experienced by decision-makers implementing a trauma-informed model in residential care in Australia, Galvin et al. (2021) interviewed nine executive and upper management staff members from a centre in Victoria, Western Australia. Enablers of implementation included leadership and organisational drivers, which were the foundation of successful, sustainable practice and organisational change. One of the major challenges of the residential care system in Australia is the over-representation of Indigenous children and young people, which McNamara and Wall (2022) state could be improved by privileging family, community and country connections together with an increase in indigenous staff and intensive training around cultural safety.

Throughout the literature, as detailed in the section to follow, the particular theme of participation of young people in decision-making warrants particular and separate attention. A focus on participation of young people as central to any decision-making framework is especially important given the known complex factors affecting decision-making across eco-systems, many of them out of the young person's control and unrelated to their specific needs or family contexts.

Participation of Young People in Decision-Making

The UNCRC states all children should have a say in matters affecting their lives and this right to participate is central to many child welfare service systems globally (UNCRC 1989). Models of participation (e.g. Lundy 2007) are well embedded in many systems, including in Ireland (e.g. Brady et al. 2018). Munro et al. (2011) consider how the Convention contributes specifically to supporting young people making the transition from care to adulthood. They highlight the low level of focus on transitions and argue that this governance framework is not simply a 'top-down' influence. There are many good examples of how participation in line with Article 12 of the Convention is implemented internationally, although there is also evidence that the requirement to ensure participation is not always enforced (see for example Jamieson,). Also, there is ongoing evidence to show that providing a space for young people to participate and shape their assessments and decisions is an area of practice that needs more attention (Brady et al. 2018; Kennan et al. 2018). Low levels of participation have been highlighted in particular for children with complex needs who are eligible for residential care or a secure placement (Kloppenborg and Lausten 2020).

Henriksen (2022) found in her analysis of Danish children's participation in decisions surrounding their placement in secure care that there were multiple barriers affecting such participation. Barriers included frequent change of case managers and care workers, which significantly affected trust and continuity. Other barriers included the exclusion of children's voices in order to protect them, as well as their being viewed as biased or untrustworthy. In addition, the young people involved had a limited understanding of the decision-making process and were kept uninformed by their case managers. The author suggests use of an advocate to assist young people in understanding the decision-making process and provide them with a safe space to share their views with an impartial adult. This finding resonates through other studies and contexts such as Kennan et al. (2018). The effectiveness of other participatory processes reviewed by Kennan et al. (2018), such as young people attending

assessment, planning or review meetings, or family welfare conferences, and the recording of their views in writing, was found to be more mixed. Other important factors noted were how young people were listened to and facilitated to express a view, how their views were acted upon, and the level of preparation the young person had for participating. Also, 'the formality of the decision-making meeting and whether the child had an input into its planning; the professional's communication skills; and support for the participation principle by professionals and parents' (2018, 1998). Whatever the approach to facilitating participation, the importance of a trusting relationship between the young person and their case worker in particular was emphasised, as is reflected throughout much of the evidence and discussion here.

As discussed earlier, young people in residential care have typically experienced significant trauma and/or neglect in the care of parents/caregivers whom they trusted, and have often been excluded from decision-making, resulting in difficulty trusting people and decision-making processes. Once placed in a residential care setting, they then face a number of life decisions about their future relationships, education and plans. As such, their participation in decisions around their lives is crucial. McPherson et al. (2021) identified five themes in their research on young people's participation in decision-making in residential care:

- genuine participation in 'everyday life' decisions but little or no say in 'major life' decisions.
- bureaucratisation and formal processes impact participation.
- professionals' attitudes and beliefs about young people and participation influence their behaviour.
- organisational culture facilitates or constrains young people's participation; and
- relationships and relational practice have a central role in facilitating young people's participation.

They recommended organisations to challenge professional attitudes that hindered practices towards including young people in decisions affecting their lives. Furthermore, they highlighted the need for residential care staff and social workers to provide young people with information as well as safe places, to support them to form their own views, which must be taken seriously. Jackson et al. (2020), in their focus on collective decision-making for young people in care, show the importance of recognising the important contribution young people with direct experience can make to informing policy and practice beyond their own experiences, to improve outcomes for all in similar situations.

As mentioned, the Lundy model (Lundy 2007) is widely used to implement Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) in relation to child and youth participation. However, as Kennan et al. (2019) argue, it is more difficult to find detailed examples of how the specific concepts of the model – space, voice, audience and influence – are operationalised. Kennan et al. (2019) provide a number of examples from practitioners to inform practice in how best to engage young people, which resonate with much of the existing literature. They emphasise the importance of 'a range of options available to children and options that accommodate their individual preferences and abilities at each stage of responding to a child welfare or child protection concern' (Kennan et al. 2019, 216).

The question of who holds the power in relation to decision-making about a child/young person in care is important. As McGregor et al. (2021) show, parents, foster parents and young people all identified unequal power relations and the impact of power not being used well as important factors affecting stability and permanence in foster care. Reflecting specifically on residential care, placing a young person in residential care is usually the result

of decisions made outside of the control of the young person. This lack of control can intensify as the residential placement continues, as decisions being made for and about them accumulate. Decisions range from everyday routines (such as when to eat, wash, go to bed) to case planning (having a voice in care-planning meetings, when to have contact with family members) (Gharabaghi 2019). Franklin and Goff (2019) highlighted additional considerations especially relating to children with disabilities in residential settings. They found this included an extra risk of isolation for the children, lack of independent scrutiny by social workers and visitors, as well as gaps in services needed to support the care of the young people. They also identified some examples of best practice, including skilled approaches and attentive relationships with children with disabilities, multi-disciplinary supports, use of creative methods for communication such as communication passports, symbols, photos and technology.

Because admission to residential care can often be a 'crisis' (Brown 2016) for the child/young person and their family, wherein they present with significant needs, decision-making needs particular consideration and care. Clarity about who makes decisions about a young person's future at the point of admission is crucial, in order to ensure it is constructive rather than a cause of further harm (Brown 2016). In her research, Henriksen (2022) described young people having 'multiple experiences of professionals meeting to talk about their life, with or without their presence … often linked to a vague understanding of how the systems works and who decides' (p. 791). There can be lack of clarity about who made the decision and why; for example, parents and children may have different information about this, which can lead to a diversion of responsibility and confusion (Henriksen 2022).

Overall, emphasis on a child-centred approach, informed by the UNCRC, is expected to underpin the ongoing development and implementation of decision-making processes, with family, child and youth participation central to this. As demonstrated in practices in different jurisdictions, it is clear that the scope, potential and limits of such an approach are affected by historical and current trends and developments in child welfare system orientations, resources and approaches. Many of the organisational and pragmatic factors affecting use of residential care may seem like a barrier to effective participation of young people in decision-making about wider exo and macro factors. For this reason, an emphasis on collective as well as individual participation of young people is essential (Jackson et al. 2020) so that young people are in a position to influence their own pathways as well as inform wider policy and practice developments.

Conclusion

There is considerable agreement in the literature on the ingredients that contribute to best practice in residential care service provision – a family-oriented, preventative approach; developmentally appropriate care; emphasis on services to address behavioural, mental health and trauma-related issues; participatory approaches and addressing of diversity. But the way this is achieved is a result of a complex interplay of factors across ecological systems from macro-level historical, legal and social processes to micro and meso levels of quality of practice, relationships, service, support and continuity. When it comes to decision-making, it is well established that this must balance broader algorithms and data with relational practice. But it is also far more complex and must be understood as such – affected by historical legacy, resources and commitments, integration or lack of it within systems, availability of alternatives, philosophies, commitment to participation, legal frameworks and policy imperatives. Specifically focusing on private residential care, further complexities arise regarding:

- market imperatives,

- chrono-level factors affecting trends across welfare systems in privatisation and marketisation of care,
- balancing meeting need with profit/viability, and
- achieving appropriate governance and service delivery arrangements across statutory, voluntary and privately run services.

Furthermore, residential care, private and otherwise, needs to be critically considered in its own right but also within the wider context of alternative care policies and provision. Throughout these considerations, the interests, safety, rights and needs of the young person are central. A balance must be struck between recognising the 'factors' and 'indicators' that lead to decisions to place in residential care (like trauma, behaviour), and not unfairly labelling young people or their families for 'individualised' 'problems' when in fact the factors are more related to external issues around lack of support, supply issues, and insufficient earlier services. The research also highlights the importance of awareness of power and power relations in decision-making and the imperative for those leading and practising in the system to continue to work towards breaking down power barriers, challenging paternalism, and enhancing the power and autonomy of young people as far as possible.

Chapter 5: Phase One Findings

Introduction

This chapter provides an overview of Phase One findings.

The objectives of Phase One were as follows:

1. To describe the current usage of private residential care placements for children and young people in Tusla in the two regions.
2. To identify any relevant trends or patterns in this usage from 2015 to the commencement date of this research (March 2022), with an emphasis on understanding the decision-making process leading to the use of private placements.
3. To provide a profile of the cohort of children and young people being provided with private placements.
4. To identify any trends or patterns in the case histories of this cohort of children and young people.
5. To identify any missed opportunities for the provision of prevention and early intervention services to this cohort.

A total of 127 young people's files were analysed. The sample consisted of 61% (n=77) males and 39% (n=50) females. The majority of young people were Irish at 66% (n=84), followed by Irish Travellers, 16% (n=20). Young people whose ethnicity was described as African or Black Irish were the highest population of non-Irish young people, at 6% (n=7), followed by British at 5% (n=6), as can be seen from Table 3 below.

Table 3: Number of participants and ethnicity

Ethnicity	Males	Females	Total
Irish	56	28	84 (66%)
Irish Traveller	7	13	20 (16%)
Asian Irish	3	0	3 (2%)
Czech	1	0	1 (0.6%)
Pakistani	0	1	1 (0.6%)
African/Black Irish	5	2	7 (6%)
Egyptian	0	1	1 (0.6%)
Russian	1	1	2 (2%)
Polish	0	1	1 (0.6%)
British	3	3	6 (5%)
Not Recorded	1	0	1 (0.6%)
Total	**77 (61%)**	**50 (39%)**	**127**

To provide a profile of the population, based on the information that was available, the following tables and figures provide data including:

- Young people's origin and current residence
- Place of Residence Prior to Private Residential Care
- Type of care order
- Age on admission to PRC

- Age of child at first involvement of social work child welfare service
- Nature of first concerns
- Reasons for child placement in care
- Time between first involvement and date of admission to PRC
- Causes of placement breakdown leading to PRC
- Number of Meetings Prior to Placement
- Availability of allocated social worker at time of placement
- Young person's involvement in decision making
- psychological /psychiatric diagnosis of young person
- Physical/mental health issues of young person
- Experience of Homelessness prior to PRC
- Impact of drug/alcohol related issues prior to PRC
- Gaps in school attendance
- Young Person Involvement in Criminal and Youth Justice System

56% of the young people were originally from DML (n=71) and 44 % (n=56) were from the West. Their origin and current residential placements are detailed in Table 4. Most young people were placed outside of their own regions. Of the 71 young people whose origin of residence was DML, 22 (31%) were placed in a PRC in the same region. In the West, of the 56 young people whose origin of residence was the West, 14 (25%) were placed in the same region. Of the 127 young people analysed, a total of 36 (22 DML + 14 WNW) (28%) were placed in their area of origin.

Table 4: Young people's origin and current residence

ORIGIN		CURRENT RESIDENCE					
	Total	**DML**	**DNE**	**SE**	**SW**	**MW**	**WNW**
DML	71 (56%)	22	31	6	2	2	8
WEST	56 (44%)	8	17	5	9	3	14
Total	**127**	**30**	**48**	**11**	**11**	**5**	**22**

Table 5 details where the young person resided prior to being placed in PRC, showing a mixed trajectory. Approximately half (47%) resided in foster care prior to placement. 19% were in emergency accommodation, 15% lived at home and 7% were living with relatives. Only 3% of the young people had moved from a previous Residential Care Centre prior to being placed in their current PRC. Other placements included hospital (3%) and respite care (3%). One person was moved from a 'Special Care' placement.

Table 5: Place of residence prior to placement in PRC

Place of Residence Prior to PRC	**No. of Cases**
Foster care	47% (n=60)
Emergency accommodation	19% (n=24)
Parents' home	15% (n=19)

Relative care	7% (n=9)
Hospital	3% (n=4)
Residential care	3% (n=4)
Respite care	3% (n=4)
Not recorded	2% (n=2)
Special care	1% (n=1)
Total	**100% (n=127)**

Most young people were on either a Full Care Order (36.2%) or an Interim Care Order (23.6%) under Sections 17 and 18 of the Child Care Act 1991 respectively (see Table 6). Over a third (37.8%) were on Voluntary Agreements meaning that parents had agreed to share care with Tusla and entered into a voluntary arrangement under Section 4 of the Child Care Act 1991.

Table 6: Type of Care Order

Type of Care Order	Frequency	Percentage
Full Care Order	46	36.2%
Interim Care Order	30	23.6%
Voluntary Agreement	48	37.8%
Not recorded	3	2.4%
Total	**127**	**100%**

Table 7 shows that the most common age group for admission to PRC is 13–16-year-olds at 57.5% (n=73). Over one-third of admissions to private residential care are in the 6–12-year-old age group at 35.4% (n=45).

Table 7: Age on admission to PRC

Age Group	Percentage
2–5 years	1.6% (n=2)
6–12 years	35.4% (n=45)
13–16 years	57.5% (n=73)
17 years	4.7% (n=6)
18 years	0.8% (n=1)
Total	**100% (n=127)**

Table 8 shows that for this sample, the majority of children and young people were engaged with social work services within the child protection and welfare system from early on in their lives. A quarter of young people (26%, n=33) had first social worker involvement prior to their birth, highlighting existing concerns about those families. Most young people had social work involvement by the age of ten and less than 15% of the overall cohort had social work involvement commencing after this time.

Table 8: Age of child at first involvement with SW within the child protection and welfare system

Age	Frequency	Percentage
Pre-Birth	33	26%
1 year old and under	25	19.7%

2–5 years	29	22.8%
6–9 years	18	14.2%
10–12 years	11	8.7%
13–14 years	5	3.9%
15–16 years	5	3.9%
17–18 years	1	0.8%
Total	**127**	**100%**

Table 9 details the reasons for concern when the young people came to the attention of child protection and welfare services. Neglect was mentioned most often in case files as a first concern (n=58) followed by concerns around parental alcohol and/or drug abuse (n=46), and domestic violence (n=41).

Table 9: Nature of first concern when child/young person (YP) came to attention of child protection and welfare services

Nature of First Concern	Times Mentioned
Neglect	58
Alcohol and/or drug abuse	46
Domestic violence	41
Physical abuse	28
Parental capacity/inability	20
Emotional abuse	18
Parental health/mental	16
Sexual abuse	15
Criminality (parental)	11
Child protection & welfare concerns	11
School/appointment non-attendance	8
Social work involvement pre-birth	7
YP's at-risk behaviour	7
Accommodation issues/homelessness	7
YP's sexualised behaviour	6
YP's physical health concerns	6
Parental behaviour	5
YP threatening parent/carer	5
Siblings already in care	4
YP's mental health concerns	4
Non-engagement with services	3
Parent death	3
Support from professionals perceived to be unnecessary by young persons (I.e. focused on parent's needs)	1

Table 10 details the reasons why children were placed in care, with neglect mentioned most often (n=44), followed by young people's behaviour (n=41), parents/carers unable to care (n=39) and parental drug/alcohol abuse (n=39).

Table 10: Reasons for child being placed in care

Reasons for Child Being Placed in Care	Times Mentioned
Neglect	44
Young person's behaviour (including sexualised behaviour)	41
Parents'/carers' inability to care/incapacity	39
Parental drug and/or alcohol abuse	26
Domestic violence	25
Physical abuse	22
YP's health, safety, welfare concerns	21
Emotional abuse	18
Sexual abuse	18
Parents health (including mental)	12
Need for specialised treatment/complex needs	8
Relationship breakdown with parent/carers	7
Parental criminality	7
School/appointment non-attendance	6
Accommodation issues	5
Parent/sibling death	5
Parents not accessing services	4
Parent previously in care	2
No information provided on file	1

Table 11 details the time between the date the young people came to the attention of SW to the time they were admitted to PRC. The data shows that in over one fifth of cases, there had been social work involvement 16+ years ago and most people had involvement for three years or more. While the length of contact was substantial in most cases between first contact and data of admission, the data available did not provide sufficient evidence about what was happening in the intervening years regarding early intervention, prevention, supports etc.

Table 11: Time between dates of first social work involvement and date of admission to PRC

Time Between	Frequency	Percentage
>1 year	6	4.7%
1–3 years	12	9.4%
4–6 years	20	15.7%
7–10 years	25	19.7%
11–15 years	35	27.6%
16 +years	28	22.1%
Not recorded	1	0.8%
Total	**127**	**100.0%**

For the young people who had experienced a placement breakdown prior to being placed in PRC, the causes are detailed in Table 12. Behavioural issues of the young person were cited most often as a cause of previous placement breakdown (n=147) followed by issues experienced within the placement (n=60).

Table 12: Causes of placement breakdown leading to PRC placement

Causes of Placement Breakdown	Times Mentioned
Behavioural	147
Placement related	60
Emotional	2
Relationship breakdown	2
Geographical	1
No breakdown in placements	26

Table 13 provides a more detailed picture of the causes of placement breakdown that were recorded. Placement-related breakdowns included foster carers being unable to provide the care the young person needed (n=26) or being unable to keep the young person safe (n=8). Behavioural issues of the young person were cited as challenging behaviour (n=21), aggressive/abusive behaviour (n=20), negative behaviour (n=18) and sexualised behaviour (n=10), among others.

Table 13: Causes of placement breakdown leading to PRC placement (detailed)

Causes of Placement Breakdown	Times Mentioned	Nature of Cause
No breakdown/not applicable	26	-
Foster carers unable to provide care needed	23	Placement related
Challenging behaviour	21	Behavioural (young person)
Aggressive/abusive behaviour	20	Behavioural
Negative behaviour	18	Behavioural
Sexualised behaviour	10	Behavioural
Threatening behaviour	8	Behavioural
Foster carers unable to keep YP safe	8	Placement related
Risky behaviour (substance misuse, drinking, getting hurt)	8	Behavioural
Property damage/criminal damage	7	Behavioural
Allegations against foster carers	7	Placement related
Impact on others in care	7	Placement related
Escalating behaviour	6	Behavioural
Violent behaviour	6	Behavioural
Absconsion	6	Behavioural
Relative carers unable to care for YP	6	Placement related
Self-harm/suicidal ideation	5	Behavioural
Verbally abusive behaviour	4	Behavioural
Breakdown in relationship with foster carers	4	Placement related
Physical behaviour (biting/kicking)	3	Behavioural
Bullying others	3	Behavioural
Stealing	3	Behavioural
Dangerous behaviour	2	Behavioural

Assaultive behaviour	2	Behavioural
Targeting staff	2	Behavioural
Rule breaking	2	Behavioural
Poor family relationships	2	Relationship breakdown
Centre closed	2	Placement related
Concerns for progress/welfare	2	Behavioural
Short-term placement ended	2	Placement related
Complex behaviour	1	Behavioural
Defiant behaviour	1	Behavioural
Emotional behaviour	1	Behavioural
Controlling behaviour	1	Behavioural
Tantrums	1	Behavioural
Cruelty to animals	1	Behavioural
Inability to engage	1	Emotional
Unable to regulate themselves	1	Emotional
Selling drugs	1	Behavioural
School refusal	1	Behavioural
Suspension from school	1	Behavioural
Poor relationship with fellow residents/foster children	1	Placement related
To be closer to family	1	Geographical

Table 14 sets out the number of meetings that took place prior to the young person being placed in PRC. This is recorded as it gives an indication of the decision-making processes. The majority of cases recorded that one meeting took place prior to placement (n=47), 36 case files showed two meetings took place and 14 cases recorded three meetings. Nine case files did not have this information recorded on file.

Table 14: Number of meetings prior to placement in PRC

Number of Meetings prior to PRC Placement	Meetings noted on files
0 Meetings	1 case file
1 Meeting	47 cases
2 Meetings	36 cases
3 Meetings	14 cases
4 Meetings	6 cases
5 Meetings	5 cases
6 Meetings	5 cases
7 Meetings	2 cases
8 Meetings	2 cases
Not recorded	9 cases
Total	**127**

Table 15 shows that for the majority of case files (96%, n=122) there was a social worker in place at the time the decision was made to place the YP in PRC. Five cases (4%) did not record that information. All but one of the 127 files showed that at the time the files were analysed there was a social worker in place. Forty-four (35%) of the 127 files showed no gaps

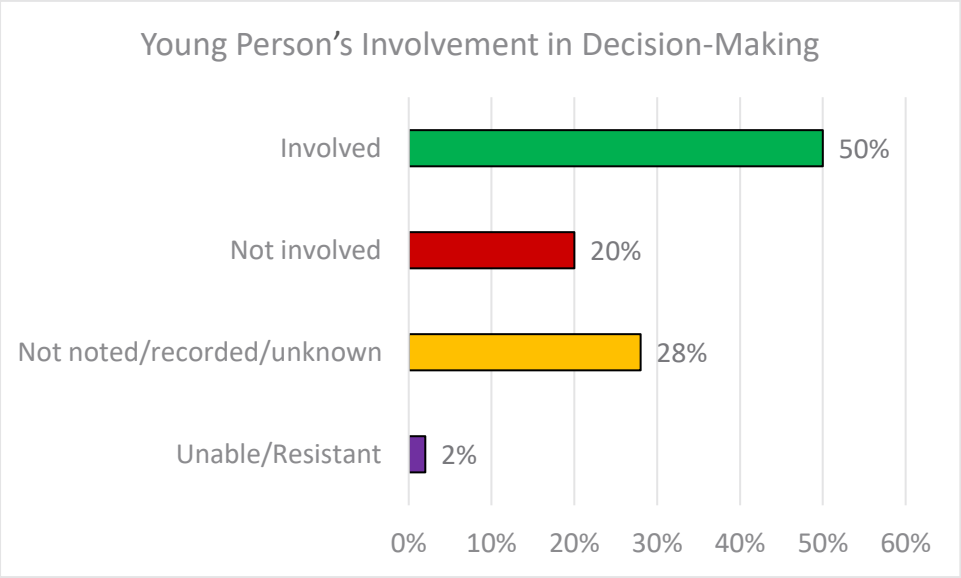
in social work allocation while the majority of files did not record that information (65%, n=83).

Table 15: Whether or not a social worker was in place at the time decision made to place YP in PRC

Was a social worker in place at the time of decision made to place in PRC?	
Yes 122 (96%)	Not Recorded 5 (4%)
Is there a social worker currently in place?	
Yes 126 (99%)	Not Recorded 1 (1%)
Have there been any gaps in social work allocation?	
No 44 (35%)	Not Recorded 83 (65%)

Figure 3 shows that half of the case files noted that the young person was involved in the decision-making process surrounding their placement to PRC while 20% were not involved. 28% of case files did not record this information while a further 2% stated the young person was unable or unwilling to take part in the decision-making process.

Figure 3: Young person's involvement in decision-making



Half of the sample were in care (mostly foster care) before admission to PRC and another 19% were in emergency accommodation.

Table 16 details the number of times diagnosed psychological or psychiatric issues were mentioned in relation to the young people. Thirty-two files stated there were no issues while in 15 cases there were no psychological or psychiatric diagnoses recorded on the files. The most common type of psychological/psychiatric diagnosis mentioned in the case files was that the young person had a cognitive or learning disability (n=32), followed by attention deficit disorder (n=26). Emotional or behavioural disorders were mentioned in 18 case files while dyslexia was mentioned in 15 files followed by Attachment Disorder (n=12).

Table 16: Psychological/psychiatric diagnosis of young person

Name of Diagnosis	**Times Mentioned**
None	32 cases
Cognitive/Learning Disability	32 cases
Attention Deficit Disorder (ADD/ADHD)	26 cases
Emotional/Behavioural Disorder	18 cases
Dyslexia	15 cases
Not Recorded (at top)	15 cases
Attachment Disorder	12 cases
Autism Spectrum Disorder (ASD)	10 cases
Speech & Language Difficulty	8 cases
Opposition Deficit Disorder (ODD)	6 cases
Dyspraxia (DCD)	6 cases
Post-Traumatic Stress Disorder (PTSD)	5 cases
Foetal Alcohol Syndrome	4 cases
No Diagnosis	4 cases
Sensory Processing Difficulties	3 cases
Developmental Disorder	3 cases
Dyscalculia	3 cases
Familial Global Developmental Delay	3 cases
The following diagnoses were each mentioned once: Disinhibited Social Engagement Disorder; Obsessive Compulsive Disorder; Micro-Duplication Syndrome; Auditory Difficulties; Motor Deficiency; Borderline Personality Disorder; Anxiety; Epilepsy; Selective Mutism; Psychotic Disorder	Once

Table 17 lists the number of times a physical or mental health issue was noted on the case files with only 20 files recording no issues and 11 files stating there were no issues recorded on file. Self-harm was mentioned in 33 cases, followed by attempted suicide or had suicidal ideation (n=27). Anxiety, depression and stress were noted on 25 files, followed by behavioural or emotional issues (n=12).

Table 17: Physical/mental health issues of young person

Physical/Mental Health issue	Times mentioned
Self-harm	33
Suicide ideation/attempt	27
Anxiety/depression/stress	25
None	20
Behavioural/emotional issues	12
Not recorded	11
Speech & language issues	11
Asthma	7
Attachment issues	5
Enuresis	5
Poor motor skills	5
Eczema	4
Obesity/overweight	4
Sensory processing difficulties	4
Cognition issues	4
Eating disorder	3

Epilepsy	2
Kidney issues	2
Familial global developmental delay	2
Chromosome imbalance	2
The following issues were each mentioned once: Early Onset Puberty; Foetal Alcohol Syndrome; Pervasive Developmental Disorder; Systolic Murmur; Hypermetropic Astigmatism; Scoliosis; Osteochondrosis of the Foot; Auditory Issues; Allergies; Diabetes; Sleep Apnoea; Von Willebrand Disease; Growth Hormone Deficiency; Poor Eyesight; Benign Intracranial Hypertension; Vitamin A Deficiency; Porphyria; Dyscalculia; Poor Coping Skills	Once

Figure 4 details whether any of the young people experienced issues of homelessness prior to being placed in PRC with the vast majority having had no issues (89%). Nine per cent had had issues of homelessness while 2% of files noted issues with parental homelessness.

Figure 4: Issues of homelessness prior to PRC

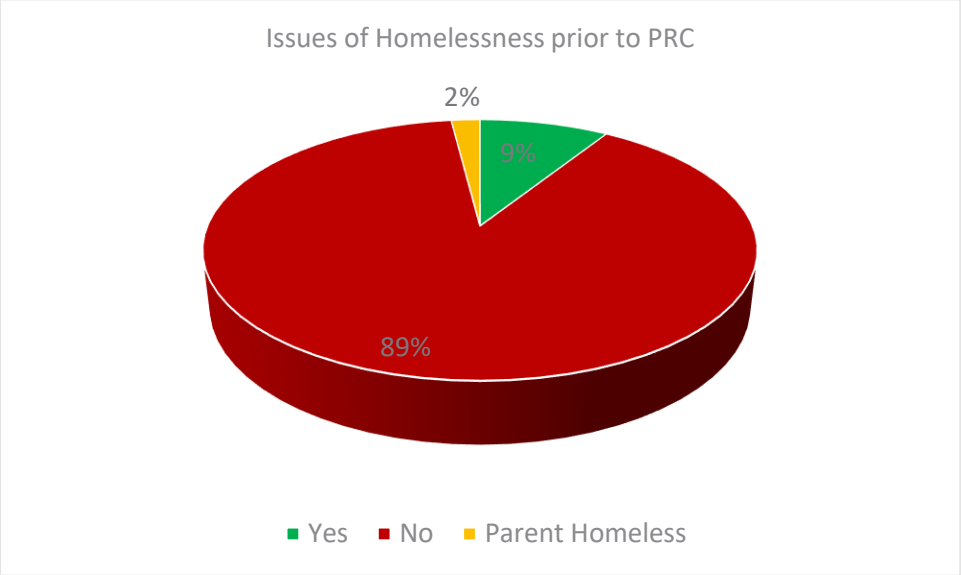


Table 18 sets out the impact of drug and or alcohol abuse prior to the young person being placed in PRC with 49% (n=62) of cases stating there were issues of parental drug/alcohol abuse. Seventeen per cent (17%) (n=37) of case files noted issues of drug/alcohol abuse in relation to the young person while 29% (n=37) had no issues. Nine per cent (9%) (n=12) of files did not have this information.

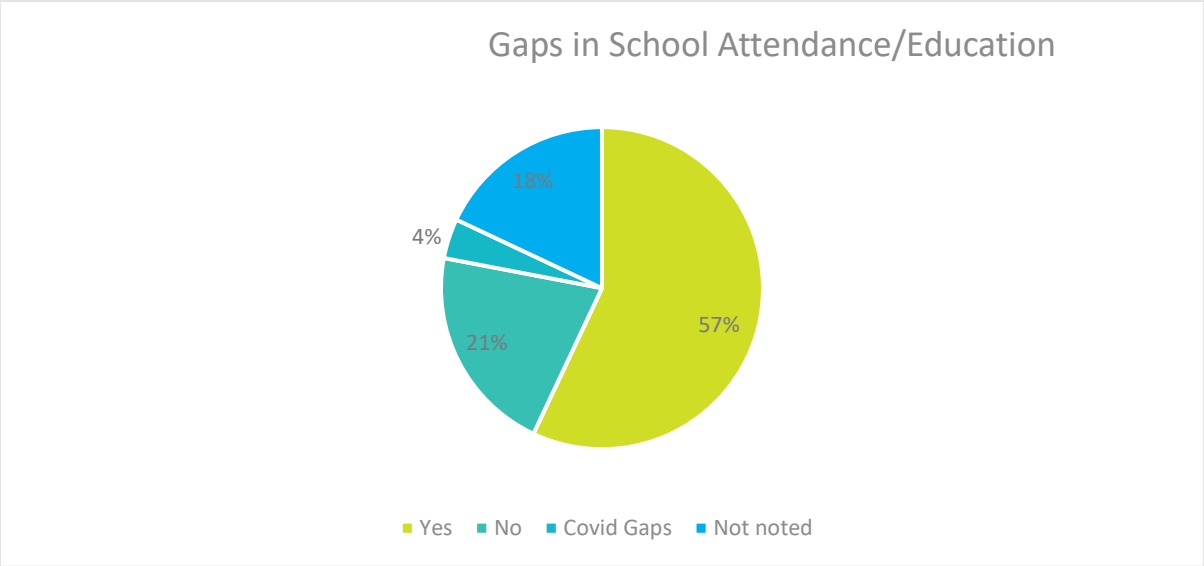
Table 18: Impact of drug and/or alcohol abuse prior to PRC

Impact of Drug and/or Alcohol Abuse Prior to PRC	Times Mentioned	Percentage of Cases
Yes – parental issues	62 cases	49%
No issues	37 cases	29%
Yes – young person issues	22 cases	17%
Not recorded	12 cases	9%

'Yes' – not stated whose issues	2 cases	1.5%

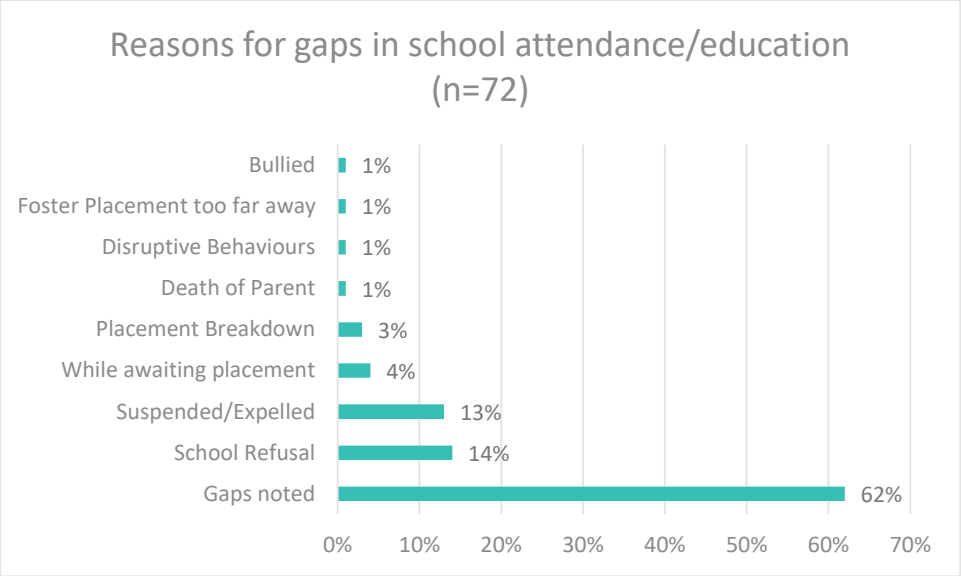
Figure 5 details whether there were any gaps in school attendance noted on the case files with 57% (n=72) stating there were gaps. Twenty-one per cent (21%) (n=26) noted no gaps in school attendance while 18% (n=23) did not record this information. Four per cent (4%) (n=5) specifically stated gaps were related to Covid-19 school closures only.

Figure 5: Gaps in school attendance/education



For the 57% (n=72) gaps noted, Figure 6 further expands on the reasons set out in the files for non-attendance. In 62% (n=44) of case files it was merely stated that there were gaps without any explanation as to why. Fourteen per cent (14%) (n=10) stated the gaps were in relation to the young person refusing to attend school. Thirteen per cent (13%) (n=9) noted that the young person had been suspended or expelled from school as the reason for the gaps. Four per cent (4%) (n=3) had gaps in school attendance while awaiting a placement.

Figure 6: Reasons for gaps in school attendance/education



Of the 127 case files, 66% stated there was no criminal or youth justice involvement with a further 4% not recorded or noted. 30% of young people's case files recorded criminal/youth justice involvement.

Table 19: Young Person Involvement in Criminal and Youth Justice System

Criminal/Youth Justice Involvement	Out of 127 case files
Yes	30% (n=38)
No	66% (n=84)
Not noted/not recorded	4% (n= 5)
Total	**127**

Summary Phase One Findings

In response to the specific research questions relating to Phase One data, the report above gives a snapshot of the usage of PRC for children and young people over the period in question based on the data that was available. Analysis of the files to record the case histories of the young people from data and files alone could not provide a full 'profile' per se. However, it does indicate important themes and trends to note.

The fact that most young people had a social worker from child protection and welfare services before the age of 10, with a quarter being involved with child protection since birth, would suggest many missed opportunities for provision of earlier intervention, prevention and family support.

The fact that the majority of children and young people had a recorded psychiatric or psychological disorder is a very notable finding raising questions of what interventions could have been implemented prior to admission to PRC. This is reinforced by further findings of the number of recorded physical and mental health issues.

Drug and alcohol use by either parent or child is another notable trend, again indicating that interventions could be targeted at an earlier stage in the genesis of the issue. Indeed, the data shows that the reasons for placing children in care and the nature of first concerns portray issues that could be a focus of early intervention.

The data shows that previous placement breakdowns occurred predominantly due to behavioural issues of the child. However, this does not tell us if the placement breakdown is in the foster care system or in residential care. In addition, the number of meetings recorded prior to decisions being made to place the child in PRC were mostly small indicating that more specific, standardised data entry and data collection is needed. While the data shows that 50% of children and young people were involved in decision-making, the level and type of involvement is mostly absent from the records. Furthermore, 57% of children and young people were identified as having gaps in their education. The reasons for those gaps are not accurately recorded in the case files. 30% of young people's case files recorded criminal/youth justice involvement.

Twenty-six (26%) of the cases explored had first social worker involvement prior to the birth of the child, highlighting existing concerns about those families. Moreover, the gap between the time the children came to social worker attention and the time they were admitted to PRC is substantial in most cases. However, the data does not provide evidence about what was happening in the intervening years, e.g., nothing at all, early intervention, prevention, supports, etc.

Indeed, social work involvement with children and young people is more difficult after admission into PRC as the majority of children and young people are placed outside their areas of origin. Of the 127 children/young people 41% (n=52) were placed in their areas of origin while 59% were not.

The data shows that most children and young people were in another form of care prior to admission to PRC, with 47% in foster care, 24% in emergency accommodation and 15% coming directly from their parents' home. Most children and young people were the subject of Care Orders, although a significant minority, one-third, were on Voluntary Agreements Over one-third of admissions to private residential care were in the 6–12-year-old age group (35.4%). However, the majority were in the 13–16-year-old age group (57.5%), with the most common reason for placement relating to behavioural issues. This could indicate that teenage behavioural issues warrant targeted, earlier interventions both in the home and in the foster care setting.

Overall, as discussed in Chapter 7, this data gives important insight into trends and trajectories. However, in itself, it was limited with regard to providing a depth of understanding of the decision-making pathways. It implies there were many missed opportunities, but it is not possible from this data to specify exactly what those were and when they occurred. In Chapter 7, we will discuss this data further and make recommendations based on the learning from the data, and about future data collection and integration of data to inform further research.

Chapter 6: Phase Two Findings

Introduction

This chapter reports on the findings relating to Phase Two interviews. Findings are presented from participants as follows: children and young people with direct experience (children and young people), key workers, centre managers and social workers providing direct services and supports, and organisational/management representatives including the National Office and Chief Regional Officers.

Findings from Interviews: Children and Young People

The profile of the four children and young people in this study is as follows; all are aged between 11 and 17, two are boys and two are girls, all have complex backgrounds. One young person has special needs. Three of the four children and young people have contact with their families. The main themes arising from interviews with children and young people were:

- Reasons for placement in residential care
- Relationships with residential care staff and feelings about being in residential care
- Relationship with social workers
- Involvement in decision-making
- Voice being heard.

Reasons for Placement in PRC

All children and young people had foster placements that had broken down for various reasons and consequently they were moved to PRC. Some had a number of foster placement breakdowns prior to residential care placements. A number of reasons for those breakdowns were identified, for example:

> So just like any family, you have fights, it's part and parcel. And you don't expect the move. You could be grand one minute with them and be falling out with them the next minute and that just continues on and then you get moved in the end. In some cases you just have to make the decision to leave yourself.

One young person spoke of leaving foster placement and moving in with his friends. He was there for approximately one month and then he got a phone call to say he was being moved to residential care.

Another spoke of having different foster homes in different jurisdictions until being placed in residential care due to foster care breakdown. Another young person did not particularly like their foster placement and spoke about feeling awkward there: 'It was awkward there. We didn't really have any internet. It just felt really awkward there as well. The feeling when I was in the house and all and I couldn't sleep there.' Referring to their understanding of why they were in residential care, one young person thought it was because their foster parents 'didn't really want me'.

Relationships with Residential Care Staff and Feelings About Being in Residential Care

Children and young people were generally positive about relationships with their residential staff and while they valued a transparent relationship, they were clear about the supports received from the PRC staff: 'all the staff members are here, and all look out for you and everything. They do anything they can. They're a good support.'

One young person also spoke about his feelings on first entry to PRC:

> We know everything like the back of our hands. I say to every new staff member that walks in here – you don't bullshit me; I won't bullshit you. I can see right through it because we've been through that much. We know when someone is bullshitting. Why are you lying to us?

Some children and young people spoke about the rules in residential care and did not think they were fair. For example, one young person spoke about not being able to have friends over, not being able to go to other people's houses and her friends not being allowed to come in the car with her.

> Rules are a bit too rigid, to make people safe. But they went a bit too far. Like I'm not allowed to have any friends over or go to their houses. These kind of rules. I don't like them rules.

Another young person expressed similar views about the rules: 'There was like a firebox in the hallway and fire extinguishers in every room …We're not allowed to use the staff bathroom. I have to go upstairs. That's weird.'

Relationship with Social Workers

All of the children and young people interviewed had a number of different social workers throughout their care experiences ranging from 3 to 4 social workers up to 12 to 13 social workers. The children and young people spoke about their experiences of social workers and how the high turnover of social workers made it hard to trust them. As one young person explained:

> If you put your trust in one, then they break it, it's hard to trust anyone else and then you have to repeat yourself and say all the stuff that you've already said before. None of them would stay to their word because they all say they will stay and do this and do that, but they don't.

One young person disliked his current social worker as 'she gets nothing done. She's always off.' The children and young people also spoke about infrequency of contact with their social workers, and some could not identify whether they liked their social worker or not as they had not met them that often, e.g., one young person could not say whether he liked her or not. For another, it bothered her getting different social workers: 'it would be easier having the same one'.

One young person identified lack of consistency in the support he received from social work:

> Just more regular check-ups with social workers cause they're meant to come out and see you once a month but they're hardly there to come out once a month so if they came more often there would be more stuff done, possibly.

Another young person suggested an information leaflet might help with lack of consistency and give the young person information about what is happening. As discussed in the section to follow, one of the main issues arising for children and young people was their involvement in decision-making within the residential care setting itself and with social workers.

Involvement in Decision-Making

All of the young people were asked about the decisions to place them in residential care and whether or not they had an opportunity to voice their opinions about their placements. All responded that they did not have the opportunity to express their opinions and mixed views were expressed about the placement in residential care. Regarding giving their opinion, one person stated: 'I was just told. I was living with my friend for a while and the social worker

just called me one day and said there was a placement, and I came here. They just sent me in here and a social worker came down.'

This young person did not know who made the decision to place him in residential care but thought it might be the social workers and at team meetings. When asked how that decision was reached, they stated: 'I don't know to be honest with you. They told me it's all your age and your background and all this carry on. They don't give you an option of going back to foster or residential.' Regarding why they were placed in a residential placement, they stated: 'They never said. Nobody says to be honest. I think it was an emergency placement or something. It was the first spot they could find … I was just thrown in here one day and the next minute the social worker went off for three-and-a-half months and I had no social worker.' This respondent also did not agree with being sent to a placement far away from his home: 'I don't agree with any of them to be honest. What's the point in sending me here if everyone else is there. There are plenty of places where I'm from.'

Another young person was satisfied with the decision the social worker had made for them. 'She decided it would be best for me to come here and I thought that was a smart decision on her behalf. I love it here now.' However, while happy with the decision ('at the start I was pissed but I love it now'), they stated their opinions were not taken into account: 'No. You don't get an opinion. It's what's best for you.' The need for more clarity around decisions being made by social workers was highlighted by one young person who stated that:

> They should have made out a plan a few weeks before I was placed here. Like, being clear I suppose on the planning … Like all of us should have sat down, the foster carers, myself and the manager, the social worker, to see what was best. I wasn't involved in any of those meetings.

The specific need to consult social workers surrounding everyday decisions was a considerable source of stress for the children and young people. There were a number of decisions being left to social workers that the children and young people felt in reality their key workers were better placed to make, e.g., whether or not they could have a mobile phone, get a piercing, use contact lenses or go to the shop. Three of the children and young people were of the view that the decision-making 'should be changed to the people who are actually in the residential centre rather than trying to call someone about a decision, they are off for annual leave for three months or whatever'. Some of the decisions being made seem to be based on the age of the children and young people rather than on their individual abilities or capabilities. For example, an argument was made by one person that, at the age of 16, they 'should have the authority to make decisions on my own. If a 16-year-old wants to go and get a piercing, they should be able to go and get one without having to ask.' This connected with a view that staff were too 'by the book':

> There needs to be a tiny bit of leeway. Like I wasn't allowed to get an X-Box. X-Box is live, and all the boys were like why can't you play?… They play too much by the book and it's weird.

The need to balance safety with autonomy is reflected by the following viewpoint: 'They think it's their job to make sure we're safe and all and it's good that they want us to be safe but me not being allowed a phone, that was protecting me, well that to me was them holding me back.'

For others, it was a matter of trust and recognition that it is more capacity than age that should count:

> They said a 13-year-old can't be trusted with that [contact lenses] with the hygiene part of it … I think I'm responsible enough. Like not every 13-year-old will have gone through the same things I have. Like I know some 13-

> year-olds who can't tie their shoelaces yet, but it is whatever way you have been reared. I was reared with common sense.

One young person's social worker agreed to her using a mobile phone but only with a Parenting App installed on it to monitor her usage. She expressed concern over this:

> They can look at my phone whenever they want, and I don't like that. I'm not a little baby anymore. I said it about 20 million times, and she still won't take it off my phone.

Some respondents had contact with their families on a regular basis while others had no contact with their families whatsoever. Those who had limited contact with their families had some issues around the decisions made in this area:

> Sure I'm still fighting for stuff I didn't get 9 or 10 years ago. My access is still only once a month for one hour … Last month they would allow me to see my mother and get the bus down by myself. That was supposed to happen a year ago. They really took their time about it … I get once-a-month access. It doesn't sit well with me.

One young person stated she had to fight to get to see her grandmother and was not happy with the length of time allowed: 'They only let me stay for one hour, so it wasn't enough time.' Another young person had no contact with his biological family but did get to see his foster parents on a regular basis.

Voice Being Heard

The findings above already indicate that participants viewed age-related decision-making as too 'by the book'. Views were expressed that decisions should be made based on the individual ability of each young person rather than on their age. The need for flexibility around decision-making was highlighted. There were mixed views on whether young people's voices were being heard in their residential care placement. Some have learned that persistence is the key to being heard:

> My voice is heard very well because there was a couple of times when I wasn't being heard and one thing with me is I won't take no for an answer. I always ask and ask and ask until they give up and get fed up of saying no.

For another young person, they felt they were not being listened to, 'There is no argument, it is them that makes the decision … The simplest way to put it is they put it on the long finger. They will say they will look into it, but it doesn't actually get done.' When the young person read about their own rights, they found out they were entitled to attend care meetings: 'They've started including me in meetings now because God knows what they could say. They're talking away. I showed them the policy. I showed them where I should be involved. I had to get the policy.' As another young person stated that care services 'should actually listen to young people, let them have a say and not control 14- or 15-year-olds … It's the same with the younger ones. They don't get much of a say either.'

Findings from Direct Practice: Residential Care Key Workers, Centre Managers and Social Workers

This section of the findings presents views of keyworkers, centre managers and social workers. Many similar themes were identified from these different positions of practice and support with children, young people and their families. Findings for this section are presented under the following headings:

- Trends and patterns before entry to PRC
- Role of prevention and early intervention and family support

- Decision-making processes
- Voices of children and young people
- Availability of and relationships with social workers
- Aftercare support.

Trends and Patterns Before Entry into PRC

When asked about trends or patterns in the profile of children and young people who are placed in PRC, keyworkers indicated that all of those placed had experienced some form of trauma and are sometimes younger on entry into PRC than has been the case historically:

> It is the first time there have been so many younger children … it is the first time that we had derogation for two children in the one house, it was normally like maybe, there would be very few [times] that there would be a child under 12 who would be coming into residential. I suppose that has been a kind of pattern over this past while.

They also identified the breakdown of foster placements as being the predominant cause of placement into PRC. 'Like every child that is in this house, their foster placements have broken down, you know, it is not the first port of call ever, as you know, residential is not anyway … some of them have been placed with foster carers, that it was their first child, that they were new foster carers.' Social workers also indicated that those who are placed in PRC often have higher needs: 'I think young people that are referred to private residential mainly are probably more challenging and I think that they take in a lot more young people that would have a lot more high needs.'

In relation to foster care, lack of experience in dealing with the complex needs of the children and young people, a lack of support and information for foster carers, and the need for more assessment were identified as contributing to placement breakdowns leading to entry into PRC-by-PRC managers:

> These children that are here they obviously have really complex needs and presented with higher risk. And I often wonder if there had been kind of more assessment done whether they would have been placed with those foster carers in the first place and then whether it would have broken down.

The need for better child protection training for all who work with children in a professional capacity was identified by social workers in this context. This could ensure that preventative supports are put in place faster and more effectively if needed. Indeed, a reduction in 'red tape' is also needed to achieve this goal. Specialised training for foster carers to manage challenging behaviours was also cited as needed by social workers who were of the view that such training could reduce foster placement breakdowns.

> If we can just get more foster carers and especially specialised foster carers, foster carers who are specially trained to, who would be able to parent children with behaviours that are very challenging … So more specialised foster carers and training for them would probably help.

Lack of information prevented respondents discussing trajectories and trends that led to placement in care. For example, keyworkers discussed their limited knowledge of the history of the children and young people and how they had practically no knowledge of the circumstances that led them to being in a PRC placement, except that the breakdown of foster placements led many to be placed in PRC. Keyworkers noted that this makes supporting them difficult, particularly when they are looking for answers about their history and circumstances or even trying to identify reasons for particular behaviours.

> The pre-work before you even get to even see a residential, all that their stuff should be I think more straightforward. If I have the access to the young person's information instead of me looking through everything and sending that onto somebody else and then they are looking on clarifications on so much. I would feel that everybody should be able to access a file if they are identified as a child in residential, to me that would just make more sense.

Social workers and centre managers also referred to the very limited background information available to them about the decisions to refer children or young people in PRC. Because of gaps in referral information, sometimes keyworkers are 'working blind' with very little knowledge of the traumas suffered: 'You do go into some cases that bit blind and you do have to, to a degree, rely on the relationship-building process and reading situations and tread carefully I suppose, for want of a better word, for a period of time.' This makes their work difficult at times because of the lack of context and background information:

> We often find when we get referral information there are massive gaps, there are massive grey areas. Even my key child has been here for three years now and there is still parts missing … I can imagine but I have no idea what he went through. I am still waiting on that … Having it as a matter of priority I think is so important. Because you need the context of where have they come from, what has happened to them, what have they seen, do you know what I mean? I have nothing on his formative years, do you know what I mean?

The broader need to improve provision of information to young people was also cited by social workers. Firstly, information for young people entering care needs to be improved, particularly in terms of explanations of what care is and what it means, and the differences in care types. As one social worker expressed, echoing concerns expressed in the findings from children and young people, young people need more honest communication earlier on about the processes for care placement as they often do not realise that once behaviour becomes unmanageable in foster care then residential care is the next step.

> The statutory side should be explained to the young people, especially ones in foster care where it is like normal teenage behaviour where there are moody days isn't going to affect the placement. But if it is ongoing and severe and long and you can see it in two years' time breaking down, I think the best thing is to be honest with them about the process in the future.

Role of Prevention, Early Intervention and Family Support

The need for greater attention to prevention, early intervention and family support was widely discussed. Keyworkers for example discussed the need for support for both birth and foster families, as well as for families where reunification is a possibility:

> Our other young boy, he has had 12 social workers … so he has a very different relationship with the social work department and sees it as a negative thing. I think the most important thing … is those early interventions are so desperately needed. The interventions with the foster family, the interventions with the birth family.

Recognising the role of prevention and early intervention (PEI) in preventing the requirement for placement in residential care, keyworkers were of the view that PEI may work in some cases but noted many missed opportunities for earlier intervention. For example, one comment was:

> I think we don't pick up quick enough when things are going wrong in family situations and then we are intervening at the stage where these kids need to be removed because that is the absolute priority, but we have missed the opportunity to put things in place earlier a lot of the time, yes, absolutely.

Some keyworkers questioned the availability of such supports for parents after placement in PRC has commenced, whereby such supports are needed to ensure reunification: 'Even when kids have been removed with parental support, I feel like the focus then shifts to the young people and their care, rightly so, but there is not enough work done with the family to make those changes so that we can reunify.'

Social workers were likewise of the view that more focus is needed on prevention and early intervention rather than working on responses to crises:

> I think a large proportion of Tusla's budget goes on fixing the problem after the fact … I know that is hard because obviously we are in such a crisis in the care system at the moment that it is going to be hard to move our funding and our allocations away from emergencies to prevention.

For one centre manager, the issue was that more needs to be done when families come to the attention of child protection social work in the first place, following models in the UK where different professionals are much more involved at the early intervention level: 'There is no kind of procedure in place to go, right that is three, four, five times that family has been flagged … So I think there could probably be a more robust procedure in place in terms of flagging up those early indicators.' Some keyworkers discussed how one main barrier to parents and guardians seeking support at the early stages is fear of Tusla:

> There is a trust thing, unfortunately Tusla have a reputation of they come in and they take our kids. And that is the way they see it … The first step is acknowledging that these are issues, and I guess there is a lot of it is fear, they [parents] try to hide situations and not deal with them because they think that is the better way of doing it.

To address this, more public information on the role of Tusla was identified as a need by keyworkers:

> You hear Tusla and you go, oh Jesus, do you know what I mean? If it was more open … people don't feel embarrassed now talking about sexual relationships, about periods, about their mental health, why should there be this embarrassment about child rearing, about struggling about that? Tusla should be more open and say, look we just don't take your children away, this is what we do, we are here to help.

Keyworkers also emphasised the need for family support for foster carers to enable them to care for children and young people with complex needs and to avoid placement breakdown:

> A lot of the cases I have seen over the years since I have been here have come from broken-down foster placements … there has to be some kind of intervention for the foster carers where they get the support that they need from Tusla, where they are given the information that they need, because these are complex children.

From a PRC Manager perspective, it was also noted that expectations of foster carers regarding young people's behaviour can be too high: 'More often than not maybe two foster placements later or whatever and they have tried again, and it has broken down again. And often because the expectations of the foster carers is different than what the expectations of [parents are].' And residential care was deemed to offer 'higher tolerance' for certain

behaviours: 'the level of tolerance, like obviously working in residential our level of tolerance to certain behaviours is a lot higher [than those] who have taken on a foster placement'. Managers added the need to recognise that new foster families are not appropriate placement options for children with very complex needs: 'Even on paper without having a lot of information two of the children here would have looked to me as high risk and [having] very complex needs and I would wonder was it the best decision for them to go into a foster care [with foster parents] who had never fostered any children before.'

The need for better support for foster care was also highlighted:

> So I wonder if the correct interventions and support were put in with the foster carers, if they would have ended up with us at all. I suppose I found that sometimes the interventions were put in after the difficulties or at a kind of very, they are nearly unmanageable by the time the correct supports are put in place.

The notion of residential care being a 'last resort' was discussed in the context of balancing the principles of prevention, early intervention and family support with the needs for some children to be in care generally or residential care specifically. For example, key workers understood the attitude that placement in residential care is a 'last resort' as being influenced by Tusla's view that the best interests of the child are better served when they reside with a family and focus is on prevention and early intervention: 'We have always kind of felt that the end of the line is kind of residential.'

However, it was also suggested that Tusla needs to move away from one line of thinking on 'last resort' because some children and young people are unable to cope with a foster placement and they need the wraparound supports offered in residential settings to progress. As one social worker stated:

> He has really thrived since he has gone into residential which I don't think would ever have happened in a home foster placement setting because of his background and his pre-care experience … Some youngsters are not able to cope in a foster placement whether that be relative or a general foster placement … my argument was well he is settled because there is such a good wraparound package there.

Another social worker spoke about how Ireland's constitutional focus on the family and the focus on family reunification makes it difficult to put permanent child protection measures in place when children first come to the attention of social work.

> It is back to our constitution in Ireland … our courts are led of course by our constitution, it is very much the family, the family exists. Whereas I would work near the border, I worked in the North, and of course the children's order is the permanency piece about the child. And we say it is in this state too but in practice … it is not about the child front and central.

Indeed, the focus on a family environment being the best place for a child is viewed by some social workers as preventing an acknowledgement that in some cases children and young people do better in residential care.

> We still have this belief that mammy, daddy, 2.2 children, the dog and the cat, you know. Whereas there is absolutely nothing wrong with residential. And even I think across society, schools, you name it, there is a lot more labelling, a lot of labelling goes on for kids in care anyway but if the child is in a residential it is more frowned upon.

Linked to this is the importance of recognising that it is sometimes the young person who wants this form of care. As a social worker stated with reference to an example:

> This person would have a loving foster home, but it is just unfortunate that they can't make that transition, that bond, it was that young person's decision, and we are just trying to meet her needs and try and get her into a residential because some people don't want to be part of a second family.

Decision-Making Processes

Much of the discussion with practitioners about decision-making focused on day-to-day decision-making and the way in which decision-making regarding the young person in care is managed between residential staff and social workers/Tusla services. Many challenges in negotiation and boundaries around day-to-day decision-making and other formal processes of decision-making were identified. For example, PRC managers spoke about making day-to-day decisions through the course of the children's and young people's time in PRC. Some indicated that the day-to-day decisions are made between the centre management and the staff team for the most part: 'Well I suppose it would be myself, the deputy manager and the staff team would make the day-to-day decisions for the young person.'

Ideally, this needs to take place in the context of a relationship of trust with the social worker, which needs time to be built up. One centre manager described how day-to-day decisions for the children and young people were made collaboratively between the PRC and the social worker as follows:

> Overall we as a team would but I suppose there is a process. Initially we are getting to know the social worker, the social worker is getting to know us. Sometimes if we have a social worker who has had a referral here before, they know the team, they trust us, so there is this kind of period of building trust with the social work department. So the decisions initially would probably be more collaborative.

Likewise, social workers spoke about working in collaboration with the residential centres in relation to decision-making. As one worker expressed it: 'So I am working on the plans now, [for example] how will this young person communicate with the residential staff, like what is that going to look like day to day. So we are trying to get them plans before they move there.' For most, social work involvement is high during the transitional process on entry into residential care and this reduces over time once the child/young person has settled. The social workers described their role as providing assistance at points of care planning, breakdowns, referrals or preparation for residential care: 'Because that is generally progressed by the time the youngster comes to our team and the only experience we would have is when placements break down and then we make referrals onwards for a change of placement.'

Even though involvement diminishes after placement, social worker continues to retain the day-to-day decision-making power for 'big decisions' as described below by a social worker:

> So when the young person enters, obviously I would have a big part … especially at the start of it, the transitional part. And then as they settle in the residential they will get their key worker and that key worker then gets to know that young person, builds up that relationship, identifies the needs and risks along with the residential place, the other staff members and especially the management … Whenever it comes to bigger decisions like the access to family members, a plan would be done by myself, we would rely on the residential to make sure that the child gets there, gets back, unless they need obviously my help for that.

In discussions about day-to-day decision-making from a keyworker's perspective, it was accepted that significant decisions regarding the care and welfare of the children and young people are made on the basis of the type of Care Order in place, with parents being consulted

for those on interim Care Orders and the appointed social worker having the final say for those on full Care Orders. However, an inherent frustration was expressed by all keyworkers on the need to consult social workers about more day-to-day decisions that could easily be decided in-house given the staff experience: 'We have obviously been established for 15 years, we are all professional background, but I feel like some social workers are very tentative with letting go of the reins and allowing us to make decisions.'

And the difference in scope for decision-making was noted depending on the nature the relationship with the social worker. Where there was a well-established relationship and the social worker was known to the centre, it was thought more decisions (other than those regarding 'bigger issues') were devolved. However, lack of an established relationship, or lack of flexibility on the part of the social worker were also noted as affecting decision-making:

> I have had experience with social workers who, if we want to be flexible in free time with kids, we had to run everything up the pole. And so that can be frustrating, and I suppose, you know, that is down to individual social workers and the relationship we have built with them. So it is social worker and relationship dependent really.

PRC managers were also of the view that their years of professional experience, regulations and inspections should qualify them to make more of the day-to-day decisions needed and that they should be trusted to do so:

> We are inspected and regulated, that we have to be able to make those day-to-day decisions anyway but I suppose it can be that the social worker knows this now and that they trust us to make the decisions whereas you would like to be trusted from day one … Based on your reputation, I am not on about new companies opening up and expecting it but [PRC Centre] has been around for nearly 20 years now.

The fact that residential staff do not have the authority to make 'big decisions' was likewise acknowledged to be problematic by the social workers, recognising that they were not solely in positions either to make decisions: 'And of course they don't have that decision-making capacity either in terms of those big decisions so I suppose that can cause problems as well.'

Key workers expressed a view that more flexibility is required and appreciation of the professional qualifications and experience of the teams:

> I still think maybe some social workers, they want to make all the decisions for the young person … we are then feeding back to the young person … they have actually said no you can't do this and maybe you are not allowed to go there, you are not allowed to do this. We then get the brunt of the behaviour, and it fractures our relationship with them.

Without this, 'it is very hard to kind of build trust …' and more freedom around decision-making is needed: 'yes make decisions by all means, but I think there has to be a bit more freedom to go, right you see the day-to-day stuff, you need to make those decisions. Connected to this is the need to develop the young people's decision-making capabilities and ability to learn from their mistakes, which is vital to prepare them for life after care. As a keyworker stated:

> A little bit more flexibility. A little bit more just freedom for the young people to make their mistakes … we keep such a tight control of them and then they turn 18 and they are released into the wild … If a child decides not to engage with aftercare, then they are on their own. You would rather see them make those mistakes so that we can help them learn now when they are in care … We don't do them any favours, we don't.

The need for more consistency in decision-making and relationship development was highlighted by centre managers. The changeover of social work staff has an impact on the daily decision-making capability of the centre teams and the children and young people residing there. The need to constantly build trusting relationships with new social workers and deal with delays in decision-making because of staff turnover was a particular source of frustration: 'He is like, oh you used to be able to make the decisions about that and now you can't. And it is difficult because I am never going to say anything unprofessional about any of the social workers, but you feel like you are picking up that slack …' This manager discussed how this meant that they 'are constantly apologising' for the length of time some decisions can take: 'So yeah, that is very frustrating, the amount of changes in social workers for the young people and then for us as well.'

Likewise, another manager made clear that generally social workers needed to be more involved notwithstanding the issues with shortages of social workers at present:

> They are involved to a certain extent …, but they are meant to visit, they have a timeframe that they are supposed to come and do visits to the centre, that doesn't always happen. I understand there is a shortage of social workers at the moment, again it is across the board, and there is a shortage of social care workers as well.

This involvement is especially important to enable relationships to develop with social workers. As one manager noted: 'two of my young people are on their third social worker since March so they haven't developed a relationship, they don't have a relationship. One of them didn't even know her name the other day when I said I was speaking to so and so, they were like, who is that?'

Keyworkers also discussed their views about the need for social workers to be clearer about their decision-making role and capacity, as outlined below by one keyworker:

> Even in terms of their decision-making process, stop saying to the kid, I need to run this past my team leader … Because they are constantly thinking you can't make decisions for me so who is this person who is making these decisions? So we have had a few times to say, look if you can't make the decision there and then come up with something other than I need to ask someone else. That is really frustrating.

Linked to this, the need for follow-up was also emphasised: 'get back to them as quick as you can. There is a wee running mantra that they have here, oh that will go on the long finger now that is on the long finger, that decision will be pushed down the road. And that is unfortunately all of their experience.'

Finally, another influence on decision-making discussed by social workers was lack of availability and the types of care placements available. For example, the need for resources to be concentrated on increasing Tusla residential centres rather than relying on private businesses was highlighted as an area for improvement by a social worker: 'I do believe that Tusla needs to buy some properties, and we need to have our own residential … Because we have all the resources at hand, we have excellent resources, we just need to be using them in-house.' Moreover, access to resources and options to consider for placement decisions has been described as a 'postcode lottery' with some areas feeling that they are missing out when it comes to the provision of resources from a social worker's perspective.

Voices of Children and Young People

There was unanimous recognition of the importance of hearing the voice and opinion of young people in relation to decision-making. The child in care review process was noted as

one of the main mechanisms through which this is achieved. All children and young people have the right to attend their reviews with the frequency dependent on the age of the child and the length of time the child is in residential care. However, it was noted by a social worker that the children and young people often find the reviews boring and as a consequence don't attend:

> I do think it probably is a bit boring as a young person to sit there and talk about … Because if you think about young people who are not in care, they would never sit down with their parents and talk about their health. They would never sit down with their parents and talk about their education. It would never be a thing so definitely it is too formal.

The key workers also indicated that for the most part at residential level the children and young people have their voice heard in the decisions made about their care and welfare, with policies in place to ensure this. As well as child in care reviews, Tusla 'tell us' was also cited as a mechanism through which this is achieved. In addition, hearing the voice of the child in decision-making is achieved by talking and listening to the children and young people and advocating on their behalf. Managers also emphasised how children and young people are involved in day-to-day decision-making in the residential centre: 'I suppose they [children and young people] are involved in decisions all day every day, do you know what I mean, in terms of the basic things around what they are eating, what they are wearing, where they are going after school. All those decisions, they would be part of those.' Both centre managers indicated that policies and procedures are in place that the young people can access if they are not happy about any decision being made including 'non-notified complaints', which are dealt with in-house, and 'notified complaints', which are dealt with by the service manager and social work department. The option to include EPIC (Empowering People in Care) was also discussed as another option available for young people.

While a number of mechanisms for hearing young people's opinions were described, most stakeholders also recognised the need for improvements in this. One of the barriers, already discussed, to better involvement in decision-making was where there was not a good relationship established with the social worker responsible for facilitating this. As a keyworker stated: 'I think the relationship that these young people have with their social worker needs to be the key to doing anything, you know. Of the three kids that we even have here right now none of them has a good relationship with their social workers, none of them particularly want to see them coming.'

Another issue identified was the challenge that some decisions may take time, and the decision might not be one that the children or young people like or understand, but they are involved. As a manager stated: 'Sometimes they mightn't feel like that but sometimes you have to bear in mind that they are in residential care … things mightn't always happen at the pace that the young people want but I feel they are absolutely really involved.' Decision-making for protection and safety reasons was one area identified in particular where young people may not realise the reasoning behind this at the time. As one manager stated: 'there are some decisions that need to be made and the young people may not understand why we are making a decision and it could be for their own safety, but they can't see past that … they don't see the dangers in some things so they might struggle and feel like they are not being heard.'

Availability of and Relationships with Social Workers

As discussed earlier, availability of and relationship with social workers was discussed. Keyworkers identified one significant factor affecting the development of relationships between social workers and the children and young people as the geographical proximity of

the social worker to the residential home. Where there is significant distance between the two, it is not conducive to the regular visits which are required for the development of good relationships.

> We had a child from [...], we have one from [...], and they are absolutely from all over the country and then ... Even in terms of having a relationship with your social worker, are you really going to see them once a month because they are travelling the whole length of the country? So yeah, those sorts of things are frustrating.

Social workers likewise identified the lack of geographical proximity, heavy caseloads and staff turnover as problematic. For example, regarding high turnover, one social worker commented that:

> I think I am the 15th social worker in ten years. Obviously, it is a long period of time but still it is too many, definitely I see that. And another kid that it would be maybe their second or third. I am nobody's first social worker ... it made it more difficult to build up that relationship and gain their trust.

Linked to this is an acknowledgement by social workers that lack of availability of consistent social work puts pressure on the residential staff: 'It is unfortunate because their voice is being left to just the residential and there is a lot of pressure then on residential to make up for the lack of the social worker and definitely it is recognised.'

Geographical distance can be even more problematic when it comes to aftercare and aging out of residential care. Aftercare workers are assigned from the children and young people's county of origin rather than the county where they are residing in care. This results in many young people not utilising the service when they age out of the care system, as a key worker noted: 'when their aftercare worker is at their county of origin, it doesn't work ... So that is a huge issue, if you are placing kids outside their county aftercare needs to be looked at in a better way.'

Keyworkers made clear that the children's and young people's relationships with social workers need to be prioritised. The turnover of social work staff, gaps in social work provision, heavy caseloads and geographical barriers to regular visiting were all identified as contributing to a lack of direct social work involvement with children and young people. Linked to this, and echoing comments from earlier, is the impact of the resultant lack of a relationship with social workers, which becomes a barrier to young people having a voice in their care experience. As noted by a keyworker:

> Sometimes those stumbling blocks in relation to social workers and things like that are not nearly what they should be, do you know what I mean? They should be able to ring their social worker with an issue if they want, sometimes they don't get answered or other times they don't necessarily have that relationship with their social worker because they are changing, or they don't know them ... So that end could improve in my opinion.

Social worker availability is cited as one of the biggest areas that requires improvement by social workers also. They also cited heavy caseloads and high turnover of staff as well as increased geographical distance as having an impact on children in residential care in terms of absence of a relationship with their assigned social worker, in addition to the voice of the young person being lost at that social work level.

> I found what kind of came up was they feel that people aren't listening to them. So they think, I just don't know what the magic wand is to fix that, I think it is definitely down to potentially having, I suppose, less caseloads

> would mean that you would have more time to speak to your children. You would have more on the ground experience with the young people and I suppose that would mean that they would have more of a relationship with you and have their voices heard.

Moreover, lack of availability of social workers is putting pressure on key workers to fill the gap: 'Like one of the young people that I have in that private residential, they actually won't speak to me without the staff there and they are very shy, and they just won't communicate because I am a stranger to them ultimately.' There was a concern by social work of too much pressure placed on residential care staff to compensate for lack of social workers: 'It is unfortunate because their voice is being left to just the residential and there is a lot of pressure then on residential to make up for the lack of the social worker and definitely it is recognised.'

Aftercare Support

Aftercare support or the lack thereof was identified as a significant issue from all perspectives. For example, all keyworkers expressed the view that 18 is too young to leave care and be left 'on their own': '100% main thing for me is the kids going out of here at 18, it makes everything, all the investments, all the time, all the energy that is put in up to then, it is waiting for it to fall flat on its face. It is the whole reason, in my opinion, the kids don't necessarily thrive after their placement.' Key workers spoke about the frustration of knowing that all the progress made with young people is at risk when they have to leave care at 18; some maintain that this is the biggest let-down to the whole child welfare and protection system. They spoke about what they see as the definitive negative outcomes for young people leaving care without proper supports: 'Yeah, and that is the biggest let-down to the whole system. It doesn't matter what we do and how great the child is coming out of here and how wonderful they are, they are going back into that environment or left in a homeless shelter on the day of their 18th birthday, and it just wipes everything out from under them.' And moreover, the progress and potential built up during the care experience can be undermined:

> You are invested, this is why you do what you do because you are wanting the best for them, you are trying to change and undo some, anyway, of the damage that has been done and you can see potential, which is the frustrating part … And that is the killer part of it and chances are they will just go back to the environment they were in or end up homeless.

PRC managers also discussed age 18 as being too young to leave care and the need for better supports to be available: '… I think it is very unfair to expect an 18 year old to go out into the world and navigate that … going from one day to being woken every morning, to have your dinner handed to you on the kitchen table to being put into an apartment on your own that you can cook your own meals and navigate the world.' Centre managers spoke about trying to do their best when young people have left care and turn to their care home for support: 'A few of them I would still speak to, and they would still make contact to the house quite a lot. I suppose the house is the only stable thing they have ever had.' But they also noted the restrictions on what they could do: 'they would ring and say, oh my God I need money for this. And you are saying, well I can't help you with that, but I can tell you to go to the bank, I can tell you to do anything, but I can't help you. So the expectations that are placed on them are not fair.'

The way lack of support impacted on young people suffering adverse outcomes was also discussed. One keyworker recalled that 'When I started, I had a young lad, and then the day he turned 18 we dropped him to an apartment in […] and I was just like, oh my God this is a disaster … He struggled to pay the rent, keep the place clean, he lost it within a month. The last I heard he was in prison; do you know that sort of a way? He needed us for a little while

longer than 18.' Likewise, social workers also expressed significant worry about the young people that age out of care, particularly those in residential care: 'Because if you are in residential all your life and then you are going into the real world it is just, what is it? It was made clear that there should be more support for young people transitioning to adult services especially to prevent adult homelessness that can often occur. Whenever you are 18 and in a lovely children's residential house going into the adult homeless centre that I would work in, it is a very dramatic change. It is half the size, half the support.'

Findings from the Organisational Perspective: Chief Regional Officers and Private Placement Team, National Office.

The findings from the Chief Officers and National Office focused in particular on the organisational and wider context of provision. The themes discussed below are under three main headings:

- Roles and decision-making
- Benefits of use of PRC
- Challenges relating to use of PRC.

Roles and Decision-Making

The importance of recognising the variety of nuances that influence the decision-making processes around children in care was highlighted: 'So I think some people underestimate the complexities of it, they think it is just finding a bed for a child and as it stands it is, but there are a million things that have to be considered.' It was noted that placement breakdowns require immediate action in terms of seeking an alternative placement. Capacity issues and possible inspection conditions are all nuances identified.

The role of the Chief Officers in decision-making generally pertains to them ensuring that they can locate and secure a suitable care placement when needed. They ensure that all other options have been explored prior to residential. They work on location if and where possible and they provide the approval to source a placement and also to ensure alternatives have been considered 'like did we try family welfare conference, are we sure we have checked all foster placements, are we sure we couldn't put in an in-home support and in fairness I am in that position where I could maybe say well look rather than this we could approve funding for intensive home support, you know'.

The National Private Placement Team has a number of roles to support this work. They are responsible for commissioning residential care places nationally. They have a certain level of governance responsibility around private placements in terms of managing the contracts that they have commissioned. They are responsible for processing the referrals that come from each region. Their main task is to assess those referrals and secure placements for the children and young people, taking account of the needs of the children and young people, the stability of the centre, the request from the social worker, the young person's profile, and the availability of suitable placements. They maintain a vacancy register so that they are aware of the places available to the team. They then hand over to the PRC centres to make a decision on suitability based on the young people in the house, and on a placement proposal, i.e., their care plan for this child in light of the information they have received and their risk assessment outcomes. The final decision on accepting or rejecting the placement rests with the social work/child welfare service: 'All those decisions are made by the social workers and the centre because they are ultimately the people that know these kids better. We do the process, we do the transactional stuff, we do all that sort of stuff but ultimately are you going to be happy with this placement comes to the social worker.'

The Significant Event Notification (SEN) Team comes under the remit of the National Private Placement Team, where all significant events for children and young people in care placements are collected. This information is collated by the SEN Team and sent to the relevant regional managers to deal with. These notifications are needed for the team to make the best decisions for children and young people: 'We will look over the young people, and the other young people's SENs to get a sense of what is happening to see first of all can additional supports be added, is it something the centre maybe are doing? If they have had a good influx of staff or high turnover. So we look at all those nuances to try and make the best decisions for kids.'

Accumulated knowledge of the system and relationships which have developed over time which helps the process of decision-making towards a placement. It was highlighted that there are many children and young people that are well settled and cared for throughout the system who experience little difficulty: 'People have to remember there are a certain number of young people placed happily and safely every single day across residential and the majority of these kids will come into us, like there are so many kids on my books, I couldn't tell you half of their names but I will never need to know them.'

Communicating decision-making to the children and young people about their care is an area that was highlighted as needing improvement even if the messages and information may be difficult for a child or young person to hear:

> I think a key priority is how we communicate our decision-making with children and young people … Well we are going to all these residentials to offer you a placement, but we haven't been able to find one yet. Now that message for a young person must be awful in terms of rejection … [the] leadership [we] should be giving is paying attention to how we [translate] our work behind the scenes into how we communicate with a child and young person around their care plan.

As with key workers and social workers, the importance of prevention and early intervention was also highlighted by organisational stakeholders: 'I suppose the first thing would be prevention in the first place, that is probably the soul-destroying piece that we would all see, we have children ending up in residential care, you can nearly see the missed opportunities.' It was acknowledged that in some cases there are missed opportunities in decision-making by not taking steps towards prevention earlier: 'whether it is a missed opportunity in education, whether it is a missed opportunity in a community. There is a whole range of things. Was it a missed opportunity, and maybe that term isn't the right term to use, but like from antenatal care, you know, … what is the saying, you stop the child falling into the river, not go and get them out of the river.'

More collaborative working with local CCA coordinators to implement services was identified as one way of getting children home from care:

> If you can get the kids on point of entry you stand a much better chance of getting them home with supports but again, we would have to have access to the supports. And the way we were going to do it was link into the local coordinator with the creative community alternative because they have access, they would know of services I wouldn't ever hear of, but it is getting that expertise and that collaborative working.

Research and evidence to inform decision-making was identified as lacking across care provision. This includes the need for measurement of outcomes and cost-effectiveness, and for longitudinal studies. The need for research on the care experiences of children and young people across the different care placements and services and across the private placement

sector was also identified to ensure relative consistency and to assist with decision-making towards developing services.

Benefits of Use of PRC

As key stakeholders explained, PRC provision helps Tusla meet its statutory responsibility to provide care for children and young people who for whatever reason require the care and protection of the State. It is seen as an additional supply of care places for the State: 'It helps in terms of the statutory responsibility to provide care for young people or children who require I suppose a care placement. And I suppose our public statutory services over the years, it just hasn't been enough to meet our demand. And really it just provides an additional supply.'

It was explained that the National Placement Team supports the regions to fulfil their needs for residential placements. They create the service level agreements; they check out the providers and they ensure that standards are met through monitoring and inspection. The National Team deals directly with any issues that arise from the providers themselves, inspection reports or monitoring bodies. This was discussed as giving confidence to the regions that those areas are covered, and a good standard of care is provided: 'That actually takes a lot of pressure off the local areas and gives a sense of confidence that all those bases are covered and [means] a lot of things less to worry about in the regions … I am confident that children going into those places will receive a good standard of care. So that is the main way I would say it helps our region, that is what it does.' Indeed, it was suggested that all placements should be covered by the National Team, that the provision of placements should not be split: 'One thing I want to be really strong on, the National Private Placement Team do not do all private residential care. They don't. And that is a huge problem. You either do it all or you don't.'

The issue of division in care responsibilities between the National Private Placement Team and regional areas specifically as they pertain to Special Care arrangements and children and young people raised mixed views. Arguments in favour of and against a singular approach to this were considered. The merits of 'all under the one roof' were highlighted:

> if I have access to a small number of foster care services, a small number of dual diagnosis services, a small number of drug addiction centres, that when the kids come in, I get to look at the kids, or a disability centre, and I say well actually your disability would work with this model of care and these produce it …

Having access to different specialist options is seen as a benefit of PRC and important when particular needs for support are identified: 'if we have to have centres that specialise with looking after young people with disabilities, well then that is what we need to have. If we need to have centres that, again with the right clinical support, with the right team, but we think that is when we could get to a place of right place, right time.' All organisational stakeholders referred to PRC provision as a means to help Tusla meet its statutory responsibility to provide care for children and young people who for whatever reason require the care and protection of the State. It is an additional supply of care places for the State: 'The demand is high in Tusla and has been high in Tusla and is only increasing with the different cohorts of young people across all services from foster care, residential care, to young people seeking international protection … But without the private sector to complement that and to support that we would not have availability of safe placements for these young people.'

Developments within the National Office towards piloting higher-support, semi-independent units were discussed as another positive feature:

> We are also in collaboration obviously with our CRS [Children's Residential Services] colleagues, we have now introduced different service types, so we are running a number of pilot projects. Because we recognised that there are some young people who don't fit or don't necessarily want to live in the traditional style residential unit. So we are doing higher-support semi-independent units. We are trying to establish a step-up, step-down unit from Special Care.

Another identified benefit of private providers was that they are seen to be more flexible than statutory care providers: 'They can be swifter, more agile, and more flexible … They are just more agile. They can have maybe a greater ability to be more creative and innovative quicker I suppose I think than maybe the statutory public sector, voluntary sector piece.' The greater flexibility gave greater scope for employment of multi-disciplinary teams and different disciplines: '… private residential care can adapt their services quicker than the statutory can. So if you look at private residential care, they can use a variation of a cohort of staff. So in the statutory service it can only be social care staff. In the privates we have worked with our registration inspection colleagues, worked with different professionals around the area and come up with a number of equivalent disciplines.'

Another benefit of PRC placements was its provision of Enhanced Care Placements focusing on specific therapeutic care provision as outlined below:

> The private residential, we have enhanced private residential provider, so the enhanced is very specific, it is all done in the EU tender, but it is an enhanced package of care. So they would have to have a number of therapeutic components to their arsenal. And there are a number of providers who are therapeutic providers. So when we are sending a young person to an enhanced provider, we understand that they will get their education, they will get their psychological needs met, they will get any assessment they need, so if there is OT needed. And the majority of our enhanced providers have these on-site.

Challenges Relating to Use of PRC

A number of challenges regarding the use of private placements were discussed, including societal issues of the time like Covid-19 and the cyberattacks, which put significant pressure on the system. Lack of needed services such as the Child and Adolescent Mental Health Service (CAMHS) puts pressure on the system as does staff turnover and the need to expand care services in some areas, consequently reducing resources in other areas. The lack of availability of places seems to be one of the biggest challenges noted from both national and regional perspectives. As expressed from one respondent: 'the demand far exceeds the vacancies to be quite honest, far exceeds it…… If we had five vacancies, there could be ten kids looking for those vacancies. So there is a lot of movement through the private sector.' Another commented that: 'On the ground, I sound terribly negative, but it is realistic, you have got a private placement team that is not delivering the private placements that are required. They deliver a cohort, but it is not enough to meet the demand, and far from it.' Unlike other services such as mental health or disability services, for example, the residential services cannot say no. As a consequence, the issue is that certain things may slip down the list of priorities while the services are trying to do their best for the children and young people involved: 'Residential can't say, I don't have a service. Because that kid needs somewhere to live safely, we have the statutory responsibility under the law to place that young person, so we don't get to say no. We get to just try and do the best we can for these kids in the multiple competing challenges', especially regarding lack of resources: 'a lack of foster carers … a lack of aftercare placements … a lack of mental health services … a lack, lack, lack …' Another challenge is 'to make sure we are not doing it in isolation, we have to do

it in an integration and sometimes that integration can become maybe a little bit down your priority list when you are trying to deal with a million other things'

Increasing statutory placements was identified as an area where consideration is needed and is something that is currently on the agenda in Tusla: 'my priority would be to try and reduce the dependency … I do believe there is a place for both, but I think we have probably the balance tilted too much in Tusla [in favour] of private provision and that is maybe legacy decisions that were made on closing down residentials.' The cost of utilising private providers was identified as another challenge: 'you could say, and we are paying an awful lot of money, but the outcomes aren't always great'. Another issue was that of providers only accepting fewer challenging children and young people.

> She was telling us that a lot of providers are asking about lower risk children to place in their last bed in their unit, they don't want high risk children, should we go ahead? And the Chief Officer said, well you should go ahead and fill those beds with kids who need them. And really the fact that they won't take the high-risk child is not a justification to leave the bed empty because you are depriving somebody else of a resource.

However, an alternative view put forward was that, while it may be technically possible to be selective in decision-making about referrals, it would not pay them to engage in such practices:

> Look there is that myth out there that private providers can pick and choose their kids, and technically yes, they can, they can pick them. But what happens is they will get a referral for XXX, they don't know who is coming behind XXX. If XXX doesn't fit the mix they will say no. But we have to remind people that while they don't have a kid in placement, they are not getting paid. It is not in their interest to not take children.

The geographical location of private residential care placements was discussed by all organisational respondents reflecting similar concerns of practitioners, managers, children and young people. For example, it was noted that: 'we have maybe children going to different parts of the country and that is definitely a challenge both for the children and young people, for their families, for maintaining links. And then also [the] resource challenge. I have staff up and down the road to […] that is very challenging.'

The negative impact of placing children away from their local areas was highlighted as follows: 'That is excellence. Placing all our kids around the country and giving them a half-baked service just based on what is available where at any given time, it breaks so many rules in terms of good practice.' Concern was expressed that: 'the outcomes are not good' and that it results in young people being 'ripped out of their local community'. Furthermore, after making new links and settling, when they turn 18 the reverse happens: 'then they get to the end of that unit when they hit 18, what happens then? They get ripped out of their community and all their relationships again and you have [an] aftercare service really struggling to reintegrate them back into their local community where we ripped them out of in the first place. It's beggars' belief.'

This also impacts on local integrated planning. There is system pressure whereby local integration is lost: 'Integrated planning is hugely compromised, huge, and if there was any core criticism of the organisation that is it. You are not sitting down around a table talking about a child, knowing what resource is available to you, where it is, how best to support it, how long it should be.' This also impacts on relationships: 'You have no relationship really with the staff in that unit and you have no connection to the management of it because that is

dealt with elsewhere.' The difference in how a social worker can engage locally compared to when the placement is out of the area is expressed as follows:

> So if it is local and there is a problem with the child, a social worker rocks up to the unit and says, okay look there is an issue, let's sit down and let's talk about this and let's sort this out. And a whole series of relationships get developed around the child. But for [us] at the moment they are travelling halfway around the country, don't have the time, that creates more pressure, so you are talking about recruitment and retention here of staff in a difficult environment. So you can see how the pressure builds here on frontline staff.

The view was expressed that autonomy around the provision of care for children and young people in local areas should revert to the regions as this will ensure continuity of services and integrated planning: 'It allows continuity in education. It allows continuity in connection with the HSE. And a lot of these kids are involved with disability, primary care, CAMHS'. It was suggested that Chief Officers should have control at regional level over 'private and mainstream centres'

The geographical availability of places, and issues with supply, means that while best efforts are made to keep children and young people in their own areas, the safety of the children and young people have to be the priority:

> it is due to demand because if you only have a finite number of resources and you have a significant amount of young people looking for them, if you have a bed in Cork and this kid lives in Dublin, if you are living in Dublin in an unsafe situation and you are going to get a safe situation in Cork it may not be ideal but the preference is safety. So yeah, it is absolutely consideration. We always try to keep people within their own areas.

The need to ring-fence local provision was also discussed: 'so there is no ring-fencing of local provision for local kids and children, which actually then makes it so difficult.'

The need to increase regional engagement was highlighted. While this is developing, more work is needed to maximise cooperation and share expertise:

> I think we could do a bit more regional engagement … with the local area managers … getting back to the point where we are putting in maybe quarterly or six-monthly engagement, but engagement in relation to strategic planning. And where we are all sitting down and going, right what is your cohort, geographically what are you seeing in your area, what do you need off us. And then let's try and deliver that.

In doing this, the value of benefitting from shared expertise is highlighted. For example, the comment was made that 'I have the expertise now in contract management and private providers and staffing and all that sort of stuff and placing young people. But I don't have the expertise with all the family stuff and the community stuff and what the kids need, the social work areas do, but between us we bring enough expertise to the table.' Another particular challenge relates to complexity of some monitoring arrangements. Generally, the autonomy of the PRC centres is seen as a limitation in the provision of care in Ireland as is their regulation by Tusla instead of by HIQA: 'Now they do have Tusla registration inspections … But I suppose the draw[backs] are they are private companies; we don't get to see what goes on under the body whereas with the statutory we have full oversight. So there are those sort of things.' Also, the different system of managing special emergency arrangements was discussed. Special emergency arrangements are to be utilised when no placement is available and there seems to be a serious concern with these type of arrangements as they do not come

under the remit of the National Placement Team and are therefore not monitored the same way as other care arrangements are.

The growth in PRC has meant that 'a whole load of companies has sprung up around the country and some of them we know but there are a lot of new ones we don't know. This is putting huge pressure on the system because of the risks around these placements, they are monitored weekly within the areas by the area manager with the local staff.' The remoteness of oversight on some of these services was identified as causing 'huge, huge safety issues': 'And nobody wants these placements but go back to the beginning where I was saying, okay it takes two weeks for a kid to get allocated within the National Private Placement Team and we don't know where or when they are going to be placed.' The difference in monitoring and governance of the special emergency arrangements was also highlighted: 'For those special emergency arrangements, that now passes onto the local team. Who have no experience in doing that whatsoever because that has been taken off them for the last God knows how many years, it is not an activity they are used to.' Likewise, the responsibility for placing children and young people with disabilities rests with local areas and is separate to the National Placement Team and while this work is often done under a joint protocol with the HSE, sometimes it is not. There are concerns that disability placements are not subject to the same rigour that private placements are and that this is a weakness that needs to be addressed

The Strategy for Residential Care Services 2022–2025, which was published shortly before these interviews took place, was welcomed as a way to address some of the organisational and system-led issues in particular. Overall, stakeholders recognised a range of benefits as well as challenges in the use of private residential care. The importance of joined up thinking, integrated approaches and effective working between regional and national offices was emphasised. Evident from the responses is a recognition of the complexity of the issues on the one hand alongside a common shared goal to work towards improving experiences and outcomes for young people on the other.

Conclusion

Even though we had small numbers participating in Phase Two, we were able to collect rich and informative findings to address our research questions. Each stakeholder highlighted particular issues, and some themes resonated throughout the findings. From young people, emphasis was placed on themes including reasons for placement in residential care, relationships with keyworkers and social workers, involvement in decision-making, and their voices being heard. Issues regarding the voice of young people and the availability of and relationships with social workers in particular also emerged from the findings from those on the 'ground' as managers, keyworkers or social workers. Other themes raised by these stakeholders were trends and patterns before entry to PRC, the role of prevention and early intervention, decision-making processes (especially between 'big' and 'day-to-day' decisions) and aftercare supports. Similar themes were discussed by stakeholders including roles and responsibilities in decision-making, and the benefits and challenges of the use of PRC.

As demonstrated in the discussion to follow, many of the points made resonate with what we have found in the international literature. Others add to this specifically within the Irish context. The issues and themes identified span the ecological system from micro to macro and chrono level and will be discussed in detail, within this context, in Chapter 7. Chapter 7 discusses the findings in the context of the literature, leading to recommendations from the study.

Chapter 7: Discussion and Recommendations

Introduction

This discussion provides an analysis of the findings leading to recommendations for the study to inform research Objectives 8–10. Section 1 focuses on improving the approach of Tusla to providing the best possible care, support and outcomes for this cohort (Objective 8). Section 2 focuses on learning from the research to recommend a framework for ensuring the decision-making process on the use of private placements is as robust as possible (Objective 9). Section 3 focuses on how the findings inform the implementation of the Creative Community Alternatives and Tusla Therapeutic Services as these relate to this cohort (Objective 10).

Section 1: Findings to Inform Recommendations to Improve Tusla Approach in Providing the Best Possible Care, Support and Outcomes for Children and Young People in PRC

Eight themes are derived from this research, and these are discussed below:

- The need for more extensive prevention and early intervention services
- Attitudes to the value and appropriateness of residential care for children and young people
- Private residential care provision within the overall care provision context
- Involvement of young people in decision-making
- Importance of relationships across the ecological system
- Aftercare supports as an integral part of care plan and residential care service
- Lack of sufficient data and integrated systems to track decision-making processes
- Assessment and decision-making processes impacting on trends and patterns of placement in PRC especially in relation to 'reasons' for entry to private residential care.

At the end of each section, we make recommendations, although note many of these also overlap. Some recommendations relate specifically to PRC while others are relevant to both PRC and all forms of residential care provision.

Theme 1: The Need for More Extensive Prevention and Early Intervention Services

The importance of prevention and early intervention services is clearly demonstrated internationally (e.g. Courtney and Iwaniec 2009; Whittaker et al. 2015, 2022). Generally, policy and principles, such as the UN Convention on Alternative Care, assume that maintenance with families, or in family-style care, is usually the best outcome for children and young people. The emphasis on family preservation and support, through prevention and early intervention, resonates throughout the work of Tusla since its inception. This is shown in the development of the PPFS programme in Tusla (see Canavan et al. 2021), the Strategic Plan for Residential Care Services, Tusla's continuum of support and protection, and the wider legal context. This research reinforces the urgency of the first recommendation of the Strategy for Residential Care Services to increase supports for early intervention and prevention in relation to residential care. This study has highlighted how many opportunities to intervene are missed due to lack of earlier intervention or prevention. Phase One findings provide indicators that earlier intervention in relation to the particular needs of children, young people and their parents could have ensured more stable placements prior to PRC and for some, prevention of entry into care. While we were not able to establish the trajectories of the cohort examined in Phase One due to limited data, there are clear indicators that

different interventions or decisions could have been made earlier and in a way that could have prevented the entry to care or the entry into PRC following previous care placements.

Prevention and early intervention before care admission

Regarding prevention of entry to care and the need for wider family and child support services, evidence of the importance of early intervention both in terms of age and with regard to the identification of difficulties for a young person or a family is well established. 'Early intervention' and 'prevention' are often used interchangeably but each has its own specific in-depth conceptual and empirical base (Devaney et al. 2023). The evidence from this study reinforces the concern that while services may be involved 'early on' – many young people had long histories of involvement of social work for example – it does not necessarily follow that this led to a preventative approach. Twenty-six per cent (26%) of young people had their first involvement with the child protection and welfare system pre-birth and the majority were engaged with services by the age of ten. Parental/family issues prior to placement in PRC are further indicators of possible areas that could have been addressed. This includes the finding that half of all cases recorded parental drug or alcohol abuse and 17% of children and young people had issues with drugs or alcohol. Another pattern is the gaps in education experienced by children and young people in the care system. The findings show that gaps in school attendance were noted in 57% of cases and 18% had no record of this information noted on file, which indicates a need for better monitoring of school attendance for children and young people in care. The main concerns related to neglect (n=58) followed by concerns around parental alcohol and/or drug abuse (n=46), and domestic violence (n=41), indicating the importance of parenting and family support.

A related concern about missed opportunity relates to the evidence that all but 20 of the 127 children and young people in the Phase One profile had some physical or mental health issues. Moreover, the majority were recorded as having some form of psychological/psychiatric diagnosis. The most common of those were cognitive/learning disability, attention deficit disorder, emotional or behavioural disorders and attachment disorder. Behavioural issues, classified as either 'threatening', 'risky', 'negative' or 'challenging', were the most common reasons for placement breakdown leading to PRC placement. While one cannot assume simplistically that these issues could have been addressed, this data is a reminder of trends that feature in reasons for care across systems (Whittaker et al. 2022). The data indicates the need for child welfare and protection systems to invest strategically, urgently and heavily in earlier supports for families and carers to address wider social, family and personal issues that are so clearly associated with placement in alternative care.

Phase Two likewise reinforces the importance of early intervention and prevention. Devaney et al. (2023) provide evidence that 'wide-reaching strategies to provide evidence-based support at a population level translate to fewer children and families in need of more intensive services, while also enhancing the well-being of the greatest number of children'. With recent evidence to support this (e.g. Webb et al. 2020, 2021; Bennett et al. 2021), it is clear that early intervention and prevention not only produces better outcomes for young people and families but has also been proven to be highly cost-effective. The costs of not intervening early are also evidenced in Devaney et al. (2023) citing examples including Allen (2011) and Hickey et al. (2018).

Another important barrier for families engaging in early intervention, prevention and family support services is lack of public awareness of child welfare services and supports (McGregor et al. 2019; McGregor et al. 2020). As well as lack of services, fear of engaging with and seeking support earlier from Tusla was identified in this research as a barrier to earlier help-

seeking. The need for better public awareness about the continuum of services Tusla provides was identified to challenge misunderstandings about its role and that its focus is child protection and removal. In order to engage effectively with services, people need to know about, understand and have confidence in them, and understand that they have the dual role of support and protection. There is no simple approach and there is a need to move beyond linear thinking in order to appreciate the more nuanced and realistic understanding of the complex interconnections between early intervention and child protection and welfare systems (Devaney et al., 2024, forthcoming). One way to address this is to frame services within the context of 'protective support' and 'supportive protection' (McGregor and Devaney 2020a, 2020b). This is not just about how services are explained and organised but also about how practitioners are supervised and encouraged to consider their work, across all aspects of their continuum of practice (ibid).

Prevention and early intervention after care admission

The need to continue efforts to intervene 'early' at the point of placement and work towards alternative responses was discussed by many stakeholders in Phase Two. The view of residential care as 'last resort', 'end of the line' or caring for young people with complexities that are beyond early intervention practices is challenged. The literature and research especially when framed within a life course perspective are clear that it is never too late to intervene 'early' to prevent further harm and to ameliorate harm already experienced. The earlier age of children coming into PRC was highlighted as a particular cause for concern in the literature and is reflected in this study, where a third of children and young people in the Phase One sample were aged 6–12 years. The tendency for the system to be led by crisis was identified as another barrier to prevention, earlier intervention with prior placements. Needs for support for foster carers as well as their availability, recruitment and training were emphasised. The value of recognising 'indicators whenever the children are younger' would mean it may have been possible to offer family support sooner.

The need for greater support for foster carers when they are supporting young people with complex needs is also highlighted in the literature and the research findings. The need for more training and support for foster carers was also recommended, including specialised training to help with management of challenging behaviours that can lead to placement breakdowns. The findings support recommendations in the Strategy for Foster Care Services 2022–2025 relating to improving training and support for foster carers.

As discussed in Chapter 4, parents and members of the wider family need better ongoing support after a care placement to help maximise opportunities for reunification. For example, in Phase Two, findings from young people highlighted a frustration with limited permission to contact a grandparent. It is notable that there are no specific recommendations in the Strategy for Residential Care Services to strengthen supports for 'birth' parents and carers of children in care, although this is a recommendation in the Strategy for Foster Care Services. This should be reconsidered in future strategies.

Regarding support for both foster carers and parents/carers, there are many examples of best practice provided in the literature of how this can be done. Regarding foster care support, in the US, therapeutic foster care models have been posited as cost-effective alternatives to residential care with additional targeted supports provided to foster carers (Fisher and Gilliam 2012). Regarding parent support for children in residential care, as discussed in Chapter 4, creative strategies like having parents accommodated with children and young people in residential care for certain periods of time have particular benefits for improving outcomes.

The importance of early intervention and support, in care, to help with the transition to adulthood is also emphasised in Chapter 4 and reflected in our findings. As Devaney et al. (2022, forthcoming) argue, interventions or help should occur in the early phase of a difficulty regardless of age. This means that difficulties can be addressed to prevent them becoming more serious, entrenched, or disruptive. Greater attention at a much earlier stage to preparation for leaving care is urgently needed to improve the experiences and outcomes of children and young people in residential care. Whatever model of 'care' a private residential centre offers, focus on preparing the young person for their future should be central. The importance of a life course approach across practice is increasingly recognised (e.g. McGregor and Dolan 2021). For example, Kelly et al. (2023) outlines a number of considerations to inform policy and practice to inform a life course approach to care transition through a 'a focus on interdependence, participatory practice, biography and cultural transition planning alongside efforts to redress systemic, oppressive barriers facing care-leavers in society' (p. 1). This 'implies the need for integration or early intervention and prevention not just towards universalism through public health measures but also towards balancing support and risk assessment' (Devaney et al. 2023). This needs to continue throughout the care journey, not just at points of entry, transition and exit. It should also extend into 'extended care' processes that ease the transition from care to independent living (Van Breda et al. 2020).

Recommendations

- Extend and develop early intervention and prevention supports specifically for children in private residential care reflecting an ethos that it is 'never too late to intervene early' to prevent further harm and support development.
- In developing and enhancing early intervention approaches, ensure prevention is considered across the continuum of care moving from progressive universal to targeted approaches for those at risk of coming into care.
- In developing early intervention, prevention and family support *prior to care* admission, increase public awareness of the continuum of Tusla's services to promote greater trust and understanding of Tusla's dual role of support and protection.
- In developing early intervention, prevention and family support *after care admission*, practice improvements could include:
    - Targeting services for young people in care from Tusla Therapeutic services (Tusla TherapyTusla - Child and Family Agency) and Creative Community Alternatives
    - Enhancement of availability of and supports to foster carers as set out in the Strategic Plan for Foster Care Services 2022–2025.
    - Promotion of a life course approach that focuses on supporting young people in transition through care placements to positively influence trajectories and achievement of best outcomes through interventions and supports.
    - Engagement with families of young people in care more proactively to enable greater involvement in decision-making throughout the care experience and beyond with particular emphasis on decision making relating to private residential care placements.
    - Provision of key support services relation to issues such as disability, mental health, and addictions.

Theme 2: Attitudes to the Value and Appropriateness of Residential Care for Children and Young People

While there is consensus regarding the need for early intervention and prevention of entry to care, this should not lead automatically to a view of residential care as a bad choice. The literature discussed in Chapter 4 shows strong evidence-based arguments regarding the simplicity and inappropriateness of such a blanket view. The findings from Phase Two show that for some young people residential care was deemed the best decision, or their choice. Similar to the situation in other low-usage countries, it seems that even though Tusla recognises the need for PRC in some instances, it can sometimes be presented as a last resort and never ideal. As discussed in Chapters 2 and 4, attitudes to the use of residential care varies and are influenced by complex historical events, socio-political factors and welfare ideologies. For example, we discussed how Ireland has been impacted in particular by the trajectory of moving strongly away from institutional care as a policy since the 1970s. The many revelations of systemic abuse within institutions for children and young people referred to in Chapter 2 have left a particularly negative legacy that current residential care workers and centres still feel affected by (Brown et al. 2018; see also Cahill et al. 2016). Caution with regard to the labelling of residential care as necessarily a 'last resort' is emphasised by many authors (e.g. Gilligan 2022; Whittaker et al. 2022; Thoburn 2022). Even with a strong orientation towards early intervention, prevention, family support and family reunification, the necessity to recognise the diversity of need among young people and the suitability of residential care for some is clear in the literature and in our findings. Moreover, far from being a 'last resort', even if it is the result of a number of other moves, a residential care placement when properly allocated and matched to the young person in need, can provide the transformative and therapeutic support to enable stability, if not permanence.

As discussed in Chapter 4, stability and permanence, while often referred to interchangeably, also need more in-depth analysis (Moran et al. 2017; Devaney et al. 2023). As Thoburn (2016) argues, stability in a residential care context is associated with feelings of family and belonging and should be an essential focus whether the placement is over a short or longer period of time. And, as Woodall et al. (2023) make clear, even when the planned placement is short term, it is still essential to pay attention to the permanence plan – taking into account what went before the placement and the goals to be achieved following the placement within the overall plan. For example, residential care may be part of a permanence plan towards transition home, back to a foster placement or back to the community. For those placed for longer periods, the permanence plan orients towards maximising stability and preparing for life after care. The key message from the research is the importance of understanding the permanence plan as both objective (stable place to live, ability to be connected and supported) and subjective (a feeling of belonging, security, identity, safety) (see Moran et al. 2017; Woodall et al. 2023). As outlined in Tusla-commissioned practice guidance: 'Recognise and be reminded of the significant contribution to stability each individual practitioner makes in their support work with children, young people and adults. Ensure this is valued, supported and adequately resourced. Learn from the critical points made in the research that what may be routine in a practitioner's daily and busy work may be exceptional in the routine of the service user' (Moran et al. 2017b, 8).

Recommendations

- Tusla should develop a bespoke communication strategy to promote better public and professional understanding of residential care in general and private residential care in particular.

- There needs to be an understanding that provision cannot be uniform and that a range of residential service provision needs to be in place to meet the needs of individual children, and where possible to support home or onward permanency planning.
- Any communication strategy should be linked to the messaging as part of the implementation of the national placement request pathway.

Theme 3: Private Residential Care Provision Within the Overall Care Provision Context

Many of the findings reported in the study pertain to all forms of residential care, including private provision. In addition, there has been a specific focus on PRC, which has produced findings that support a number of the recommendations from the Strategy for Private Residential Care. In particular, it supports recommendations to increase capacity across statutory and voluntary residential care services (R2); improve governance, accountability and integrated decision-making for residential care placements (R4); and promote more consistent regulation of all residential care centres (R8). Many benefits and challenges were identified in relation to the use of private residential care, as outlined in the literature and the findings. From the overall findings, the two main issues identified specific to private arrangements, and discussed here, are: placements provided at a geographical distance, and provision, governance, management and monitoring of PRC.

Impact of placement at geographical distance

While efforts are made to maintain children and young people in their own areas, because of lack of supply and ring-fencing of local private provision for the regions, many young people are placed far away from their homes and communities. For example, 60% of young people in the Phase One cohort were placed outside of their Tusla Area. A strong theme across findings was the negative impact of placement at significant geographical distance from the young person's family and community. This issue came up across discussions with all stakeholders.

While acknowledged to be linked to lack of supply, the problems with what one worker called a 'postcode' lottery are significant barriers to best practice. These include: the extra costs to support such placements, greater difficulties building relationships with social workers, and difficulties building and maintaining continuity for the young person. The negative impact this had on maintaining family and community links was highlighted. The particular challenges involved in supporting young people placed outside of their area through aftercare was also discussed. For example, respondents in the findings for Phase Two highlighted how placement of children and young people at a distance from home broke many rules of good practice. Considering the issue within an ecological frame highlights how such practices – clearly acknowledged as undesirable but necessary within the system – can deny young people's rights to family life, community, a sense of identity and belonging, as well as permanence and security. Well evidenced in our understanding of how best to support stability for people in care (e.g. in Moran et al. 2017; Woodall et al. 2023) is the importance of attention to the fact that when in care, young people already have to deal with 'overlapping' eco-systems relating to their original family/home and their alternative care placement. Best practice implies the importance of maintaining, as far as possible, connections within one's system, across the ecological system, rather than placing a child not only within an alternative care context but practically within a whole new eco-system. When such moves are inevitable, careful attention needs to be given to the process of transition not only to the new *setting* but also to the *context* it is in. The significant impact of transitions in care, and the need for practice models that support this, are well established from existing evidence, and this can be drawn from to inform better practice (e.g. Dima and Skehill 2011; Kelly et al. 2023; Pinkerton 2011; Stein 2019; Stein and Munro 2008). While the issue of

resources and practical problems with travel and accessibility are significant, supporting transitions for young people in and through care needs to be a key concern for the advancement of care models and practice–policy approaches in alternative care policy and provision. Many examples of best practice and evidence are available to support this work including the development of 'extended care' supports (Van Breda et al. 2020).

Recommendation

- When implementing recommendations from the Strategic Plan for Residential Care Services, prioritise the ring-fencing of placements within areas to avoid placements geographically distant from young person's family, networks and eco-system, unless a distant private residential placement is specifically in the person's best interest.

Theme 4: Provision, governance, management and monitoring

Many benefits of PRC have been identified in this research. These include the flexibility of service and the use of multi-disciplinary approaches capable of meeting the complex needs of many children. Provision of safe places for a range of cohorts, including young people seeking international protection, was recognised. That many children have stable placements and are doing well was also noted. The way in which the growing PRC market has helped to meet supply was also acknowledged, with PRC seen as filling a major gap in provision at statutory level. The specific benefits and potential of use of private residential care are also highlighted in Chapter 4, and the use of such provision in Ireland reflects international trends towards greater use of private services. This is not exclusive to the residential care sector for children and young people but rather reflects a wider global trend in recent decades towards the marketisation of care, and the expansion of a welfare economy shared between 'traditional' statutory services and voluntary services, to increased private and for-profit services.

Many challenges with use of PRC were also noted. Supply of PRC places to meet demand was identified as a major concern impacting on ability to respond to need. The number and diversity of small providers in the private sector was discussed as another issue. The more limited monitoring systems in place for PRC raises questions about whether there is sufficient governance, management and quality assurance of private placements. The current residential strategy was welcomed as a response to this, as it includes a recognition of the need to address supply and monitoring issues.

The need for greater balance between private residential care and other forms of overall residential care provision has also been emphasised. The specific cost of PRC was noted. While not discussed by stakeholders, a related challenge, seen in the literature discussed in Chapter 4, is the additional complexity of balancing service provision for care and protection with profit-making. The discussion on commissioning and social leadership in Chapter 4 provides useful insights to inform how, going forward, cost-management of for-profit private enterprise could be improved. Potential learning from other sectors, such as early childhood care and education, was also highlighted (see O'Sullivan and Sakr 2022). Many respondents expressed concern that another issue is the tendency of providers to accept fewer challenging children and young people in the context of limited places. However, this was challenged from a national perspective as a 'myth', through the argument that the providers had to fill beds but also had to ensure the right mix within a home. Perception of providers accepting fewer challenging children also relates to absence of adequate service provision (particularly single/dual /therapeutic services) to meet the needs of 'hard to place' children. This is resulting in use of unregulated placements or SEAs.

The lack of integration with local services arose as another related theme discussed by many stakeholders. This affected policy and practice at many levels. At the organisational level, there is a need to review governance and oversight, or give some autonomy to regions, to allow for better local planning for young people and engagement with local resources. The value of greater local provision was also connected with continuity of education and relationships within the young person's community. This is especially important noting the finding in Phase One about gaps in school attendance (for example), indicating the need for better monitoring of school attendance for children and young people in care.

At the same time, the value of more central coordination was recognised, although noting diverse views on this and the complexity of getting the right balance between national and regional management, governance and coordination. For example, for the National Team it makes sense to have all care decisions come under Children's Residential Services (CRS). However, it was suggested that in doing this there should be ring-fencing of local provision to enable children and young people to remain in their localities and in closer proximity to their social workers, families, schools and communities.

At the practice level, less integration of services has meant less connection with PRC management staff and social workers travelling around the country, which puts pressure on time and the creation of relationships with children. The negative impact of lack of local integration on building relationships with centre staff and management or engaging with the local context if there is a problem for a child, was also discussed and resonates through this discussion as a major issue.

The split between private placement teams and the National Placement Team was also deemed problematic. As mentioned, the different levels of regulation were discussed and the fact that private organisations were subject to fewer governance measures was highlighted and reflects themes discussed in the literature reviewed in Chapter 4. This is a particular issue in relation to the needs of children and young people with disabilities, as these do not come under the remit of the National Placement Team. For example, it was reported by Chief Officers that responsibility for placing children and young people with disabilities rests with local areas and is separate to the National Placement Team; while this work is often done under a joint protocol with the HSE, sometimes it is not. Because of this, there are concerns that disability placements are not subject to the same rigour as private placements, and that this is a weakness that needs to be addressed. This also affects the monitoring of placements especially in the context of 'special emergency arrangements', which have limited monitoring, and concerns were expressed by local staff about governance of and support for such arrangements.

Recommendation

- Tusla, under leadership of the Director of Children's Residential Services should continue to implement the recommendation of the Strategic Plan for Residential Care Services regarding supply (R2) and the need for improved governance, accountability and integrated decision-making for residential care services (R4).
- Such implementation should be made in the context of Tusla's planned reform under the Local integrated programme delivery programme and in the context of the national placement request pathway being introduced in 2024 as well as under the local integrated delivery programme.

Theme 5: Involvement of Young People in Decision-Making

The importance of involvement of young people in decision-making is clearly evidenced and articulated throughout this report. Many dimensions of involvement are highlighted in the literature in relation to the principles of youth participation, the challenges arising from ongoing low levels of meaningful participation, and the limited extent of control and power children and young people have over processes relating to their care. Challenges and best practice in relation to decision-making while in care regarding everyday life have been outlined (e.g. McPherson et al. 2022). The impact of external forces, organisational leadership and management of resources has also been outlined. So too has the importance of parental and family involvement in all aspects of decision-making for and with young people in residential care. The need for advocacy for young people around decision-making is emphasised (e.g. Kennan et al. 2018; Henriksen 2022; MacAlister 2022) and themes regarding balancing autonomy and inclusion, versus protection and sometimes paternalism, recur in the literature and the Phase Two findings.

Overall, our findings show evidence of strong commitment to child and youth participation but have highlighted many gaps and areas that need to improve. For example, in Phase One, only half of the young people were recorded to have been involved in decision-making. In Phase Two, while reference was made to clear decision-making processes by stakeholders, how young people viewed their involvement differed. It seems that even where involvement in decision-making is evidenced – e.g. in care planning and reviews – there is a discordance between the perceived involvement of young people in decision-making and the views of young people themselves on the quality and extent of this inclusion. The findings show that the young person themselves may not fully understand or have all of the information about this process even though that information may be deemed to be 'routinely' provided. Workers may think they have consulted them effectively, but a young person may not be of the same view.

Evidence from literature and current policy and practice within Ireland reflected, for example, in the Tusla Child and Youth Participation Strategy, 2019–2023, shows that efforts to include young people in a meaningful way in decision-making have been long-established (e.g. Brady et al. 2018; Kennan et al. 2018; Whittaker et al. 2022). And it is important to acknowledge that some of the young people in this cohort (from 2015) may not have benefitted from more recent developments and improvements in participatory practice, guided in particular by the Child and Youth Participation Strategy. However, despite many 'best practices and the possibility that some improvement may have happened in the system more recently, the findings, supported by the literature, clearly show the urgency of improving the engagement of children and young people in a meaningful way. While professionals and managers outlined how young people and children were included in decision-making, children and young people themselves had more mixed views about it. Even when young people were satisfied with their placements, generally they gave the message that decisions were made for them more often than *with* them. The evidence from this research reinforces the need for urgency in response to the fact that while some good practice in involvement in decision-making by young people is identifiable, and certainly a commitment to it is evident, they are often not included in a way that is meaningful for or evident to them. Significant steps are required to ensure young people's rights to participation are prioritised across all aspects of the decision-making processes. Given the significant role such processes have in influencing their life experience and life course development through points of time during childhood, adolescence and into adulthood, maximising potential for meaningful participation should be to the forefront. From the research and literature available, the many ways this can be done are evident. Less evident is how this translates to practice, which is operating within complex system contexts not always

conducive to best practice. As discussed in Chapter 4, it is clear that many external factors negatively impact on child and youth participation. In this research, factors such as lack of time, space to build relationships, continuity and integration between regional and national systems were noted in particular. The need for critical attention to our ongoing 'attitude' to 'supporting and protecting' children and young people, which can still trend too much towards paternalism and not enough towards autonomy, is implied by the literature and research findings. Taking a life course perspective, our findings suggest that more engagement with practices developed in adult safeguarding and decision-making may help develop our critical acuteness to how we maximise independence and control in decision-making, while also taking into account the specific differences in responsibilities between child and adult safeguarding (e.g. see McGregor and Dolan 2021, 60–61).

The importance of relationships, which resonates through so much of the literature and evidence discussed in Chapter 4, is likewise reflected in the empirical findings. In particular, the importance of young people having a good relationship with their social worker to enhance involvement in decision-making was emphasised. Barriers to this included lack of availability and accessibility, especially when young people were placed outside of their area. Absence of a good relationship led to delays or reluctance in relation to engaging in decision-making by children and young people, despite strong evidence of wanting to participate more. Throughout the findings, the potential to use existing structures better to improve participation was discussed, such as improving how childcare reviews are managed. Reference was made by young people that processes like care reviews are too formal and not conducive to participation by children and young people. The unsuitability of the formality of such processes is well known and our findings suggest these practices need further review and consideration. Linked to this, young people expressed concerns about too many rules binding their day-to-day lives and decision-making in residential care. Phase Two findings also highlight the need for greater attention to age-related decision-making and the importance of recognising the changing needs and contexts of adolescents. For example, findings from children and young people in particular highlight the need for greater recognition of peer-related issues like access to phones and computer games, and more opportunities to engage with friends and peers. Findings from young people in other studies discussed in Chapter 4 internationally reinforce these points.

As well as having a right to participate in decision-making, the importance of young people being involved in decision-making to help develop their own capabilities and prepare them for life after care was also highlighted. There was a view that young people needed to be given more flexibility and the ability to make more decisions for themselves. Hearing the voice of the young person needs more time than is usually afforded in current structures and processes. The issue of better communication of decisions to young people was also highlighted, including recognition of the impact of delays in decision-making. The sensitivity needed in communication, especially where there are delays, was also emphasised, for example, finding the balance between clear communication and not giving a message of rejection to a young person when informing them how many places had been contacted that did not offer them a placement. Suggestions were made for more active involvement, such as explaining how some decisions are made, and acknowledging more explicitly with young people that they may not always agree with practices carried out in the interests of safety and protection, but they still have the right to this information. These findings reinforce the importance of the interconnected themes of relationships, communication, support and continuity discussed in Chapter 4 (Moran et al. 2017; Devaney et al. 2019; Woodall et al. 2023).

A major finding from this study is the need to define the nature of decision-making and greater clarity on who makes the decisions. Our findings resonate with discussions in

Chapter 4 about the need to differentiate and clarify for young people their roles and powers in relation to different types of decision-making. In this study, young people questioned the 'distance' between social work and their day-to-day lives and suggested the residential care workers should have more direct involvement in day-to-day decision-making in particular. This view was echoed by key workers, who suggested some social workers were tentative about giving over such control. Social workers generally found that their involvement with the residential centres would be high at the transition period and then diminish over time. It was also noted that often it was not social workers who held the decision-making power, but that this needed to be communicated and explained more clearly. A clear differentiation was made by social workers and key workers between decision-making on access and wider care-planning issues and decision-making on the day-to-day life of the young person in care.

Reinforcing earlier discussion, the quality and nature of relationships with the social worker was seen as a significant factor in enabling good cooperation regarding such day-to-day decision-making. Key workers argued that there was a need to give more recognition to the professional qualifications and experience of the PRC staff team and a need for greater partnership between keyworkers and social workers in decision-making. This was reinforced strongly by PRC managers, who noted the level of regulation of the PRC homes and the training and qualifications of the staff as arguments in favour of greater autonomy over day-to-day decision-making. PRC managers described well-established internal processes of support for decision-making between managers and staff and identified the building of trust with the social worker as key. Social workers echoed a concern about lack of authority divested to residential staff to make some of the 'bigger decisions', recognising that on the one hand, more reliance was placed on the staff to make up for the lack of the social worker, but at the same time, they had limited decision-making powers.

It seems that the particular issue of negotiating decision-making powers between the child welfare service/social workers and the PRC system were particularly pronounced because of governance issues. While negotiation of decision-making between residential centres and child welfare services/social workers is an issue that arises in a more general context, it seems particularly challenging where the care provider is not part of the Tusla governance structures. In particular, it seems to pose additional challenges to the devolution of responsibilities regarding statutory care and protection standards and requirements and day-to-day care. However, even if that is the case, evidence from the study also shows that better and more established relationships enable better ability to use appropriate discretion and negotiation to decide best processes for the child and centre in question. The reality of the current problem of lack of availability of sufficient social work support places even greater responsibility and urgency on those responsible to address how decision-making about day-to-day life is facilitated and overseen. Residential care staff show great frustration at not being able to support such decision-making despite their closer relationships and expertise with young people. Social workers also struggle with the dilemma of balance between what decisions are made at statutory level and what can be devolved to those caring directly for the young person, or directly to the person themselves. Young people gave a number of examples of their own experiences that indicate the importance of paying attention to this within the context of best practice principles and actions on participation and decision-making.

Recommendations

- Tusla should review childcare planning and review processes to enhance youth participation and organise in a way that is more inclusive and conducive to participation.

- Ensure decision-making frameworks pay particular attention to differentiation between day-to-day decision-making and wider care-planning decisions.
- When updating the Child and Youth Participation Strategy, including the setting of standards recommended by the Tusla Task Force on Special Care (2022) pay particular attention to best practices to promote participation in care contexts.
- Enhance and expand staff training (including joint training for PRC staff and Tusla staff) to maximise practice approaches based on principles of youth participation, with focus on working in partnership to balance protection and risk management with participation and promotion of autonomy.
- In the current development of Tusla Service User Experience Feedback Framework currently in development could pay specific attention to views and experiences of young people in PRC.

Theme 6: Importance of Relationships Across the Ecological System

The significance of relationships in child welfare practices has been well established and was brought to the fore significantly following the Munro Review of Child protection (2011). In Chapter 4, the interconnectedness of relationships, support, communication and continuity across all levels of the ecological system was discussed. In the discussion so far, relationships have arisen as a recurring theme across a number of areas covered. It is important this is not just considered in a linear way, such as the relationship between children and young people and the professionals working with them. The literature and this research leave little doubt that decision-making takes place within a much more complex set of relationships between the young person, family, social workers, residential workers and the wider child welfare system, its orientation and historical legacy. In this study, specific themes relating to relationships included relationships between young people and keyworkers, young people and social workers, key workers/centres and social workers/child welfare service, young people and their families/carers, regional and national organisations and residential care providers and the wider child welfare system. These will be considered in more detail in the Section 2 discussion, which promotes the need for an ecological system decision-making framework to capture and negotiate this complexity. For the remainder of this section, we focus specifically on relationships between young people and those with direct responsibility for their care and support within their ecological system.

Young people reported they had positive relationships with their key workers and keyworkers discussed the importance of building and maintain relationships in their work. This reflects best practice from the research where authors such as Cahill et al. (2016) emphasise how building positive, supportive relationships with young people is fundamental. Several factors are needed to achieve this including: time spent building relationships; the residential centre's environment; the skills, knowledge, personalities and levels of genuineness of professionals. However, it is also emphasised that factors outside of that environment strongly influence a young person's ability to trust staff and engage in relationships. This can include abusive relationships earlier in their lives, staff turnover, lack of voice in decisions affecting them, and multiple placements. The general lack of information keyworkers report having about a young person's past experiences is another barrier to enabling relationship building, which needs to take cognisance of the person's experience and likelihood of trauma as a result of this.

Another significant factor we found in this study to affect the quality of relationships was the combined effect of geographical distance and lack of availability and continuity of social workers. Lack of regular visits negatively affected the building of good relationships with both young people and centre staff. The lack of consistency of support, especially from the

child welfare service via social workers, has a major impact on relationship building, especially with young people. One person who was in care for ten years had, for example, 15 social workers. The need to constantly build trusting relationships with new social workers was a source of frustration for centre staff and a worry for social workers, who recognised this negative impact. Children and young people explained the difficulty of building trust due to limited or no contact given the number of changes of worker and the low frequency of contact. Social workers spoke about young people not wanting to engage with them as they were a stranger to them, and their desire to have their residential staff present for social work-related meetings. Centre staff discussed the pressure on keyworkers to 'fill the gap' in the absence of social workers.

While some of the main factors negatively affecting relationship building may be outside the control of the child welfare social worker service in the immediate term (e.g. shortage of staff, extra time and resources to support young people placed outside the area, turnover of staff), there are a number of actions that can be implemented. One concrete action may be to review the management of day-to-day decision-making between residential care workers and social workers. The level of concern and frustration of young people and staff about how day-to-day decision-making is managed has been highlighted in the findings and is discussed more in the following section. While we did not compare how this is managed with statutory residential care, it does seem there may be particular issues regarding sharing and devolving decision-making between Tusla and private organisations that should be considered in the review of governance and monitoring recommended by the Strategy for Residential Care Services. For example, the scope for devolved processes within a clear accountability framework could be explored. Alongside this, the wider issues of recruitment and retention of social workers needs to be aligned with the emphasis in the Strategy for Residential Care Services regarding recruitment and retention of residential care staff. Together, these two professionals, in their respective roles, are responsible at the front line for building relationships in a way that enhances and enables best outcomes for children and young people – in partnership with them and their families. It may also be helpful to clarify the role of the social worker for children and young people and for care staff. By the nature of the role and responsibilities, social workers are more to the fore at points of disruption and transition (see also McGregor and Dolan 2021). The findings suggest a benefit in differentiating more clearly this relationship-based role from the sustained relational support of day-to-day life at the centre provided by residential care staff. However, it is not just about clarifying roles. The findings, and literature, also show clearly the importance of flexibility and partnership working between residential care staff and social workers. For example, our findings highlight how day-to-day decision-making and agreement about roles and responsibilities were better managed and negotiated where there is a good relationship between the social worker and the centre, in particular, one that has been built up over time.

Relational practice models that emphasise building safe and trusting relationships, as discussed in Chapter 4, provide a guide for residential care practice in general (e.g. McPherson et al. 2021) and therapeutic residential care in particular (e.g. Whittaker et al. 2015). 'Relational practice' (Folgheraiter 2004) gives particular emphasis to the broader scope of relationships especially in the context of networks of people and networks of systems that can be harnessed and engaged with in order to maximise capacity. This is very much aligned with principles of building social capital, participatory methods and partnership approaches. This resonates with use of the ecological model in child protection, which avails of the model to

- best understand the context from micro (e.g. child and family) to exo (e.g. the organisations) macro (e.g. policies) and chrono (Specific context of time) levels of the ecological system
- identify specific network nodes to build relationships with across the system to inform responses and
- recognise the importance of supervision, and space for reflective practice and support, in relation to maximising the potential for relationship-based practice and relational approaches.

This relational approach can also be applied to enhance resilience among the workforce, recognising the complexity, emotionality and intensity of good relationship-based practice where an ecological and transactional view of resilience is applied to organisational contexts more broadly (Russ et al. 2020). A relational–reflective approach is proven in the literature to increase and enhance resilience in a workforce, and potentially reduce system turnover. As Russ et al. (2020, 10) found, 'in turn, an experienced and committed workforce operating in an organisational culture that promotes relationship-based and reflective practice is likely to achieve improved client outcomes.'

Recommendations

- Tusla to update and develop Practice Guidance for Promoting Permanence and Stability within an ecological context (Tusla-commissioned work, 2017) and update Tusla Permanency Planning Handbook to give a more substantial focus on supporting young people in residential care
- Promote a relational model of practice in the context of networks of people and systems that can be harnessed and engaged with in order to maximise capacity (e.g. joint fora with community and voluntary sector, youth participation strategy, care planning and practice reform and standard setting.
- Enhance collaborative working across the sector to enhance capacity and joint ownership of shared challenges and solutions

Theme 7: Aftercare Supports as an Integral Part of Care Plan and Residential Care Service

The need to improve aftercare supports was discussed by many respondents. They discussed the abruptness of the move, the inadequacy of services to support the transition, and the fact that young people often find themselves transitioned into adult homeless services. The impact of poor supports and stability at the time of transition from care is well established, as discussed in the literature reviewed in Chapter 4 (e.g. Stein 2019).

All stakeholders were very critical of the absence of sufficient support for young people after they turned 18. Noting that whatever progress was made during time in care, young people were leaving care with inadequate supports, and returning to the environment they had been removed from or going into homeless services. The need for Tusla to do more to support young people after care was strongly argued. In-depth examples were given of young people coming back to the PRC seeking help with housing or money, and the PRC not being able to help them. Social workers also identified lack of sufficient aftercare support as a major area that needed to be improved, and the stark and inappropriate transition for some young people from a residential centre to adult homeless services leaving care was highlighted.

Numerous examples of young people leaving care at 18 and suffering adverse outcomes feature in the findings and reinforce what we know from the evidence and experiences elsewhere (e.g. Stein 2019; Medes and Snow 2016). There was collective agreement that 18 was too young to leave care and be left on their own. This issue is compounded by limited

access to aftercare supports for some young people, especially for young people in PRC areas outside of their own jurisdiction. Such lack of support puts young people transitioning from care at risk of social exclusion. The need for stability in care placements to support transition, the importance of preparation, and the need to focus on identity, identity formation and education have been well established (e.g. Stein 2008). Evidence from international debates about transitions from care and the value of 'extended care' (e.g. Van Breda et al. 2020) suggests the urgency of addressing this deficit.

While disruption caused by events within a family or foster home that led to a placement in residential care cannot always be prevented, responsibility for failure to promote security and stability once a child is in care lies directly with the service providers. It is also well known that needs for support are greatest at points of disruption and transition. In promoting best care and informing decision-making towards that, more attention needs to be paid to the strong evidence about the impact of transition and the need for support during transition, as discussed in Chapter 4. The importance of considering this within an ecological context is also highlighted (e.g. Pinkerton 2021), using a life course approach that takes account of past experiences and projects forward to how supports in transition can be provided through and after care.

Recommendations

- Support transitions between care placements and from care as a central aspect of permanency planning and include this in relevant agency processes and updates of guidance such as Pathways to Permanence Handbook (Tusla, 2020).
- Ensure the principles informing a model of care implemented (as recommended in the Strategic Plan for Residential Care Services) includes planning and preparation for leaving the residential care placement (at whatever life stage) with emphasis on life course trajectory, continuity and stability.
- Ensure a decision-making approach incorporates 'deciding forward' towards possible family reunification alongside a wider variety of pathways from care including options of 'extended care' for those who are most vulnerable.
- In providing supportive, therapeutic and/or community alternative interventions, pay particular attention to the diverse needs for support in both the psychological and social transition process.

Theme 8: Lack of Sufficient Data and Integrated Systems to Track Decision-Making Processes

Another important theme from the literature in general and this research in particular relates to the lack of adequate data to inform decision-making. For example, one indicator explored to understand the trajectory and decision-making processes in Phase One was the nature and frequency of contacts with social workers prior to placement. While we presented some data about the numbers of meetings taking place, there was a lack of reliable data on which to base specific conclusions regarding the level of contact involved in the decision-making process around the placement. While the data shows whether there was social work involvement, it did not indicate who actually made the decision to place the children and young people in care or who else was involved when this is made. Overall, despite the exceptional efforts of the staff who assisted in the data collection, we were unable to determine from the data in this research specific accurate paths of decision-making in sufficient detail to fully answer research questions 1–5. The small qualitative sample involved in Phase Two across all stakeholders and the fact that not all views were represented (e.g. no parents) could not produce sufficient evidence either. In order to track important decision-making processes that would help with understanding of the pathways

that led to the PRC, a more robust and detailed recording process would be required combining data held by the National Office, which we accessed, and data from the Tusla records, which we did not access. In working towards recommendations R11 and R12 of the Residential Care Strategy regarding improving data management and integration across systems, attention to collation of specific data on the decision-making process would be essential to inform an overarching framework for decision-making. Also, if it is intended to move forward with recommended longitudinal studies as set out in the recommendations of the Strategy for Residential Care Services, a focus on decision-making based on robust quantitative and qualitative data would be essential. Ideally, such studies should take a practitioner research focus that allows data collection from the 'inside', and an action research methodology that would enable responsive feedback loops and actions during the research process to address missed opportunities identified at the earliest possible time. This could align with evidence regarding the use of predictive risk models in decision-making, as discussed in Chapter 4 (Chor et al. 2022). Whatever the approach taken, the importance of including young people in decision-making should be to the fore. As shown here, while major strides have been made in practices reflected in Chapter 4 and some discussions in this research, substantial work is needed to ensure any framework to inform decision-making has young people's views, opinions and rights to participate to the fore.

Recommendations

- Promote implementation of the recommendation for integration of data from the Residential Care Strategy to ensure greater consistency and timeliness of data collection and develop key data measurements including admission to care, waiting lists, numbers of placement breakdowns and reasons for it, geographical distance and length of stay (Tusla, 2022a).
- Work towards a more robust and detailed recording procedure in order to track important decision-making processes that would help with understanding of the pathways that led to the PRC including processes of involvement with child welfare services, review processes, social work involvement, in so doing, consider how the implementation of TCM (Tusla Case management System) will support this objective.

Theme 9: Assessment and Decision-Making Processes Impacting on Trends and Patterns of Placement in PRC Especially in Relation to 'Reasons' for Entry to Private Residential Care

Decision-making and intervention in the absence of a thorough understanding of the reasons for the young person's entry into care is directly opposed to best practice regarding stability and security. A number of important findings from this study suggest the need for attention to:

- the recording of reasons for entry to care
- the way reasons are represented and labelled
- information sharing
- combining better collection of data on trends and trajectories with best practice regarding supporting and preserving children's and young people's life stories.

Overall, our findings support the need to improve data collection, monitoring and reporting of key metrics as set out in Recommendation 11 of the Strategy for Residential Care Services. They also add further critical considerations to inform best practice developments in this area, as discussed below.

The findings of this research show that more critical reflection is needed on the classifications of 'reasons' for a child or young person being in residential care. Much of the discussion about reasons for use of residential care in international contexts identify 'behaviour' as by far the most common 'reason', and this is likewise shown in our Phase One data. Yet there is clear acknowledgement by services (e.g. Residential Care Strategy), and within this research, that many reasons for placement in care or subsequent placements in residential care include external factors that young people have had little say or decision-making role in. There is a starkness for example in the data in Tables 12 and 13 in Chapter 5, which show 'behaviour' mentioned most often (147) as the reason for entry to PRC, and the many dimensions of this. Yet, in the Phase Two findings, the young person's behaviour features much less than issues including trauma experienced by the young person, placement breakdown, lack of sufficient support for a previous foster placement, lack of sufficient training and many failures to intervene earlier towards prevention and support. The 'recording' of reasons focused mostly on the micro level of the system – the young person, their behaviour and needs. The international evidence corroborates this showing a trend towards more emphasis on individual and family reasons rather than on wider system reasons. While of course individual and family reasons are significant, failure to identify other factors within the ecological system that caused or influenced the care placement can inadvertently unfairly label the young person as 'problematic', or at fault.

The terminology and the way the reasons for care placement are recorded also need to be critically reviewed. While the need for longitudinal studies recognised in the Residential Care Strategy and in this research is clear, there is no need to wait for findings of such studies to know the negative impact on adults who have experienced institutional care when their situations are misrepresented through outdated language still used today that is triggering, stereotyping and traumatic (see for example McGregor et al. 2023). Continuing to frame reasons for entry into care only in the context of the micro–meso level 'problems' of the young person and/or their families, despite the acknowledged fact that there are also many exo- and macro-system wide reasons for the placement, poses the risk of unfair labelling and misrepresentation without accurate context. It also limits the potential for achieving the goals of improved decision-making towards better outcomes, in the absence of a more holistic context.

Furthermore, how 'reasons' are 'assessed' should also be better informed by the growing strength of evidence, discussed in Chapter 4, for the need for a trauma-informed approach which moves away from 'what is wrong with you?' to 'what happened to you?' Likewise, in developing and improving care and decision-making, the use of a system wide lens, such as the ecological model, is essential to capture the complexity, ensure better accountability, and inform more sound approaches to decision-making, as previously discussed and developed further in Section 2 below. Indeed, the Alternative Care Handbook (2014) specifically identifies the importance of a focus on the social ecology of the young person. The services and systems and their impact are part of, not separate to, this ecology. The role the 'system' plays in the reasons for entry to care needs to be more explicit. Statutory permanency-planning processes can be used more effectively to identify the impact of external factors and acknowledge the limits of provision, and as far as possible, to mitigate this impact through decision-making processes. For example, in the Phase Two findings, reference was made to young people not always knowing the complexity of reasons why they are in the placement or why there is a problem securing the placement. While concerns about 'protecting' the young person throughout these processes are understandable, the principles of youth participation indicate the need for greater inclusion and information sharing with the young person throughout the process of planning and intervening, relating to the reasons for where and how they live.

This leads to another important finding regarding lack of information availability and information sharing for young people more generally. As long-established (e.g. Bell 1999), one of the first steps towards participatory practice is information sharing, which is necessary to work towards more advanced forms of participation through consultation and joint involvement in decision-making. Children and young people made reference, for example, to the lack of information about processes they were involved in and not enough updates on what was happening within their care planning and care processes. To form a basis for relationships and trust, the need for more information for parents and the public was also highlighted. Social workers also set out a number of areas where more information was needed, such as information about the care system and different care types for young people entering care. It was noted that young people were unaware, for example, that the option of residential care can be a next step where behaviour becomes unmanageable within a foster placement. As already discussed, core information about the background of young people and their own histories were not always available to keyworkers or social workers. This made it more difficult for them to support young people, especially when they were seeking answers about the young people's history or circumstances to identify reasons for particular behaviours. It also limits the potential for work to enhance permanence and security, given the well-established knowledge of the importance of continuity between 'prior life' and pre-care experience and experience in long-term care. Without basic information to inform support, the question arises as to how young person's life stories are preserved, understood and respected. And yet, the value of life story work, when used well, is established and demonstrated in literature (Hammond et al. 2020) and has been a long-standing best practice tool for supporting young people in care (e.g. Fahlberg 1991). In the absence of the most basic accurate and fair information about trajectories and histories, there are many missed opportunities to better support young people in care. At organisational level, other practices of data management and information sharing also need to be improved. The implementation of an integrated ICT system and infrastructure across children's residential services (R12 of the Strategy for Residential Care) has potential to address some of the concerns expressed here. Consideration also needs to be given to how information sharing occurs between centres and specific social work teams at practice level, in participation with young people, to ensure the person's life story and trajectory is carried with them through the care process. This will contribute significantly towards a trauma-informed approach, which necessarily requires empathy and insight into a person's experiences, as opposed to a behavioural approach focused on the immediate 'presenting' issues.

Recommendations

- Improve data collection, monitoring and reporting of key metrics as set out in Recommendation 11 of the Strategy for Residential Care Services specifically in recording reasons for entry to care and care trajectories from point of entry. Such developments need to be linked with national reporting systems.
- Ensure integrated data systems are designed to collect comprehensive data across the whole ecological system to provide a more robust explanation of the reasons young people are in PRC beyond focus on individual and family issues only.
- Regarding information sharing about reasons for being in care and trajectories:
    - At organisational level, implement the integrated ICT system and infrastructure across children's residential services (R12 of the Strategy for Residential Care)
    - In developing a decision-making framework, pay specific attention to how information sharing, and information recording occurs between centres and

specific social work teams at practice level, in participation with young people, to ensure the person's life story is carried with them through the care process.

Section 2: Findings to Inform a Framework for Ensuring Decision-Making on the Use of Private Placements Is As Robust As Possible

Each stakeholder in the system has a different role to play in relation to decision-making. Tusla child care teams are responsible for decision-making connected with care reviews, access to families and other planning decisions relating to placements. Key workers and PRC managers/staff are responsible for day-to-day decision-making in terms of the daily routine of the children and young people. The complex interaction between the role of the social worker and the centre staff in decision-making has been emphasised as a key area of attention. The role of young people in decision-making is also highlighted showing some differences in how young people perceive their role in decision-making and how it is framed within the professional and organisational contexts. It is within the wider organisational and management components of the system that decisions about availability, type and governance of care placements are made. Generally, the importance of clear policies and procedures relating to decision-making has been highlighted in the findings. Crucially, children and young people need to know what these are and how they can engage with them. Chief Officers make decisions about locating and securing care placements when needed, and are expected to ensure all other options, such as family welfare conferencing and alternative foster placements, are explored before approving the placement. The significant event notification (SEN) team, which comes under the remit of the National Private Placement Team, records all significant events for children and young people in care placements. Regional managers and their teams use such data to make the best decisions for children and young people. The National Office contributes to decision-making by being as familiar as possible with supply and best options in the context of individual need and geographical area. The challenge of any framework is to take into account how best to maximise interactions and cooperation between all persons involved in the system towards best outcomes for children and families.

The substantial discussion in Section 1 summarising key messages from this research to inform Tusla in providing the best care, support and outcomes for children and young people in PRC provides a number of recommendations that relate to improved decision-making on the use of PRC. In this shorter section, we build on this through a focus on how an ecological model can be used as a guide to develop a framework for ensuring decision-making is as robust as possible.

As discussed in Chapter 4, in decision-making regarding placement and support of a young person in residential care, the primary objective is to achieve stability and permanence within the context of risk assessments, safety planning and working towards best outcomes for children and young people (Woodall et al. 2023). Chapter 4 provided examples from international practice that can help inform the development of a framework to ensure decision-making is as robust as possible when using private residential care. In our discussion on the complexity of decision-making, the importance of balancing guides, algorithms and frameworks on the one hand and the centrality of relationships on the other, is established. However, it is also clear from Chapter 4 that how this is done is very complex (Taylor 2012; Benbenishty et al. 2015) and involves many possible decision-making tools and threshold frameworks (see for example Platt & Turney 2014; Devaney 2019; Munro 2011). More recently it has also involved complex algorithms and detailed risk assessment tools, in attempts to improve the 'science' of risk assessment (Keddell 2019). No matter how much guidance is provided, discretion, professional judgement and individual/team practices play an important role (Taylor 2017). Decision-making approaches balance between 'intuitive and analytical decision-making models' (McCormack et al. 2020; Devaney et al. 2020). Heuristic decision-making (Taylor 2017) is proposed as a way to take into account the number of factors that need to be considered and the role of the decision-maker in that process. To

frame this, there is strong support for a systems approach (e.g. Munro 2005), which is supported by our research. This ensures holistic consideration of the range of elements and the complex interplay of systemic factors that influence how child protection and welfare decisions are made.

In the development of such a model, particular attention needs to be paid to the specific barriers that may affect a decision-making framework that have come through in this research to date. Structural limitations across eco-systems, as well as the impact of negative views about use of residential care in the first instance, often for (chrono) historical or socio-cultural reasons, are other barriers that need attention. The need to balance promotion of early intervention and prevention on the one hand, and to challenge the view of residential care as a 'last resort' on the other, is particularly emphasised in the research. Implementation of many of the recommendations in the Strategy for Residential Care Services will address many structural barriers, especially regarding supply, regulation, monitoring and clarification of relations and processes between regional and national systems. Implementation of many other recommendations made in Section 1 can also inform best practice going forward. For example, all stakeholders recognise the impact of the shortage of social workers but were clear in emphasising the need to find ways to ensure greater involvement of the social worker with the PRC and the young people, both in terms of frequency of contact and the building of quality relationships and trust. Decision-making needs to take place in the context of personnel resources currently available and some adjustments may need to be made – e.g. review of the roles and responsibilities relating to day-to-day decision-making to respond to this reality, at least in the short term and foreseeable medium term.

Another barrier noted in these findings includes over-emphasis on micro-level factors and framing of young people's presenting issues so dominantly in the context of 'behaviour' without also recognising wider ecological factors. Taking into account the range of factors informing and influencing decision-making at micro, meso, exo and macro levels should address this. Doing so can bring together the many factors discussed in this report that impact on decision-making regarding placement of children and young people in private residential care. And importantly, it can prevent too much 'blame' being attributed to either what is 'wrong' with the children and young people or 'what happened' to them in their family, and promote questions about 'what opportunities were missed' and 'how can we intervene (even late in the day) to prevent more harm?'

Based on the findings from this study, the development of an ecological relational framework to inform decision-making is recommended to take into account the evidenced complexities involved including barriers such as those outlined above and throughout the report. It can also be used as a tool in supervision to reflect on and consider the processes that need to happen and what aspects of each 'layer' of context needs to be engaged with, influenced, involved and so on. As discussed earlier, an ecological framework derives from original work of Bronfenbrenner (1979), who provided a model for context to map micro, meso, exo and macro levels of a system. In later work, the 'chrono' level was added, denoting trends over time. This was then developed further, with a focus on PPCT (person, process, context and time, e.g. Bronfenbrenner and Morris 2006). This allows for dynamic consideration of the person, process, context and time. Time, in this context, refers to a moment in the present, past or future. While these are the main components applied, we suggest that the specific application to inform a decision-making framework should be seen as a fluid overarching frame to be developed and adapted. Specifically focusing on relevant Irish examples, Moran et al. (2017) adapted the model to reflect the overlapping micro- and meso-systems for a young person in foster care, as discussed in Chapter 4. McGregor and Devaney (2020a and 2020b) show the evolving development of the model to inform a framework for supportive

protection and protective support and McGregor and Dolan (2021) apply the ecological model specifically to promote a framework for social work practice across the life course. For this study, the emphasis should be on developing the ecological model with an emphasis on the interactions and systems involved in decision-making processes over time and context. In doing this, an emphasis on relationships, networks and relational practice throughout all interactions within the system is recommended.

The importance of working with such a framework, which captures the complexity and multi-layered nature of decision-making discussed in the literature, is echoed through the findings. Through use of an ecological framework, the different levels of decision-making from micro to macro level can be identified. Reflecting much of what is discussed in Chapter 4 and shown in our findings and discussion so far, it is clear that decision-making takes place at many intersecting points across the ecological system including:

- Macro-level decision-making about provision, type and scope of service (made at policymaking and commissioning levels).
- Exo-level decision-making, in the context of organisational policies (e.g. Tusla alternative care policy, the continuum of need, orientations towards greater early intervention and prevention).
- Exo–meso-level professional decision-making, relating to the needs and interests of children and young people, and in partnership with them (e.g. within care-planning processes, through relationships with children and young people and based on availability of options).
- Micro–meso-level decision-making, e.g. relationships, day-to-day decision-making shared between the centres themselves, social workers responsible for supporting the placement and the young people involved.
- Micro–meso-level decision-making by and with children, young people and their families/carers.

Taking into account the PPCT framework, a focus can be placed on:

- The person and the process (relationships between workers and young people and families for example).
- The context, from micro to macro, as discussed above, with an emphasis where this context is multi-faceted, often including overlapping systems especially when a placement is at a distance from a person's family and/or community.
- Time (e.g. chrono trends in greater use of privatised services and the need for responsive changes in practice due to this, and moments of time with attention to trajectories, histories, the present and the future in life course and life story work).

Essential to a decision-making framework is recognition of the complexity of these layers and how interactions develop across the system as demonstrated in this report. It is too simplistic to simply 'split' the issues into micro and macro. Emphasis can be paid to the interaction between the layers of networked relational practices of decision-making when children are being placed in private residential care. Existing decision-making models need to be reviewed to consider how these can inform such developments to ensure stronger connections and interactions between 'systemwide' decision-making and decision-making relating to specific placements for children in need of care. For example, at the exo–macro level, and through commission and business-management processes, decisions are made about use of PRC, costs, regulation and so on. Those on the ground have little to no control over this. At the micro–meso–exo level, there are the decision-making processes set out in the care-planning and review process, standards and practices informing intervention with

children and families. A decision-making framework can make clear the decision-making responsibilities at different levels and also help to clarify interactions as relevant between these. Specific emphasis also needs to be placed on involvement of parents and families, where potential for greater engagement post-care placement is evident. In developing a dynamic systems approach to decision-making, a particular consideration is the involvement of children and young people in residential care in the process, placing this at the centre of any framework that is developed.

As articulated in McGregor and Devaney (2020a, 2020b), with reference to more general practice in 'supportive protection and protective support', this can then lead to more detailed mapping of specific networks at each level, in line with relational practice discussed earlier, to identify who is involved in decision-making, at what level, and their role and the type of relationship needed to engage in best practice for decision-making. There is scope to advance this further through use of a relational approach with an emphasis on networks.

Finally, conceptually, a decision-making framework should be designed from a life course perspective ensuring attention to the trajectory of life before placement and influencing positively the future trajectory through care and into adulthood. In doing this, the full eco-system of the young person's needs will be to the fore, especially their families and communities. Current risk assessment models that inform decision-making need to reflect similar principles to SOS (Signs of Safety) with an emphasis throughout on strengths and potential, while ensuring safety, protection, development and participation. Promoting the autonomy of the young person and the rights of the child, young person and family, principles of participation and partnership within relationships at the centre should frame the underpinning philosophy of a decision-making framework. Continuing professional development (CPD) support and training will be essential.

Recommendations

- In the development of ongoing training, CPD support and development of all staff within Tusla, develop specific focus on risk assessment and decision-making in the context of life course relational approaches to decision-making and support.
- Use collective youth-engagement strategies, in partnership with advocacy agencies (e.g. EPIC in Ireland), to inform the development of the framework for complex decision-making and maximise children's and young people's engagement with this.

Section 3: Findings to Inform Implementation of CCA and TTS for Young People in PRC

Many of the findings discussed above have relevance for CCA and TTS. Also, it is acknowledged that since our research objectives were set, significant developments have already occurred regarding the development of CCA and TTS which were at early stages of development during the period of the research. Briefly, from the discussion so far, the following recommendations pertain specifically to the implementation of CCA and TTS based on the study findings.

Recommendations

- Implement the range of strategies towards earlier intervention and prevention before, during and towards leaving residential care based on recommendations from this report.
- Prioritise urgency of the need to provide better supports for children and young people given that the majority of children and young people in PRC were diagnosed as having

either a psychological or psychiatric diagnosis or specific mental or physical health needs.

- Consider the examples of international practices discussed in Chapter 4 regarding development of innovative responses to providing alternative approaches to support children, young people and their parents including learning from practices in specialist private and other residential and care provision.
- Develop wraparound services for young people leaving PRC and embed preparation for leaving care into care planning and permanency.
- Extend collaborative working with those involved in the coordination of CCA coordinators to implement services needed for children to be reunified home from care or back to their communities.
- Develop further independent advocacy support, in partnership with EPIC and other youth support organisations for young people in PRC.

Conclusion

This research is timely as the Strategic Plan for Residential Care Services comes until review for 2025. Alongside this, there are a number of developments within Tusla, many pointing towards potential improvements that should impact positively on trends and patterns for young people placed in PRC. Levels of information for young people in residential care (e.g. youth-led residential care information), support for development of services for parents of children in care, and advancements in policies and practices are continually in development (see Tusla business plan, 2022). In developing these policies, the need to integrate them is evident to ensure a holistic approach to decision-making in relation to children in private residential care.

The content of this report can inform the development of a 'standardised evidence-based model of care' in all residential settings with a 'focus on integrated care planning and permanency planning' as proposed within the Tusla Strategy for Residential Care Services (R5). However, based on the international evidence and this research study, the evidenced need for a breadth of services and types of care to meet diverse needs should be noted. There is no one size that fits all, nor should there be. There is growing consensus on the need for more trauma-informed services delivered within the broad principles of therapeutic residential care. Supported by this study, and evidence from studies elsewhere, the need to develop this model with a broad ecological systems lens is clearly demonstrated. Our report clearly supports the recommendations for improved access to therapeutic services for children in alternative care (R6) and access to education (R8) and the urgency and need for this is reflected in the findings and verified in widespread evidence of the negative impact of lack of attention to these needs. The Strategy for Residential Care Services also recommends stronger recruitment, support and retention of residential care services (R7) but this needs to be aligned with the wider Tusla strategy for recruitment, support and retention of social workers and social care/family support workers. The report supports the importance of external regulation of all residential care services (R8) but also highlights the importance in this process of focusing not just on regulation, but also on integration, joint work and cooperation to ensure smooth processes from practice to higher policy levels between private providers and the statutory services. The need for better data, more integrated analysis and further research, as recommended by the Strategic Plan (R9, R11, R12), is highlighted in the study and wider literature. But there is clearly no need for further research to establish that missed opportunities to prevent placement and intervene earlier result in some children and young people being in residential care where this might not have been necessary. Similarly, from a life course perspective, young people who are provided with more stable supports have a greater chance of thriving or surviving well in adulthood. Studies that emphasise a

practitioner-led approach are favoured to allow more safe and ethical access to the detailed data needed to track decision-making processes, and action research approaches should be used to ensure that learning and developments can influence those already in the system as well as those who may come after.

References

Ainsworth, F., and Thoburn, J. (2014). An exploration of the differential usage of residential childcare across national boundaries. *International Journal of Social Welfare*, 23(1), 16–24.

AKJ (2018). 20 Jahre KomDat Jugendhilfe. *Kommentierte Daten der Kinder- & Jugendhilfe*, 1, 1–36. https://www.forschungsverbund.tu-dortmund.de/fileadmin/user_upload/AKJStat/Komdat/2018_Heft1_KomDat.pdf

Allen, G. (2011a). *Early intervention: the next steps, an independent report to Her Majesty's government by Graham Allen MP*. London: The Stationery Office.

Andrews, D.A., Bonta, J., and Wormith, J.S. (2011). The Risk-Need-Responsivity (RNR) Model: does adding the good lives model contribute to effective crime prevention? Criminal Justice and Behavior, 38(7), 735–755. https://journals.sagepub.com/doi/abs/10.1177/0093854811406356

Assim, U.M. (2013). *Understanding kinship care of children in Africa: a family environment or an alternative care option* (doctoral dissertation). South Africa: Faculty of Law at the University of the Western Cape.

Australian Institute of Health and Welfare (AIHW) (2021). Child protection Australia 2019–2020. Child Welfare Services Series no. 74, cat. No. CWS78. AIHW.

Baker, N. (2021). Tusla, chief says level of private residential companies for children is a worry. *Irish Examiner*, 27 September. Available: https://www.irishexaminer.com/news/arid-40706966.html [Accessed 21 March 2023].

Barbosa-Ducharne, M.A., and Soares, J. (2022). Residential care for children and youth in Portugal: a change as necessary as urgent. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 256–272.

Barillas, K.H. (2011). State capacity: the missing piece in child welfare privatization. *Child Welfare*, 90(3), 111–127.

Baumann, D.J., Dalgleish L., Fluke J., et al. (2011). *The decision-making ecology*. Washington, DC: American Humane Association.

Bayliss, K., and Gideon, J., (2020). *The privatisation and financialisation of social care in the UK, SOAS Department of Economics Working Paper No. 238*. London: SOAS University of London.

Beard, L., Ismayilova, L., Claypool, E., Heidorn, E., and Guliyeva, N. (2022). From child institutions to family reunification: challenges and opportunities in building family-centred care. *The Lancet*, 10(1). https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(22)00160-7.pdf

Bell, M. (1999). Working in partnership in child protection: the conflicts. British Journal of Social Work, 29, 437–455.

Benbenishty, R., Davidson-Arad, B., López, M., Devaney, J., Spratt, T., Koopmans, C., Hayes, D. (2015). Decision-making in child protection: an international comparative study on maltreatment substantiation, risk assessment and interventions recommendations, and the role of professionals' child welfare attitudes. *Child Abuse and Neglect*, 49, 63–75.

Bennett, D.L., Webb, C.J.R., Mason, K.E., Schlüter, D.K., Fahy, K., Alexiou, A., et al. (2021). (Under review). Funding for preventative Children's Services and rates of children becoming looked after: a natural experiment using longitudinal area-level data in England.

Berrick, J.D., Gilbert, N., and Skivenes, M. (2022). *International handbook of child protection systems*. New York: Oxford University Press

Better Care Network
https://bettercarenetwork.org/sites/default/files/Making%20Decisions%20for%20the%20Better%20Care%20of%20Children.pdf.

BMFSFJ (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth) (2020). *16. Kinder und Jugendbericht* [16th Child and Youth Report]. Berlin, Germany: BMFSFJ.

Brady, B., Kennan, D., Forkan, C., Tierney, E., Jackson, R., and Holloway, R. (2019). The participation of children and young people in care: insights from an analysis of national inspection reports in the Republic of Ireland. *Child Care in Practice*, 25(1), 22–36.

Brady B., Forkan, C., and Moran L. (2018). Spaces of connection and belonging: young people's perspectives on the role of youth cafés in their lives. *Child Care in Practice*, 24(4), 390–401.

Branigan, R., and Madden, C. (2020). *Spending Review 2020 Tusla Residential Care Costs*. Dublin: DCYA. Available: https://www.gov.ie/en/publication/b4b2e-spending-review-2020-tusla-residential-care-costs/ [Accessed 18 March 2023].

Bravo, A. et al. (2022). The changing character of residential care for children and youth in Spain. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 179–192.

Bronfenbrenner, U. (1979). *The ecology of human development: experiments by nature and design*, Cambridge: Harvard University Press.

Bronfenbrenner, U., and Ceci, S.J. (1994). Nature–nurture reconceptualized in developmental perspective: a bioecological model. Psychological Review, 101, 568.

Bronfenbrenner, U., and Morris, P.A. (1998). The ecology of developmental processes. In W. Damon and R.M. Lerner eds., Handbook of child psychology, Vol. 1: theoretical models of human development, 5th ed. New York: Wiley, 993–1023.

Bronfenbrenner, U., and Morris, P.A. (2006). The bioecological model of human development. In W. Damon and R.M. Lerner eds., Handbook of child psychology, Vol. 1: theoretical models of human development, 6th ed. New York: Wiley, 793–828.

Brown, G. (2016). Finding a future beyond the crisis: looked after children in secure care. In M. Richardson et al. eds., *Fostering good relationships: partnership work in therapy with looked after and adopted children*. London: Karnac Books Ltd, 101–116.

Brown, T., Winter, K., and Carr, N. (2018). Residential child care workers: relationship based practice in a culture of fear. *Child & Family Social Work*, 23, 657–665.

Buckley, H. (2012). Using intelligence to shape reforms in child protection. *Irish Journal of Applied Social Studies*, 12(1),
Article 6.

Buckley, H., and O'Nolan, C. (2013). *An Examination of Recommendations from Inquiries into Events in Families and their Interactions with State Services, and their Impact on Policy and Practice*. Dublin: Department of Children and Youth Affairs.

Bullen, T., Taplin, S., McArthur, M., Humphreys, C., and Kertesz M. (2017). Interventions to improve supervised contact visits between children in out of home care and their parents: a systematic review. *Child & Family Social Work*, 22(2), 822–833.

Cahill, O., Holt, S., and Kirwan, G. (2016). Keyworking in residential child care: lessons from research. *Children and Youth Services Review*, 65, 216–223.

Cameron, C., Hollingworth, K., Schoon, I., van Santen, E., Schröer, W., Ristikari, T., Heino, T., and Pekka-rinen, E. (2018). Care leavers in early adulthood: how do they fare in Britain, Finland and Germany? *Children and Youth Services Review*, 87, 163–172. https://www.sciencedirect.com/science/article/abs/pii/S019074091730868X?via%3Dihub.

Canavan, J., Devaney, C., McGregor, C., and Shaw, A. (2021). *Understanding system change in child protection and welfare*. London: Routledge.

Carter, R. (2005). *Family matters: a study of institutional childcare in central and eastern Europe and the former soviet union*. London, United Kingdom: Every Child. https://resourcecentre.savethechildren.net/document/family-matters-study-institutional-childcare-central-and-eastern-europe-and-former-soviet/

Child Care Act (1991). Government Publications.

Child Welfare Information Gateway (n.d.). *Foster Care*. Available: https://www.childwelfare.gov/topics/outofhome/foster-care/ [Accessed 3 April 2020].

Children's Commissioner (2019). *Pass the parcel: children posted around the care system*, London: Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/resource/pass-the-parcel-children-posted-around-the-care-system/

Chor, K.H.B. (2013). Overview of out-of-home placements and placement decision-making in child welfare. *Journal of Public Child Welfare*, 7(3), 298–328.

Chor, K.H.B., McClelland, G.M., Weiner, D.A., Jordan, N., and Lyons, J.S. (2012). Predicting outcomes of children in residential treatment: a comparison of a decision support algorithm and a multidisciplinary team decision model. *Children and Youth Services Review*, 34(12), 2345–2352. https://www.sciencedirect.com/science/article/abs/pii/S0190740912003404?via%3Dihub

Chor, K.H.B., McClelland, G.M., Weiner, D.A., Jordan, N., and Lyons, J.S. (2013). Patterns of out-of-home placement decision-making in child welfare. *Child Abuse & Neglect*, 37(10), 871–882. http://dx.doi.org/10.1016/j.chiabu.2013.04.016.

Clarke, T., Chowdry, H., and Gilhooly, R. (2019) Trends in *Childhood Vulnerability: Vulnerability Technical Report*, Children's Commissioner's Office, UK, available: https://assets.childrenscommissioner.gov.uk/wpuploads/2019/07/cco-vulnerability-2019-tech-report-1.pdf

Competition and Markets Authority (2022). Children's social care market study. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1027863/Interim_report_221021_.pdf [Accessed 08 Dec 2022].

Courtney, M., and Iwaniec D. (2009). *Residential care of children: comparative perspectives*. Oxford: Oxford University Press.

Courtney, M., and Thoburn, J. (2009, ebook 2016). *Children in state care*. London: Routledge.

Courtney, M., Dolev, T., and Gilligan, R. (2009). Looking backward to see forward clearly. In M. Courtney, and D. Iwaniec eds., *Residential care of children: comparative perspectives*. Oxford: Oxford University Press, 191–208.

Crea, T.M. (2010). Balanced decision-making in child welfare: structured processes informed by multiple perspectives. *Administration in Social Work*, 34(2), 196–212. doi: 10.1080/03643101003609529.

Davidson-Arad, B., Englechin-Segal, D., Wozner, Y., and Arieli, R. (2006). Social workers' decisions on removal: predictions from their initial perceptions of the child's features, parents' features, and child's quality of life. *Journal of Social Service Research*, 31(7), 1–23.

Delgado, P., Pinto, V.S., and Carvalho, J.M.S. (2017). Attitudes and decision-making in the child protection system: a comparison of students and professionals. *Kriminologija & Socijalna Integracija*, 25(2), 2–14.

Department for Education (2012). *Reform of children's residential care. Report of the Expert Group on the Quality of Children's Homes*. Available: https://basw.co.uk/sites/default/files/resources/basw_34122-7_0.pdf

Department of Children and Youth Affairs (2019). *Policy Information: Special Care Units*. Available: https://www.gov.ie/en/policy-information/118b86-special-care-units/ [Accessed 3 April 2020].

Devaney, C., and Rooney, C. (2018). *The feasibility of conducting a longitudinal study on children in care or children leaving care within the Irish context*. Galway: UNESCO Child and Family Research Centre, National University of Ireland Galway.

Devaney, C., and McGregor, C. (2017). Child protection and family support practice in Ireland: a contribution to present debates from a historical perspective. *Child and Family Social Work*, 22, 1255–1263.

Devaney C., McGregor C., and Moran. L. (2019). Outcomes for permanence and stability for children in care in Ireland: implications for practice. *British Journal of Social Work*, 49(3), 633–652. https://doi.org/10.1093/bjsw/bcy078.

Devaney, C., and McGregor, C. (2022). Protective support and supportive protection: critical reflections on safe practice and safety in supervision. *Social Sciences*, 11, 312. https://doi.org/10.3390/socsci11070312.

Devaney, C., Canavan J., and McGregor, C. (2024, forthcoming). A critical analysis of early intervention in the Irish child protection and welfare system. In The Routledge Handbook of Child and Family Social Work Research Knowledge-Building, Application, and Impact (Eds) Elizabeth Fernandez, Penelope Welbourne, Bethany Lee, Joyce L. C. Ma, Routledge. London.

Devaney, J. (2019). The trouble with thresholds: rationing as a rational choice in child and family social work. *Child & Family Social Work*, 24(4), 458–466.

Dickens, J., Berrick, J., Poso, T., and Skivenes, M. (2017). Social workers and independent experts in child protection decision-making: messages from an intercountry comparative study. *British Journal of Social Work*, 47, 1024–1042.

Dima, G., and Skehill, C. (2011). Making sense of leaving care: the contribution of Bridges Model of Transition to understanding the psycho-social process. *Children and Youth Services Review*, 33(12), 2532–2539.

Duggan K. (2022). Foreword. In *Strategic Plan for Residential Care Services for Children and Young People 2022–25*. Dublin: Tusla.

EPIC (2021). EPIC, Empowering People in Care Pre-Budget 2022 Submission August 2021. Dublin: EPIC. Available: https://www.epiconline.ie/wp-content/uploads/2021/09/EPIC-Budget-2022-Submission_August-2021_-FINAL.pdf [Accessed 18 March 2023].

Eurochild (2010). *Children in Alternative Care: National Surveys*, 2nd edn. Available: https://eurochild.org/resource/national-surveys-on-children-in-alternative-care-2nd-edition/
[Accessed 3 April 2020].

Fahlberg, V. (1991). A child's journey through placement. BAAF, Adoption and Fostering.

Fisher, P.A., and Gilliam, K.S. (2012). Multidimensional treatment foster care: an alternative to residential treatment for high risk children and adolescents. *Interv Psicosoc*, 21(2), 195–203.

Folgheraiter, F. (2004). *Relational Social Work toward Networking and Societal Practices*. London, Jessica Kingsley.

Forkby, T., and Höjer, S. (2011). Navigations between regulations and gut instinct: the unveiling of collective memory in decision-making processes where teenagers are placed in residential care. *Child & Family Social Work*, 16(2), 159–168.

Franklin, A., and Goff, S. (2019) Listening and facilitating all forms of communication: disabled children and young people in residential care in England, *Child Care in Practice*, 25:1, 99-111, DOI: 10.1080/13575279.2018.1521383

Fuentes, M.J., Bernedo, I.M., Salas M.D., and García-Martín M.A. (2019). What do foster families and social workers think about children's contact with birth parents? A focus group analysis. *International Social Work*, 62(5), 1416–1430.

Furey, E., and Canavan, J. (2019). *A review on the availability and comparability of statistics on child protection and welfare, including children in care, collated by Tusla: Child and Family Agency with statistics published in other jurisdictions*. Galway: UNESCO Child and Family Research Centre, National University of Ireland Galway.

Gahleitner, S. (2012). *Traumapädagogik und psychosoziale Traumarbeit: Modeerscheinung oder Notwen-digkeit?* [Trauma-informed practice and psychosocial trauma work in residential care for children and adolescents – passing fad or absolute imperative? Trauma & Gewalt, 6(3), 206–217.

Galvin, E ., O'Donnell, R., Breman, R., Avery, J., Mousa, A., Halfpenny, N., and Skouteris, H. (2021). Interventions and Practice Models for Improving Health and Psychosocial Outcomes for Children in Residential Out-of-Home Care: Systematic Review, *Australian Social Work*, 75:1, 33-47, https://doi.org/10.1080/0312407X.2020.1856394

Gharabaghi, K. (2009). Private service, public rights: the private children's residential group care sector in Ontario, Canada. *Residential Treatment for Children & Youth*, 26, 3.

Gharabaghi, K. (2019). *A hard place to call home: a Canadian perspective on residential care and treatment for children and youth*. Ontario: Canadian Scholars.

Gilbert, N., Parton, N., and Skivenes, M. (2011). *Child protection systems: international trends and orientations*. New York: Oxford University Press.

Gilligan, R. (2019). The family foster care system in Ireland – advances and challenges. *Children and Youth Services Review*, 100, 221–228.

Gilligan, R. (2022) Residential care for children and youth in Ireland. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 108–122.

Gloster, B. (2022). *Foster Care Issues and the Loss of Positive Care Services:* Engagement with Tusla. 22 May Dublin: Joint Committee on Children, Equality, Disability, Integration and Youth debate. Available: https://www.oireachtas.ie/en/debates/debate/joint_committee_on_children_equality_disability_integration_and_youth/2022-05-10/3/ [Accessed 18 March 2023].

Goldman, P.S., Bakermans-Kranenburg, M.J., Bradford, B., Christopoulos, A., Lim Ah Ken, P., Cuthbert, C., and Sonuga-Barke, E.J.S. (2020). Institutionalisation and deinstitutionalisation of children 2: policy and practice recommendations for global, national, and local actors. *Lancet Child and Adolescent Health*. 4 (8), 606-633.

Grietens, H. (2015). A European perspective on the context and content for social pedagogy in therapeutic residential care. In J.K. Whittaker, J.F. Del Valle, and L. Holmes, eds. *Therapeutic residential care for children and youth. Developing evidence-based international practice*. London: Jessica Kingsley, 288–300.

Guidelines for the Alternative Care of Children (2010). United Nations A/RES/64/142.

Hammond, K.R. (1996). *Human judgment and social policy: irreducible uncertainty, inevitable error, unavoidable injustice*. New York: Oxford University Press.

Hammond, S.P., Young, J., and Duddy, C. (2020). Life story work for children and young people with care experience: a scoping review. *Developmental Child Welfare*, 2(4), 293–315. https://doi.org/10.1177/2516103220985872.

Helm, D., and Roesch-Marsh, A. (2017). The ecology of judgement: a model for understanding and improving social work judgements. *British Journal of Social Work*, 47, 1361–1376.

Henriksen, A.K. (2022). 'It's my life they are talking about' – On children's participation in decision-making for secure placement. *Qualitative Social Work*, 21(4), 783–799.

Hickey, G., McGilloway, S., Leckey, Y., and Stokes, A. (2018). A universal early parenting education intervention in community-based primary care settings: development and installation challenges. *Education Sciences*, 8(4), 178.

Höjer, S., and Forkby, T. (2011). Care for sale: the influence of new public management in child protection in Sweden. *British Journal of Social Work*, 41(1), 93–110.

Holden, M.J., Sellers, D.E, and Smith, E.g. . (2022). The CARE program model. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 139–153.

Holmes, L. et al. (2022). Residential care for children and youth in England. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 43–56.

Ie, J. (2023). The concept of family: perspectives of Spanish young people in foster care. *Child and Family Social Work*, 28(2) 503-514

Institute of Public Care (2015). *Financial stability, cost charge and value for money in the children's residential care market*. England: Dept of Education/Institute of Public Care.

Instituto de Seguranca Social (Institute of Social Security) (2021). *CASA 2020-Caracterizacao anual da situacao de acolhimento* [Annual report on out-of-home care].

Available: https://www.seg-social.pt/documents/10152/13200/CASA+2020.pdf/b7f02f58-2569-4165-a5ab-bed9efdb2653.

INTRAC (n.d.). *International Research Network on Transitions to Adulthood from Care* (globalintrac.com) Accessed 2023.

Irish Foster Care Association (n.d.). *What is foster care?* Available: https://www.ifca.ie/fostering/what-foster-care/ [Accessed 3 April 2020].

Jackson, R., Brady, B., Forkan C., Tierney, E., and Kennan, D. (2020). Influencing policy and practice for young people in foster care: learning from a model of collective participation. *Children and Youth Services Review*, 113, 104901.

James, S., Wilczek, L., Kilian, J., Timonen-Kallio, E., Bravo, A., del Valle, J.F., Formenti, L., Petrauskiene, A., Pivoriene, J., and Rigamonti, A. (2022). A comparative analysis of residential care: a five-country multiple case-design study. *Child & Youth Care Forum*, 51, 1031–1062.

Johnson, D., and Steckley, L. (2022). Residential care for children and youth in Scotland: keeping the promise? In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 57–74.

Kappler, S., Hornfeck, F., Pooch, M.T., Kindler, H., and Tremel, I. (2019). *Kinder und Jugendliche besser schützen. Der Anfang ist gemacht. Abschlussbericht des Monitorings zum Stand der Prävention sexualisierter Gewalt an Kindern und Jugendlichen in Deutschland (2015–2018)* [Protecting children and youth better. The beginning is made. Final monitoring report about the status of preventing the sexualized violence of children and youth in Germany (2015–2018)]. Munich, Germany: DJI.

Keddell, E. (2019). Algorithmic justice in child protection: statistical fairness, social justice and the implications for practice. *Social Sciences*, 8(10), 281.

Kelly, B, Van Breda A., Pinkerton J., Frimpng-Manso, K., Chereni, A., and Bukuluki, P. (2023). Youth in transition: exploring a life course perspective on leaving care in Africa. *Youth & Society*, 1–20. https://doi.org/10.1177/0044118X231193708

Kennan, D., Brady, B., and Forkan, C. (2018). Supporting children's participation in decision-making: a systematic literature review exploring the effectiveness of participatory processes. *British Journal of Social Work*, 48(7), 1985–2002.

Kennan, D., Brady, B., and Forkan, C. (2019). Space, voice, audience and influence: the Lundy Model of Participation (2007) in Child Welfare Practice. *Practice (Birmingham, England)*, 31(3), 205–218.

Kertudo, P., Sécher, R., and Tith, F. (2015). *L'invisibilité sociale, publics et mécanismes: l'entourage familial des enfants placés dans le cadre de la protection de l'enfance* [Social invisibility, populations and mechanisms: relatives of children in out-of-home placement]. *Recherche Sociale*, 216, 4–114.

Kirkpatrick, I., Kitchener, M., and Whipp, R. (2001). 'Out of sight, out of mind': assessing the impact of markets for children's residential care. *Public Administration*, 79(1), 49–71.

Kloppenborg, H.S., and Lausten, M. (2020). *Udsatte unges inddragelse i kommunernes sagsbehandling*. Copenhagen: VIVE, The Danish Center for Social Science Research.

Knorth, E.J., and Harder, T. (2022). Residential care for children and youth in the Netherlands: high difficulties in low lands. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 193–208.

Lausten, M. (2022). Residential care for children and youth in Denmark. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 225–238.

Lee, B.R., and Bellonci, C. (2022). Residential care for children and youth in the United States. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 91–107.

Leloux-Opmeer, H,Kuiper, C.H.Z,, Swaab, H. T. and Scholte, E.M.. (2017) Children referred to foster care, family-style group care, and residential care: (how) do they differ? *Children and Youth Services Review*, 77, 1–9.

Lerch, V., and Nordenmark Severinsson, A. (2019). Target Group Discussion Paper on Children in Alternative Care, *Feasibility Study for a Child Guarantee (FSCG)*. Brussels: European Commission.

Lotty, M., Bantry-White, E., and Dunn-Galvin, A. (2021). A qualitative study in Ireland: foster carers and practitioners perspectives on developing a Trauma-Informed Care Psychoeducation Programme. *Child Care in Practice*. doi: 10.1080/13575279.2021.1925632.

Lundy, L. (2007). Voice is not enough: conceptualising Article 12 of the United Nations Convention on the rights of the child. British Educational Research Journal, 33(6), 927–942.

MacAlister, J. (2022). *The independent review of children's social care: final report*. https://www.gov.uk/government/publications/independent-review-of-childrens-social-care-final-report

Martín, E., González-García, C., del Valle, J.F., and Bravo, A. (2020). Detection of behavioural and emotional disorders in residential child care: using a multi-informant approach. *Children and Youth Services Review*, 108, 1–6.

McCafferty P and Taylor B (2020) Risk, Decision making and Assessment in child welfare. *Child Care in Practice*, 26:2 107-110

McCormack, C. Gibbons, M., and McGregor, C. (2020). An ecological framework for understanding and improving decision-making in child protection and welfare intake (duty) practices in the Republic of Ireland. *Child Care in Practice: Northern Ireland Journal of Multi-disciplinary Child Care Practice*, 26(2), 146–162.

McGregor, C., and Dolan, P. (2021). *Support and protection across the lifecourse: a practical approach to social work*. Bristol: Policy Press.

McGregor, C., and Devaney, C. (2020a). Protective support and supportive protection for families 'in the middle': learning from the Irish context. Child & Family Social Work, 25, 277–285.

McGregor, C., and Devaney, C. (2020b). Protective support and supportive protection: critical reflections on safe practice and safety in supervision. *Social Sciences*, 9(4), 43. https://doi.org/10.3390/socsci9040043.

McGregor, C., Devaney C,, and Moran, L. (2021). A critical overview of the significance of power and power relations in practice with children in foster care: evidence from an Irish study. Child Care in Practice: *Northern Ireland Journal of Multi-disciplinary Child Care Practice*, 27(1), 4–18.

McGregor, C., Canavan, J., and O'Connor, P. (2019). *Public Awareness Work Package Final Report: Tusla's Programme for Prevention, Partnership and Family Suppor*t. Galway: UNESCO Child and Family Research Centre.

McGregor, C., Canavan, J., and Nic Gabhainn, S. (2020). A critical consideration of the relationship between professional and public understandings of family support: towards greater public awareness and discursive coherence in concept and delivery. *Children and Youth Services Review*, 113. doi: https://doi.org/10.1016/j.childyouth.2020.104952.

McGregor, C., Devaney C., and Buckley, S.A. (2023). Language, terminology and representation relating to Ireland's institutions historically known as 'Mother and Baby Homes', 'County Homes' and related institutions. Galway: UNESCO Child and Family Research Centre, University of Galway.

McNamara, P., and Wall, S. (2022). Australian residential care: creating opportunities for hope and healing. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 339–355.

McPherson, L, Vosz, M., Gatwiri K., Parmenter, N., Macnamara, N., Mitchell, J., and Tucci J. (2021). What does research tell us about young people's participation in decision-making in residential care? A systematic scoping review. *Children and Youth Services Review*, 122, 105899.

Meagher, G., Lundström, T., Sallnäs, M., and Wiklund S. (2016). Big business in a thin market: understanding the privatization of residential care for children and youth in Sweden. *Social Policy & Administration* 50(7), 805–823.

Mendes, P., and Snow, P. (2016). *Young people transitioning from out-of-home care: international research, policy and practice*. London: Palgrave Macmillan.

Mendes, P., and McCurdy, S. (2020). Policy and practice supports for young people transitioning from out-of-home care: an analysis of six recent inquiries in Australia. *Journal of Social Work* JSW, 20.5, 599–619.

Merkel-Holguin, L., Fluke, J.D., and Krugman, R.D. eds. (2019). *National systems of child protection: understanding the international variability and context for developing policy and practice*. New York: Springer.

Monson, T. A. (2020) Risk Attitudes within 'Complex Youth' Assessment and Decision Making: Professional Perspectives, *Child Care in Practice*, 26:2, 210-222, DOI: 10.1080/13575279.2019.1685462

Moran, L., McGregor C., and Devaney C. (2017a). *Outcomes for permanence and stability for children in long-term care*. Galway: UNESCO Child and Family Research Centre.

Moran L., McGregor, C., and Devaney, C. (2017b). *Outcomes for permanence and stability for children in long-term care: practice guidance*. Galway: UNESCO Child and Family Research Centre.

Moran, L., Devaney, C., McGregor, C., and Reddy, J. (2016). *Scoping review of international and Irish literature on outcomes for permanence and stability for children in care*. Galway: UNESCO Child and Family Research Centre.

Mulcahy, M., and Trocmé, N. (2010). *Children and youth in out-of-home care in Canada (Information Sheet #78). Center of Excellence for Child Welfare. Montreal,* QC: Centre for Research on Children and Families, McGill University.

Mulkeen, M. (2016). Going to market! An exploration of markets in social care. *Administration*, 64(2), 33–59.

Munn, Z., Peters, M.D.J., Stern, C. et al. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Med Res Methodol,* 18, 143.

Munro, E. (2002). *Effective child protection*. London: Sage Publications.

Munro, E. (2005). Improving practice: child protection as a systems problem. *Children and Youth Services Review*, 27, 375–391. doi: 10.1016/j.childyouth.2004.11.006.

Munro, E. (2011). *Munro review of child protection: final report – a child-centred system – Publications* – GOV.UK. [online] https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system

Munro, E.R., Pinkerton, J., Mendes P., Hyde-Dryden, G., Herczog, M., and Benbenishty, R. (2011). The contribution of the United Nations Convention on the Rights of the Child to understanding and promoting the interests of young people making the transition from care to adulthood. *Children and Youth Services Review*, 33(12), 2417–2423.

Munro, E. (2005). Improving practice: child protection as a systems problem. Children and Youth Services Review, 27, 375–391.

National Council for the Child (2019). *Children in Israel: statistical abstract*. NCC.

O'Brien, V. (2012). The challenges and benefits of kinship care. *Child Care in Practice*, 18(2), 127–146.

O'Brien, V., and Cregan, M. (2015). Fostering the future: a change agenda in the provision of alternative care. In Christie, A., Featherstone, B., Quin, S., and Walsh, T. eds., *Social work in Ireland: changes and continuities*. London: Palgrave Macmillan.

O' Sullivan, A., and Sakr, M. (2022). *Social leadership in early childhood education and care*. London: Bloomsbury.

Observatorio de la Infancia (2020). *Boletín de datos estadísticos de medidas de protección a la infancia* [Bulletin of Basic Statistics of Child Protection Measures] Vol. 22. Ministerio de Derechos Sociales y Agenda 2030. Available: https://observatoriodelainfancia.mdsocialesa2030.gob.es/productos/pdf/BOLETIN_22_final.pdf

Ofsted (2021). Transparency data – Largest national providers of voluntary and social care (March 2021). Largest national providers of private and voluntary social care (March 2021) Available: https://www.gov.uk/government/publications/inspection-outcomes-of-the-largest-childrens-social-care-providers/largest-national-providers-of-private-and-voluntary-social-care-march-2021

Opening Doors for Europe's Children (2017).
Strengthening families – Ending institutional care. (http://www.openingdoors.eu)

Palareti, L. et al. (2022). Residential care for children and youth in Italy: an evolving system. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 239–255.

Palsson, D., Backe-Hansen, E., Kallíomaa-Puha, E., Lausten, M., and Poso, T. (2022). License to care: licensing terms of for-profit residential care for children in four Nordic countries. *Nordic Welfare Research*, 7(1), 23–35.

Parton, N. (2017). Comparing child protection systems toward a global perspective. In Dolan, P., and Frost, N. eds., The Routledge Handbook of Global Child Welfare. Oxon: Routledge.

Petrowski, N., Cappa, C., and Gross, P. (2017). Estimating the number of children in formal alternative care: challenges and results. *Child Abuse & Neglect*, 70, 388–398.

Pinkerton, J. (2006). Leaving care: thinking systemically, thinking globally. *Children Australia* 31(3), 4–10.

Pinkerton, J. (2011). Constructing a global understanding of the social ecology of leaving out of home care. *Children and Youth Services Review* 33(12), 2412–2416.

Pinkerton, J. (2021). Exploring history in the social ecology of care leaving: Northern Ireland as illustration. *Child & Family Social Work*, 26(2), 270–279.

Platt, D., and Turney, D. (2014). Making threshold decisions in child protection: a conceptual analysis. *British Journal of Social Work*, 44 (6),1472–1490.

Porko, P., Heino, T., and Eriksson, P. (2018). *Selvitys yksityisista lastensuojelun yksikoista* [Survey on private RCC units]. THL – Tyopaperi 21/2018 4. Available: http://urn.fi/URN:ISBN:978_952_343_131_7.

Power, M., and Power, D. (2022). What future for voluntary children's residential providers in Ireland? *Scottish Journal of Residential Child Care*, 21(1), 74–91.

Roby, J.L. (2011). *Children in Informal Alternative Care: Discussion Paper UNICEF*. Available: https://bettercarenetwork.org/sites/default/files/Children%20in%20Informal%20Alternative%20Care%20-%20A%20Discussion%20Paper_0.pdf

Roe, C., and O'Brien, V. (2019). *Supporting the participation of parents of children in care to enhance the experience of access & contact. A collaborative study between TUSLA Mid-West Area, Clarecare, Limerick Social Service Council.* Silver Arch Family Resource Centre & UCD.

Russ, E., Lonne, B., and Lynch, D. (2020). Increasing child protection workforce retention through promoting a relational–reflective framework for resilience. *Child Abuse & Neglect* 110 (3)3: 104245, 1–1.

Ryan (2009). Report of the Commission to Inquire into Child Abuse. Dublin: Department of Children and Youth Affairs.

Saltiel, D. (2016). Observing front line decision-making in child protection. *British Journal of Social Work*, 46, 2104–2119. doi: 10.1093/bjsw/bcv112.

Scottish Government (2022). Children's social work statistics: 2020 to 2021. Available: https://www.gov.scot/publications/childrens-social-work-statistics-scotland-2021-22/

Sen, R., and Broadhurst K. (2011). Contact between children in out-of-home placements and their family and friends networks: a research review. *Child and Family Social Work*, 16 (3), 298–309.

Spratt, T. (2000). Decision-making by senior social workers at point of first referral. British Journal of Social Work, 30, 597–618. doi: 10.1093/bjsw/30.5.597.

Spratt, T., and Kennedy M. (2021). Adverse childhood experiences: developments in trauma and resilience aware services. *British Journal of Social Work*, 51(3), 999–1017.

Spratt, T., Devaney, J., and Frederick, J. (2019) Adverse childhood experiences: beyond signs of safety; reimagining the organisation and practice of social work with children and families. *Journal of Deaf Studies and Deaf Education*, 49(8), 2042–2058.

Skehill, C. (2004). The nature of social work in Ireland. New York: Edwin Mellen.

Statistics Report (2021). *Official statistics of Finland. National Institute of health and Welfare*. Available: https://urn.fi/URN:NBN:fi-fe2021060734321.

Stein, M. (2008). Transitions from care to adulthood, messages from research and policy. In Stein, M., and Munro, E. eds., *Young people's transitions from care to adulthood*. London: Jessica Kingsley, 289–306.

Stein, M. (2019). Supporting young people from care to adulthood: international practice. *Child & Family Social Work*, 24(3), 400–405.

Stein, M., and Munro, E. (2008). *Young people's transitions from care to adulthood*. London, Jessica Kingsley.

Taplin, S., Lucas, N., Suomi, A., Humphreys, C., Kertesz, M., and McArthur, M. (2021). Parents' supervised contact visits with their children in care: factors associated with cancellations. *Children and Youth Services Review,* 127, 106127.

Taylor B.J. (2012). Models for professional judgement in social work. *European Journal of Social Work*, 15(4), 546–562.

Taylor B.J. (2017). Heuristics in professional judgement: a psycho-social rationality model. *British Journal of Social Work*, 47(4), 1043–1060.

Tillard, B., and Join-Lambert, H. (2022). Residential care for children and youth in France: a solid system facing major challenges. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 288–304.

Timonen-Kallio, E. (2022). Residential care for children and youth in Finland. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. Oxford: Oxford University Press, 273–287.

Thoburn, J. (2010). Achieving safety, stability and belonging for children in out-of-home care. The search for 'what works' across national boundaries. *International Journal of Child and Family Welfare*, 12(1–2), 34–48.

Thoburn, J. (2016). Residential care as a permanence option for young people needing longer-term care. *Children and Youth Services Review*, 69, 19–28.

Thoburn, J. (2022). Residential care across jurisdictions: understanding context and comparing data. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 16–24.

Tillard, B., and Mosca, S. (2019). Les travailleurs sociaux et le placement de l'enfant chez un proche [Social workers in kinship care]. *Recherches Familiales*, 16, 25–36.

United Nations General Assembly (2010). *Guidelines for the alternative care of children*. New York: Unga.

Valencia Corral, N., Lopez Lopez, M., and Armenta, M. (2022), 'Children in residential care in Mexico: Understanding profiles, trajectories and outcomes', *Child and Family Social Work*, vol. 27, no. 2, pp. 152-162. https://doi.org/10.1111/cfs.12862

Van Breda, A.D., Munro, E.R., Gilligan, R., Anghel, R., Harder, A., Incarnato, M., Mann-Feder, V., Refaeli, T., Stohler, R., and Storø, J. (2020). Extended care: global dialogue on policy, practice and research. *Children and Youth Services Review*, 119.

Van Ijzendoorn, M.H. v., Bakermans-Kranenburg, M.J., Duschinsky, R., Fox, N.A., Goldman, P.S., Gunnar, M.R., and Sonuga-Barke, E.J.S. (2020). Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on development. *Lancet Psychiatry*, online (June 23).

Waitzkin H., and the Working Group on Health Beyond Capitalism eds. (2018). *Health care under the knife: moving beyond capitalism for our health*. New York: Monthly Review Press.

Ward H. (2022). Foreword. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, xi–xv.

Webb, C.J., Bennett, D.L., and Bywaters, P. (2021). Austerity, poverty, and children's services quality in England: consequences for child welfare and public services. *Social Policy and Society*, ISSN 1474–7464.

Webb, C., Bywaters, P., Scourfield, J., McCartan, C., Bunting, L., Davidson, G., and Morris, K. (2020). Untangling child welfare inequalities and the 'inverse intervention law' in England. *Children and Youth Services Review*, 111, 104849.

Whittaker, K., Holmes, L., Del Valle, J.F., and James, S. eds. (2022a). *Revitalizing residential care for children and youth: cross-national trends and challenges*. Oxford: Oxford University Press.

Whittaker, K., Holmes, L., Del Valle, J.F., and James, S. (2022b). Future prospects and challenges for residential care for children and youth: seeking direction from a cross-national analysis. In Whittaker, K., Holmes, L., Del Valle, J.F., and James, S. eds. (2022a). *Revitalizing residential care for children and youth: cross-national trends and challenges*. Oxford: Oxford University Press, 429–442.

Whittaker, J.K., Del Valle, J.F., and Holmes L. eds. (2015). *Therapeutic residential care for children and youth: developing evidence-based international practice*. London: Jessica Kingsley.

Woodall, T., Browne, K.D., Green, K., and Majumder, P. (2023). An exploration of young people's experiences relating to stability and permanence throughout their care journey. Qualitative Social Work, 22(4), 771–794. https://doi-org.nuigalway.idm.oclc.org/10.1177/14733250221096749.

Wu, Q., and Snyder, M.S. (2019). Factors associated with the decision-making process in kinship diversion. *Journal of Family Social Work*, 22(2), 161–186.

Zeira, A., and Grupper, E. (2022). Residential child and youth care in Israel: trends and directions. In Whittaker et al. eds., *Revitalizing residential care for children and youth: cross-national trends and challenges*. New York: Oxford University Press, 356–370.

UNESCO Child and Family Research Centre

Institute for Lifecourse and Society,

Upper Newcastle Road, University of Galway,

Galway, Ireland

Telephone: +353 91 495 398

Email: cfrc@universityofgalway.ie

Web: https://www.universityofgalway.ie/cfrc/

Twitter: @UNESCO_CFRC

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

www.tusla.ie