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Child Welfare and Protection in Ireland: Déjà Vu all over again

Helen Buckley and Kenneth Burns

Introduction

This chapter will demonstrate how social work with children and families has advanced from a very rudimentary set of activities prior to the 1970s into the current system of what could loosely be described as family-focused child protection. It will describe how it evolved along a somewhat ambiguous trajectory through the 1980s and 1990s, attempting to adopt a policy orientation based on user consultation, consensus and family participation which could intervene early and proportionately with children who were vulnerable or at risk. It will illustrate how, in the wake of scandals and revelation of poor practice, it inevitably reverted to a narrower and more strictly defined service which operated high thresholds for intervention. The chapter goes on to show how the aspirations that were articulated in early seminal policy documents and reports are once again optimistically reflected in the plans for a new structure under the Child and Family Agency Act 2013. While it acknowledges the positive opportunities underpinning the new template for service delivery, the chapter will identify some historical reasons for caution. It will also identify new challenges which stem from global trends and pose a threat to the effectiveness of the new structure.

The chapter will conclude by reviewing the opportunities and threats to the profession of social work within the new arrangements, arguing that the prospects of more diverse, welfare-oriented ways of working that are underpinned by children's rights may be hindered or limited by a combination of austerity and a failure by all relevant stakeholders to accept child protection as a universal responsibility.

Social work and the development of the child protection system in Ireland 1970 – 2013

The beginnings of child and family social work in Ireland can be traced back to the early 1970s. Although not specifically mentioned in the Health Act 1970, social work was identified as one element of the personal social services, for which the Health Boards would take responsibility. What was then, and for many years afterwards, known as 'community care social work', initially undertook a generic casework role, providing services to children and families, but also to individuals in the community including the elderly and disabled. Its gradual evolution into an exclusively child protection and welfare service began in 1974 with the assignment of responsibility

for child care services to the Minister for Health. A fairly significant shift took place over the following decade which contributed to the shape of modern child protection social work. This was the change in focus during the 1970s and 1980s from institutional to community-based solutions for children at risk (O'Sullivan, 2009). Health Board social workers began to take over from religious and philanthropic organisations, adopting the duties formerly held by Lady Inspectors and children's officers in the health authorities (Skehill, 2004). The establishment of a social work team in the Eastern Health Board in 1977 known as the Fostering Resource Group was a significant step in re-shaping children's out-of-home care from residential to foster care.

During the 1970s, child abuse had been largely constructed in terms of physical injury, generally inflicted by parents on their children. This depiction had been reflected in the earliest procedures produced for Health Board staff and other children's services, where the lead responsibility was assigned to medical staff, and the main sites for detection and initial response to such 'non-accidental injury' were identified as surgeries, clinics and hospital emergency departments (O'Sullivan, 2009). The senior community care social worker was to have an important role in responding to reported child abuse, but its nature and extent was to be determined by the (medical) Director of Community Care who had the overall coordinating authority (Department of Health, 1980a). In the meantime, the Task Force on Child Care Services (Department of Health**,** 1980b) had been set up by the Minister in 1975 to develop a blueprint for child care services and reported in 1980. Having envisaged a 'Child Care Authority' as the statutory body responsible for children's service, the report outlined a clear role for the statutory social worker in terms of identifying and assessing 'difficulties … affecting children's wellbeing and development' (p. 115) and providing appropriate intervention. The report made reference to the 'insufficient emphasis' that had been given to social work with children in their own homes and noted that most professionally qualified social workers at the time were 'concentrated in child placement services concerned with children subsequent to their removal from home and in specialised services provided by or in association with medical services' to the detriment of community-based social work services (Department of Health 1980, pp. 115-116).

This prototype for child care services, some though not all of which was adopted by the Department of Health, provided an opportunity for social work to lay claim to an area of work that was fast gaining prominence. As Skehill (2004) has argued, the incursion into child protection work was not, as some might have perceived, undertaken unwillingly by social workers at the time. Her historical account of the development of child care social work challenges the notion that statutory responsibility was foisted on the discipline. She describes how, from the mid 20th century onwards, social workers 'were desperately seeking to find legitimate space to occupy within the professional sphere of social service provision'

(p. 124), having formerly found it difficult to achieve a separate identity within the largely health-focused multi-disciplinary team. As Skehill observed, social work gladly colonised the 'site of expertise' (p. 121) that was emerging in response to new legislation and growing awareness of the incidence and prevalence of child harm. Once established in community care, social work made a bid for independence in its campaign for the establishment of the 'Fourth Programme' (Langford and Cullen, 1981), which would give the personal social services, including child and family work, autonomy from the other three medically dominated programmes being operated by the Health Boards. This movement came to naught at that time, but as the following paragraphs will show, the idea of a stand-alone agency emerged again some 25 years later.

The 1980s and early 1990s saw acceleration in the regulation of child protection, much of which contributed to the characterisation of the social work role. New legislation went through various incarnations, culminating in the Child Care Act which was enacted in 1991 and implemented at what Gilligan (1993, p. 366) described as a 'genteel pace' over the following years. Earlier versions of the law had been criticised by a large group of NGOs as well as the Irish Association of Social Workers (IASW) who pointed out the failure of the draft legislation to establish the paramount rights of children. The Child Care Act 1991 reflected a number of the UNCRC tenets, clarifying the statutory role, duties and responsibilities of the State to 'take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children it its area' (Section 3 (2) (a)). The implications were clear; Health Board practitioners were statutorily obliged to intervene early to prevent harm to children and were to do so in collaboration with a range of services.

In the meantime, what were then called the 1987 'child abuse guidelines' significantly widened the classification of child harm. The term 'child abuse' now encompassed 'physical injuries, severe neglect and sexual or emotional abuse' (Department of Health, 1987, p. 7). Whilst still allocating overall responsibility for child protection to the medical Director of Community Care, the guidelines clearly identified the community care social worker as a primary agent in the investigation and management of cases. The document also, for the first time, identified expectations in respect of different services such as schools and child psychiatry departments as well as other medical services, thus placing social work in a key position in the multi-disciplinary network. Although the 1987 guidelines identified 'severe neglect' as a form of child abuse, this particular type of child harm got no further mention in the document, nor in the appendices which gave explicit guidance on how to identify both physical abuse and child sexual abuse. During the 1980s, awareness about the extent and impact of child sexual abuse began to exert an influence on child protection social work. McKeown and Gilligan (1991) claim that Irish social workers were leaders in bringing a high profile to the issue; for example,

the Irish Association of Social Workers held a seminar on 'incest' in 1983. As professional awareness grew, the proportion of child sexual abuse reports made to Health Board social work departments rose by 54% between 1984 and 1987 (McGrath, 1996).

The publication of the Kilkenny Incest Report (McGuinness, 1993; see also, McGuinness, 2012) created what is largely regarded as a watershed in the development of child protection services, including, but not confined to, social work (Ferguson, 1996; Buckley and O'Nolan, 2013). This high-profile child abuse inquiry was critical of some elements of social work and professional practice, and inter-agency cooperation. However, the review team contextualised their comments within a more systemic perspective which highlighted the inadequacies of the system and the need for a cultural shift in attitudes towards the abuse of women and children, and children's rights. The report both raised awareness and reflected an already growing consciousness in Ireland of social problems such as gender-based violence (Kelly *et al*., 1993), child sexual abuse (Cooney & Torode, 1988), tensions between social workers and an Garda Síochána (Buckley, 1993), and children's rights (Department of Health, 1980). In response to the report, the government pledged significant investment to resource the operation of the Child Care Act 1991 and within a relatively short period, the numbers of staff employed in child protection services had expanded in number and in nature, with social care workers and family support workers joining the statutory social work teams.

By the time the Child Care Act 1991 was fully implemented at the end of 1996, a number of parallel and competing perspectives were continuing to shape the delivery of child and family social work services. Concern about the direction being taken by the child protection system was affirmed by research conducted in the South Eastern Health Board Area (Buckley *et al.*, 1997) and a study conducted in the Eastern Health Board region during the same year (Eastern Health Board/Impact Review Group 1997). These two reports used empirical evidence to show that the majority of financial resources and social work time in community care was being expended in the investigation of reports, with inadequate attention to, or investment in, early intervention services. This trend was considered to undermine the philosophical basis of the Child Care Act 1991, which was to promote the welfare of children. It also reflected a universal concern, particularly evidenced in the United Kingdom (UK) (Department of Health 1995) and the United States (US) (Waldfogel, 1998) about the forensic focus being adopted by child protection systems and the need for a re-focusing towards a supportive and preventative response to children and families in need.

A debate on the merits or otherwise of legalising the reporting of suspected child abuse which was conducted in 1996 raised similar concerns. This issue, generally regarded as a 'political football' (McGrath, 1998), arose each time a child abuse scandal was publicised, and as later sections will show, the government finally

capitulated to its introduction in 2011. It was argued at the time that social work services would be overwhelmed with referrals if failure to report was criminalised, and the government of the day decided instead to introduce measures to strengthen the child protection system. The abolition of the Director of Community Care post finally put an end to medical domination of child protection social work, which now became accountable to a general administrative manager. Furthermore, a new post of Child Care Manager was created with social workers occupying many of these senior management roles. There was considerable emphasis on the need for social work to operate collaboratively with other services, and a protocol on joint notification and investigation between Health Boards and Gardaí was published by the Department of Health (Department of Health, 1995) and later elaborated upon in *Children First: National Guidelines for the Protection and Welfare of Children* (Department of Health and Children, 1999). This move had been preceded by mutual unease from both services, each of which was seen to operate from differing perspectives (Horgan, 1996).

Another concept that was gaining traction around the start of the new millennium was 'inclusiveness'. This stemmed from a combination of advocacy, research and a general recognition of the changing population of social work clientele who now included many more ethnic groups including refugees and families seeking asylum (Torode *et al.*, 2001). The impact of gender on child protection practice and the effect of domestic violence on children (Kelly, 1996; Buckley 1999) were becoming increasingly recognised, and the particular vulnerability of children with disabilities (Kennedy & Kelly 1992) began to be highlighted. This new awareness led to an increased focus on anti-discriminatory practice, and consciousness of the perspective of service users and their exclusion from participation in child protection processes became more prominent at this time (Department of Health [UK] 1995; Ferguson & O'Reilly, 2001). Research had also highlighted the low level of direct communication with children whose situations were largely constructed in accounts provided by caregivers or professionals (Buckley, 2002, 2003). An action research project commissioned by the Southern Health Board in the early 1990s (Gilligan and Chapman, 1997) provided a national template for constructive attendance of parents at case conferences and when Children First was published in 1999, it largely adopted this framework which emphasised the importance of parental participation at all stages of child protection work. The need for direct contact with children and consideration of their views was also stipulated, and the guidance exhorted professionals against prejudice and discrimination in any child protection activity (Department of Health and Children, 1999).

The inclusion of the word 'welfare' in the title of the 1999 Children First guidance signalled the establishment of family support and early intervention as fundamental elements of child protection work. Subsequent investment throughout

the early 2000s in Springboard (see McKeown *et al.,* 2001) and other community-based projects broadened the children's service landscape considerably and social workers played a prominent role in the these services. However, many of these services were targeted to specific geographical areas of need and were not universal family support and preventative services. While social workers, at this point, had been designated by the CEOs of the Health Boards as the principal statutory agents, the number of stakeholders in the child protection network now included other disciplines whose role was to work directly with families in their homes and in the community, responding to their identified welfare and parenting needs and building supports in the community to boost social capital.

Despite the insertion of these preventive elements into the child welfare system, the more investigative aspect of child protection social work continued to dominate practice. Annual statistics published by the Health Service Executive (HSE) implied that the greater part of social work activity was spent screening and investigating reports made to it, with high attrition rates between initial referral and closure of cases and little coordination of early intervention and preventive activities (Health Service Executive, 2009). Over the decade, statistics showed a clear trend whereby welfare concerns and reports of child neglect comprised two thirds of the total number of reports received, the majority of which were screened out very quickly or only received a short-term supportive response. The *Agenda for Children's Services* (Office of the Minister for Children, 2007) sought to rectify this by laying out a blueprint for an evidence-based model of service delivery that would prioritise the support of children and families in their own communities. The introduction of differential or alternative response models in a small number of areas (Canavan and Landy, 2011; Yalloway *et al*., 2012) represented further efforts to provide proportionate and more immediate responses and integrate social work with family support services to a greater degree.

However, despite the aspiration to develop a community-based, preventive, participative and inclusive approach to child welfare, the publication of a number of high-profile inquiry reports, including the Ryan report (2009) and the Roscommon inquiry (Gibbons *et al*., 2010), followed by reports on clerical sexual abuse, kept political attention on the 'front door' of the statutory social work service with less attention paid to either early intervention or long term solutions. Since the beginning of Ireland's economic crisis, social work has been the only profession exempt from the public sector recruitment embargo, and there was a clear government intention to retain investigative social work as the main centre of child protection and welfare. Managerialist strategies were introduced in an effort to render frontline practice more consistent and thereby more measurable. These methods included the categorisation of social work interventions in the form of standardised business processes (see, for example, Health Service Executive, 2009) and the introduction of tighter control over the activities of community-based

agencies and funded services to align them with the child protection social work service. The Health Information and Quality Authority (2012) issued standards for statutory child protection social work departments and teams are now inspected against a range of performance benchmarks and indicators. In 2011 the government signalled its intention to make reporting of suspected child abuse a legislative requirement and followed this firstly with the Children First (Heads of Bill) 2012 and later with the Children First Bill 2014.

In the interim, the review of children's services in 2011 had indicated serious weaknesses in early child care and a lack of coherence, particularly in respect of mental health, access to health care and school retention (Harvey, 2011). Annual 'report cards' issued by the Children's Rights Alliance also cited a 'consistent shortcomings and the lack of real progress in the areas of poverty, health and discrimination' (Children's Rights Alliance, 2013, p. 1). These deficits have been reiterated in annual reports from the Office of the Ombudsman for Children, particularly in respect of access to education and therapeutic interventions (Ombudsman for Children 2013; Burns and Lynch, 2012)**.** Together these indicators may demonstrate that child protection and welfare is becoming narrowly defined once more, with culpability for child-related problems divided between the social work profession and parents themselves, with little regard for the structural context in which difficulties arise.

Over thirty years after the publication of the Task Force on Child Care Services, despite significant investment, a vastly increased knowledge base and some tangible efforts at reform, social work with children and families is still struggling to meet its aims of intervening early and maintaining children in the community. However, the establishment of a single agency for child protection and welfare which espouses partnership and interagency working (Child and Family Agency, 2013a), provides new opportunities which will be examined later but first we will shift the focus of this chapter from the child protection system to the children and families whose needs it is intended to serve. Available data will illustrate the challenges posed to the change and reform process and the agency's ability to provide an adequate response.

Childhood and child abuse data in Ireland

Ireland has the largest numbers of children in the European Union as a percentage of the country's total population. In the last census, out of a total population of 4.59 million, 1.15 million people were under 18 years of age (25% of the population) (Central Statistics Office, 2012). Historically, data on outcomes for children in Ireland has been inadequate, but a strong series of initiatives such as *Growing Up in Ireland: National Longitudinal Study of Children* and the *State of the Nation's Children*

Reports (Department of Children and Youth Affairs, 2006-2012) have sought to address knowledge gaps. However, data on children at risk and children in the care of the state continues to be deficient with limited and sometimes inconsistent data between areas (Buckley, 2008; Burns and MacCarthy, 2012). In particular, data on child abuse and child welfare reports (referrals), social work caseloads and data in relation to child care court proceedings has been limited and unavailable for certain years. Similar to other countries (see Gilbert *et al.,* 2011) Ireland has witnessed a steady growth in referrals. Between 2006 and 2012 (the most recent year for which data is available), the numbers of reports made to statutory social work departments effectively doubled (Health Service Executive, 2013a; Tusla, Child and Family Agency, 2014). This doubling of child protection reports has not been matched by a corresponding increase in the workforce. The Ryan implementation report (Office of the Minister for Youth Affairs, 2009) promised an extra 200 posts, later increased to 270 posts. Conflicting accounts provided by the Irish Association of Social Workers, the labour union and the Department on the actual realisation of these posts, together with acknowledged delays in recruitment has made it difficult to calculate the precise size of the workforce at present. 'Front-line' child protection social workers are primarily female and early-career, which means that regular maternity leave is an inevitability (Burns and Christie, 2013), however, many of these maternity leaves have not been covered in recent times, further reducing the overall workforce strength. Overall, it is clear that regardless of the extra investment, the capacity of the child protection system to cope with the increase in reports is unavoidably strained, a fact reflected in the reports produced by the Independent Child Death Review Group (Shannon and Gibbons, 2012) and the National Review Panel which examines child deaths (Health Service Executive, 2012, 2013b).

The pattern of referrals in 2012 (the last year for which a breakdown of abuse types was provided) was consistent with previous years, whereby just over half of reports were ultimately designated as 'welfare' and just under half classified as child protection, with close to twice as many reports in the neglect category as in the other three (physical abuse, child sexual abuse and emotional abuse) (Tusla, Child and Family Agency, 2014). The dearth of information on the nature of child welfare and protection concerns provides very little insight into the needs of the children in contact with the system. The provision of services to 'welfare' reports are not analysed; it is given to understand that the children and families concerned are linked with community-based family support services and/or short-term statutory social work services, though the nature and longevity of interventions is not documented, nor is any information provided on the accessibility and availability of family support services.

The information provided on the processing of child protection reports in 2012 provides equally scant information on the nature of the child harm reported to the system. 60% of reports are subject to initial assessment, with less than 2%

passing through the filters to the point where they become the subject of a child protection conference and listed on the child protection notification system. The report claims inaccuracies in the data, but even allowing for those, the statistics indicate a continuation of the trend which began to be of concern in the 1990s, whereby most social work time appears to be invested in investigation at the expense of intervention. This may mean a high level of screening out or it might mean that families are worked with, or referred to appropriate services where positive outcomes are achieved. However, the data does not elaborate on the nature of interventions nor provide a picture of the pathway of reports through the assessment and intervention process and the available data indicates that high thresholds continue to operate.

We are aware from other sources that many more children suffer adversity in Ireland than appear to be reflected in the official child protection and welfare statistics. For example, large numbers of children are negatively impacted by issues like parental substance abuse (Buckley *et al*., 2006; Alcohol Action Ireland, 2009; National Advisory Committee on Drugs, 2011; Hope 2011) and domestic violence (Buckley *et al.*, 2007; Safe Ireland, 2013). On the other hand, there is also evidence of improving outcomes for children and their welfare in Ireland (see Department of Children and Youth Affairs, 2006-2012). It could be concluded that opportunities to make a difference to these children's lives are being missed because of the narrow orientation of the referral and intake social work system. Our review of the available data points towards the necessity for an updated study similar to those conducted in the late 1990s (Buckley *et al.,* 1997; Ferguson and O'Reilly, 2001) that examined the nature, scope and pathways of referrals and interventions in child protection teams. In the meantime it is vital that the problem of inadequate data collection and reporting is addressed; real reform will only be effected if it is based on accurate information about what is required, what is available and what gaps exist.

New agency, new rights, new systems: From child protection to a comprehensive prevention and family support response?

The establishment of the new Child and Family Agency[i] (see Child and Family Agency Act 2013) in January 2014 represents an attempt by the government to ring-fence and raise the profile of child protection. The main impetus for moving the (primarily social work) services away from health services was, as the Minister for Children put it, 'to emancipate our child protection and welfare services from the monolith of the health services where for too long in the past they were lost and rudderless' (Department of Children and Youth Affairs, 2013c). A Regulatory Impact Analysis (Department of Children and Youth Affairs, 2013d) prepared in respect of the legislation identified 'leadership, enhanced accountability and more efficient inter-disciplinary and inter-agency working' (p. 4) as features of the reform. In her launch speech, the Minister promised that the Agency would 'pull together and give single

coherent direction to all of the strands of service for our families most in need in a way that has never happened in this country before' (Fitzgerald, 2014, p. 1). She also acknowledged that existing problems in the system will not be fixed 'overnight'; this note of caution provides some room for optimism that serious reflection will be applied to the shape which services should adopt.

The new Agency structure does provide a number of opportunities to redress some of the inexorable difficulties outlined in the previous section. The model of service delivery aspired to very closely resembles that which was envisioned in the aforementioned Task Force on Child Care Services of the early 1980s. The fact that the aspirations of the Task Force never came to fruition was acknowledged by the Minister for Children and Youth Affairs in her launch speech with the observation that 'The system failed because it was never designed to work' (Department of Children and Youth Affairs, 2013b, p. 1). However, the aphorism (variously attributed to Narcotics Anonymous and Albert Einstein amongst others) that 'Insanity is repeating the same mistakes and expecting different results' could be tentatively applied to some of the ambitions of the new venture unless some serious reflection is applied as to why the hoped-for model of service delivery failed before.

One of the major weaknesses manifest in previous attempts to provide early intervention and prevention was the lack of coherence around family support, evidenced by the absence of any attempt to quantify either its operation or its outcomes. Its profile was vague, and it had fallen into the meaningless and all-inclusive 'warm and fuzzy' sphere that had been cautioned against by Pinkerton (2000, p. 207). The more recent formalisation of community-based, non-statutory services represents a hopeful step. The establishment of the local area pathways (Child and Family Agency, 2013b) to implement the differential response model should stimulate and strengthen the community and voluntary organisations contribution to the service provision mix. However, some significant threats need to be addressed.

The first threat is the assumption that this model of service delivery can be achieved on a cost-neutral basis. The impact of the crisis in international financial and banking systems and the ensuing period of austerity and retrenchment of public services in Ireland (see Kirby, 2011; Kirby and Murphy, 2011) raises questions as to whether the change management process will be adequately resourced and whether there will be sufficient staffing to meet the increasing demand for services for all the children and families in need of support. Inadequate funding has been identified as a risk factor in the implementation of differential response in the United States (Waldfogel, 2008). Another threat is the belief that differential or alternative response approaches (DR) will work consistently or are universally understood. A special issue of *Research on Social Work Practice* published in September 2013 has demonstrated the diversity of DR approaches applied in the United States and the lack of uniformity in assessment and decision-making protocols which can risk a

return to the bias and misjudgement that gave rise to reform in the first place. Hughes *et al.* (2013) argue for a standardisation of tools to ensure a consistent response.

However, the third threat lies in this very standardisation. Featherstone *et al.* (2012) have warned that standardisation in the United Kingdom was far from successful and real care needs to be taken to learn from, rather than repeat, such mistakes. Family support, as envisaged by Pinkerton (2000), needs to challenge traditional welfare policies and accommodate the changing nature of families and their needs. This could be extended to differing communities and their needs. There is a danger that homogenisation of services will stifle pockets of initiative and expertise that have arisen in particular environments and may be best suited to meet local challenges. The new model may pose a risk to the therapeutic and supportive identities of some of the existing voluntary and community organisations, particularly if pressure leads to some quasi-statutory functions being delegated to them. With the publication of the Children First Bill 2014, Ireland is coming nearer to the adoption of a mandatory reporting model for professionals, and community and voluntary sector organisations in receipt of state funding (Department of Children and Youth Affairs, 2013), which may present a further risk to the identity of community and voluntary organisations. As Garrett (2013, p. 36) argues, the sort of initiatives described in this chapter may be thwarted and lead to failure, because of what he describes as "economic imperatives and the overriding commitment to intensified neoliberation".

A further challenge to the goal of 'one cohesive support system' (Child and Family Agency, 2013b, p. 1) will be the potential failure to bring all children's services together in one agency and it remains to be seen if different services can find a way to implement the new goals and policy from within different structures. Many jurisdictions, jaded from criticism of their child protection services, particularly the lack of shared responsibility and collaboration between services, have concluded that the most constructive and coherent approach to working with vulnerable and at risk children is through what is termed a 'public health model'. This is defined as 'a concept with currency in many disciplines including health, education and welfare' (Hunter, 2011, p. 1) and has been incorporated into the National Framework for Protecting Australia's children (Council of Australian Governments, 2009). It is similar to the popular Hardiker *et al.* (1991) model in terms of the different levels of intervention, but its difference is that it takes a holistic perspective and draws its benchmarks from a range of children and young people's services including health, disability, mental health, youth justice and education, encompassing a variety of interventions from speech and language to housing and other environmental issues (Woodman and Gilbert, 2013).

Another variant on this theme is what is often called the 'whole of government approach'. Although the Irish government has claimed this orientation

for children and family services in their recently published national policy framework, *Better Outcomes Brighter Futures: the National Policy Framework for Children and Young People 2014-2020* (Department of Children and Youth Affairs, 2014), it is more commonly applied to strategies where the responsibility of government departments to resource and operate child protection activities is named in child care legislation (see, for example, the *Keep Them Safe Programme* operated by the New South Wales Government in Australia) and mechanisms are put in place to build the capacity of adult services to be child-centred, such as the Australian federally funded project *Protecting and Nurturing Children: Building Capacity, Building Bridges* (Australian Centre for Child Protection, 2014).

Inability to get disciplines and agencies to work together has been at the root of child protection system failure since its beginnings in the 1970s. Research, along with many child abuse inquiries in Ireland and elsewhere, has demonstrated the multi-faceted tensions and failures of communication between social workers and other disciplines and agencies in Ireland (Duggan and Corrigan, 2009; National Review Panel 2013). The difficulties stem not just from physical separation of services but from a combination of complex dynamics including differing goals and perspectives, diverse funding arrangements and arguments about responsibility for the 'dirty work' of child protection which is seen to belong to social work (Butler 1996; Buckley 2003). A recent doctoral study which ascertained the views of professionals in schools, youth services, hospitals, addiction and other health and justice services on the potential impact of the forthcoming mandatory reporting legislation revealed a low level of interest, ownership and awareness of child protection issues amongst staff in these areas. This was attributed partly to deficiencies in basic grade and post-qualifying training, particularly amongst teachers and health professionals, but also to a culture that relegated responsibility to social work departments (R. Buckley, 2014).

A positive opportunity for the Child and Family Agency and social work will be the embracing of a children's rights ethos across the whole service to shift Ireland from a family-centric model to one where children's as well as parental rights are operationalised. While Ireland is a full signatory to the United Nations Convention on the Rights of the Child (1989), the implementation of a children's rights ethos throughout children's services and Irish society has yet to be realised. For example, the Ombudsman for Children (2012, p. 8) has stated that '… the core principles of best interests and respect for the views of the child are not being respected systematically in Ireland'. The attempted shift away from a legalistic and investigative approach which is characteristic of a child protection system towards a child-focused, early intervention and needs assessment model (see Gilbert *et al.,* 2011) should be bolstered by the full implementation of the new Article 42A (Children) of the Irish Constitution. The new amendment recognises that: children are rights holders in their own right; it allows for children in long-term care to be

adopted; it affirms that all children are equal irrespective of the marital status of their parents; in all proceedings 'the best interest of the child principle shall be the paramount consideration', and provision should be made in law to ensure that children's views 'shall be ascertained and given due weight having regard to the age and maturity of the child' (Government of Ireland, 2012, p. 8). These changes will underpin the future of child and family social work in Ireland. The final section of this chapter briefly considers the implications of these changes for the future of social work in Ireland and questions how the Child and Family Agency and government will ensure that the new service delivery model is implemented for the benefit of children and their families.

Conclusion: The future of social work in child and family services in Ireland

The changes examined in this chapter open up opportunities for social work with children and families in Ireland over the next decade. However, while there is much to be optimistic about, it has been our contention in this chapter that there is a element of *déjà vu* about the plan which closely resembles the blueprint for services first envisaged more than 30 years ago in the aforementioned Task Force report recommendations. We have contended that economic constraints and cutbacks to the community and voluntary sector will impede progression towards a model which provides early intervention in a meaningful way. We have also highlighted the necessity for greater integration and sharing of responsibility for child protection, adopting a more ecological approach that encompasses such sectors as health, mental health, housing and education in the delivery of child welfare and protection services. We have drawn attention to under-strength social work teams that are struggling to deal with a doubling of new reports between 2006 and 2012. Finally we have cautioned that newly imposed administrative pressures may have a stifling effect on both statutory and nongovernmental services. Of course, it is not certain that managerialism will define the new Agency, but its pervasiveness in child welfare bureaucracies across the world suggests the need for some caution.

While the planned changes have been made fully manifest, it is less clear what this will mean exactly for social work, how active the profession was in contributing to the redesign of the system and how social workers feel about these changes. A truly integrated child protection service would provide interesting opportunities for social workers to operate in diverse ways with different service user groups. Some social workers may choose to move to non-statutory settings to undertake more preventative and supportive roles with children and families that may be more congruent with their understanding of the profession. It will be important for social workers within the new Agency to adopt a critical, questioning stance towards the Agency. These social workers will be part of the Agency, but should foster a unique professional identity that seeks to: promote social integration and community and inter-personal relationships; is critical of government policies

and structures that are oppressive; and rejects individual, personal-blaming approaches in favour of ecological and structural understandings of social and inter-personal issues. The increasing workload of statutory child protection workers will make it more difficult for staff to contribute to the development of the profession and to collectively seek to progress social policy and legislative change agendas. However, such work remains a core focus of the profession and practitioners will need to find ways, for example through the media and various professional and advocacy organisations as well as pressure groups, to contribute to these aspects of professional social work.

Finally, we reiterate our contention that the confinement of responsibility for child protection and the provision of services to the Child and Family Agency in a context where referral rates continue to rise, will relegate social workers in the Child and Family Agency to a tertiary role, applying high thresholds and responding in a narrow and forensic manner to concerns about vulnerable children. Their workload may become defined in terms of serious abuse and neglect cases, with the concomitant hazards that this high-risk, high-skill work suggests in terms of staff retention and job satisfaction (see Burns, 2011, 2012). If this is allowed to happen, the problem will come full circle, with the social work profession carrying a disproportionate level of responsibility and criticism for future shortcomings in children and family services.

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[i] The Child and Family Agency is also known by the neologism "Tusla", which is a conjunction of the Irish words for new (tus) and day (lá).