

**Fourth Report of the Special Rapporteur on Child
Protection**

A Report Submitted to the Oireachtas

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LIST OF ABBREVIATIONS

BSS	Bail Supervision and Support
ECHR	European Convention of Human Rights
ECt.HR	European Court of Human Rights
HSE	Health Service Executive
ICESCR	International Covenant on Economic, Social and Cultural Rights
UNCRC	United Nations Convention on the Rights of the Child
YHS	Youth Homeless Strategy

EXECUTIVE SUMMARY

SECTION 1: YOUTH HOMELESSNESS

Despite the level of economic prosperity in Ireland for much of the past decade, the issue of homelessness has never been comprehensively addressed by our society; and now, with our recent economic decline, homelessness in Ireland is once again on the rise. Of particular concern is the level of homelessness amongst children. Children by their very nature are a vulnerable section within society and those children who find themselves homeless are particularly at risk.

The Health Services Executive (HSE) is charged with the duty of tackling youth homelessness. In addition to domestic statutory obligations in this area there are numerous international instruments that seek to provide safeguards against youth homelessness. However, guidance is largely to be found in a number of domestic policy documents. Whilst these documents are not legally binding, they do seek to establish strategies for dealing with youth homelessness.

A particular problem faced by those working in this area is the lack of accurate data for the assessment of the prevalence of youth homelessness in our society. It is difficult to obtain accurate and up-to-date figures. As a consequence, there is a lack of certainty when it comes to developing strategies and distributing resources to tackle youth homelessness.

Research has shown that children who become homeless share a number of characteristics. Many of these characteristics relate to the circumstances within their family home, or previous care history. This suggests that it should be possible to identify those children who may be at risk of becoming homeless. Steps ought to be taken at an early stage with a view to preventing the possibility of a child becoming homeless; this would in turn allow greater time and effort to be spent in seeking to provide for those children who are homeless.

SECTION 2: RIGHT OF CHILDREN WITH MENTAL HEALTH DIFFICULTIES TO BE HEARD

The issue of the capacity of children to express their views in respect of medical treatment which they may undergo has been a topic of considerable discussion in the past. That debate has not always considered a particular subset of children: those with mental health difficulties.

It is recognised both in Ireland and internationally that, subject to age and maturity, children have a right to be heard. However, the legal position as to the right of a child with mental difficulties to be heard is far from clear. This can lead to situations in which parents are making decisions in respect of their children that otherwise the children would make for themselves. Whilst this may often be the most pragmatic approach when dealing with young children, the same cannot be said in the context of adolescents.

The issue of consent to mental health treatment is one of considerable importance as it categorises the legal status of a patient undergoing such treatment (i.e. voluntary or involuntary). The assignment of a patient to either category has significant legal consequences, so the consent stage of the legal process is of the highest importance.

Not only is there a need to have due regard for the categorisation of a child prior to undergoing mental health treatment, but it is imperative that proper review mechanisms be put in place throughout the period of treatment. Children are not afforded the same opportunities as adults to advocate their views throughout treatment. Those institutions that provide mental health treatment must be regularly inspected and their procedures reviewed so as to ensure that the rights of children are being upheld.

SECTION 3: CHILDREN AND THE CRIMINAL LAW

The principle of the paramount importance of the welfare of children is the foundation block upon which the Irish civil legal system's dealings with children is built. However, this principle does not carry a similar weight in our criminal justice system. It has been the experience of other countries that to afford greater weight to welfare

considerations in respect of juvenile offenders has numerous positive effects, not just for the offender but also for society.

The criminal law also seeks to protect children (e.g. from sex offenders). There are various State agencies charged with the duty of protecting children in different contexts. By virtue of the fact that there are numerous such agencies, the exchange of information is of critical importance if the proper and adequate protection of children is to be ensured. Recent reviews have shown that this is not always the case, thereby causing children to be exposed to risk. This exchange of information would also be enhanced by the assessment of disclosure requirements in such a manner as to strike the appropriate balance between the privacy rights of a person and the welfare of children.

SECTION 4: TRAFFICKING OF CHILDREN AND PROSTITUTION – A REVIEW

In the 2007 and 2008 editions of this Report, the issues of child trafficking, grooming and pornography were addressed. Several recommendations were made in relation to these issues. However, many of these recommendations have not yet been implemented. In the last year, various advocacy groups have articulated their concerns on the trafficking and exploitation of children in Ireland. This remains an area of considerable concern. In contending with this issue on the domestic front, Ireland can learn from the steps taken in other countries, in particular Sweden. A fresh approach is required whereby the root cause of these problems is addressed. In the context of child trafficking for the purposes of sexual exploitation, one of the causal factors is the demand for paid sexual services in this country; if the demand were reduced one would expect the supply to be reduced also. This model has been implemented successfully in Sweden.

The trafficking of children is evidently a global problem, and thus needs to be dealt with on a global scale. To that end, the European Union is in the process of implementing a Directive to combat the cluster of problems around this issue.

Steps remain to be taken by Ireland in this field; steps addressed in previous editions of this Report. In addition, further and better courses of action must be followed to combat this ever-present problem.

RECOMMENDATIONS

SECTION 1: YOUTH HOMELESSNESS

1. Comprehensive review of the coordination, implementation and continued relevance of the Youth Homelessness Strategy

Youth homelessness is a very complex and multifaceted problem, and while a number of recommendations are made below in an effort to improve approaches aimed at preventing and tackling youth homelessness, the most important recommendation is that a full and comprehensive review of the coordination and implementation of the Youth Homelessness Strategy¹ (YHS) must be carried out. This review must seek to ascertain the manner in which the YHS has been implemented throughout the HSE regions. In addition, it must include an analysis of the continuing relevance of each of the objectives of the YHS. The manner in which each child was dealt with under the YHS should be assessed to ensure the interventions being made are effective.

2. Greater coordination between youth homeless providers

It is essential that there is coordination between youth homeless providers and also between the HSE and other stakeholders such as the local authority, local education representatives and local health representatives. This was a recommendation first made in the *Report of the Forum on Youth Homelessness*.² Adult and youth homeless strategies in each region should complement each other. While the HSE has primary responsibility for youth homelessness, other bodies have drawn up policies to tackle adult homelessness which will impact on youth homelessness and thus should be taken into account. In addition, the HSE should liaise with the local authority regarding the homelessness action plan for the area to ensure proper provision for children who are part of a homeless family.

3. Strengthening of statutory framework regarding youth homelessness

While the Child Care Act 1991 places the issue of youth homelessness within the remit of the HSE, there is no accompanying statutory framework to stipulate the legal contents of this responsibility. For this provision to be as effective as possible, it

¹ *Youth Homelessness Strategy* (Department of Health and Children, 2001).

² *Report of the Forum on Youth Homelessness* (Northern Area Health Board, 2000), at p. 87.

should allow for the Minister for Children to make regulations regarding the implementation of the responsibility under the Youth Homelessness Strategy. In addition, it should be possible for children who have not received the appropriate provision under Section 5 of the Child Care Act 1991 to seek redress through the courts. This would, most likely, require the legislature to specifically empower such an action as otherwise any action taken by a child would risk being dismissed as being outside the scope of the courts' powers under the separation of powers.

4. Provision of comprehensive, up-to-date information on youth homelessness

This is essential to tackling the issue of youth homelessness.³ While the *Report on the Review of Adequacy of Children and Family Services* provides comprehensive data on children coming into contact with the HSE, information from voluntary organisations must also be considered if a complete picture of youth homelessness is to be obtained. The YHS stated that a database would be established allowing access to both State and voluntary sectors. This has not been done and it would be a valuable resource if State and voluntary sector organisations were to be allowed, not only to access it, but also to log data in it. Important studies have been carried out over the past 10 years which should be fed into improving the YHS and ensuring that prevention strategies and emergency responses are as effective as possible.⁴

5. Remove the age limit of 18 on the provision by the HSE of homeless services and aftercare services

Under the current legislative and policy framework, once a child attains the age of 18, he or she is no longer the responsibility of the HSE. This strict cut-off point is problematic and can lead to young adults becoming more entrenched in homelessness. In addition, where a homeless child comes to the attention of the HSE and is taken

³ The UN Committee on the Rights of the Child criticised Ireland's collection of data on children and their well-being and recommended that measures be taken to increase the systematic and comprehensive collection of such data. See Committee on the Rights of the Child, *Consideration of Reports Submitted by States Parties under Article 44 of the Convention, Concluding Observations: IRELAND*, CRC/C/IRL/CO/2, 29 September 2006 at p. 4.

⁴ See for example, P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (Dublin: The Stationery Office, 2006); Paula Mayock and Nicola Carr, *Not Just Homelessness ... A Study of 'Out of Home' Young People in Cork City* (Health Service Executive South, 2008); Paula Mayock, Mary Louise Corr and Eoin O'Sullivan, *Young People's Homeless Pathways* (Homeless Agency, 2008); *Child Homelessness in Europe – An Overview of Emerging Trends* (FEANTSA, 2007).

into care, that child is entitled to care plans and aftercare plans when he or she turns 18. Where a homeless child is not taken into the care of the HSE, he or she is not entitled to any aftercare plan. It is recommended that all homeless children who turn 18 while homeless should be entitled to aftercare support and benefit from the aftercare protocol. To ensure that this recommendation is given as much strength as possible, it is further recommended that Section 45 of the Child Care Act 1991 (which allows for the provision of aftercare to a young adult who is in the care of the HSE when he or she turns 18) be amended to include provision of aftercare to a young adult who has been homeless as a child.

6. Coordination between local authorities and the HSE in tackling homelessness through the provision of social housing

As noted above, many homeless children are in turn, part of a homeless family. This problem requires coordination between the HSE and the local authority to ensure that it is tackled comprehensively. Under the Housing (Miscellaneous) Provisions Act 2009, each local authority has to devise a homelessness action plan. These plans should be devised in conjunction with local health offices, whose staff have knowledge of the issue of youth homelessness in the area.

7. Provision of a 24 hour ‘out-of-hours’ social work service and the discontinuance of the use of Garda Stations as part of the out-of-hours service

Recommendations for a 24 hour ‘out-of-hours’ social work service have been made a number of times in the past.⁵ While it is clear that this would involve a significant increase in the number of social workers employed by the HSE, it is a basic service to which homeless children (and indeed other children who require HSE care out of office hours) are entitled. If such a service is not going to be set up, an alternative mechanism should be found. It is unsafe and inappropriate to require vulnerable children to attend at Garda stations in the evening or night to obtain help from the

⁵ See for example, *Annual Report 2009* (Ombudsman for Children’s Office, 2009); “Emergency doctors call for HSE to provide 24 hour social work cover”, *The Irish Examiner*, 12 March 2009; numerous calls for such a service from the Children’s Rights Alliance, the ISPCC, Barnardos, the Association of Garda Sergeants and Inspectors and UN Committee on the Rights of the Child, *Concluding Observations*, CRC/C/IRL/CO/2, 29 September 2006, at p. 7.

HSE. Furthermore, Gardaí are not social workers or counsellors and are not necessarily trained to deal with such a situation.

8. Separation of newly homeless children from those entrenched in homelessness

A number of reports have noted the negative consequences of placing a newly homeless child in an environment where he or she is constantly mixing with young people who have been homeless for a greater period of time. By shrinking the social pool of the newly homeless child, such a practice makes it more likely that the child will become embedded in the culture of homelessness.⁶ It is recommended that, in so far as possible, recently homeless children should not be placed in accommodation where they would be continually mixing with children who have been experiencing homelessness for longer periods of time. While it is acknowledged that such a recommendation might be difficult to fulfil in all areas, it would have the greatest impact in urban areas where there are greater numbers of homeless children. It is therefore suggested that this recommendation be targeted in those areas.

9. Easier access to information for children

It is recommended that efforts should be made to provide a greater degree of information to children on homeless services. This could be done by publicising a Freephone number which would have an automated service detailing facilities in each area, and also through the setting up of a website with similar information. Coordination with schools is also essential, not just to provide children with information on homeless services but also to ensure that they understand the process initiated once a child is homeless.

⁶ See for example, P., Mayock and K., Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 24; and Paula Mayock, Mary Louise Corr and Eoin O’Sullivan, *Young People’s Homeless Pathways* (Homeless Agency, 2008), at p. 155.

10. *Children First Guidelines* to include provision regarding out-of-hours service

The new revised version of the *Children First Guidelines* does not include any reference to an out-of-hours social work service. It is essential that such a service be provided and it is recommended that the *Revised Guidelines* be amended before becoming operational to ensure that they include a requirement for such a service.

SECTION 2: RIGHT OF CHILDREN WITH MENTAL HEALTH DIFFICULTIES TO BE HEARD

The Mental Health Act 2001 should be amended to include a separate section which clarifies the rights of children in relation to that Act.

Such an amendment to the Mental Health Act 2001 should:

- Stipulate that individuals aged between 16 and 17 years are considered to have the capacity to consent and to refuse consent to admission and treatment. Thus adults and such individuals would have the same rights;
- Require that a mental health professional determine the capacity of children under the age of 16 years to consent on a case by case basis;
- Stipulate that children under the age of 16 years who do not have the capacity to consent to detention and treatment in an approved unit should not be referred to as “voluntary patients” simply because a parent or guardian has provided consent. This group of patients should be referred to as “informal” patients;
- Require that, where a child under 16 years of age is held not to be competent to consent, the decision to detain should automatically be reviewed by a Mental Health Tribunal;
- Stipulate that, where a child under 16 years of age is held to be competent to consent but resists admission and treatment (i.e. refuses to provide consent), the decision to detain should automatically be reviewed by a Mental Health Tribunal.

A detailed code of practice on admission to and treatment of children within mental health institutions should be published.

Consent should be sought for each aspect of the child's care and treatment as it arises.

The Mental Capacity Bill should be amended to include persons aged 16 years and older.

An advocacy service should be established which serves children who have been admitted for mental health treatment. It should assist them, amongst other things, to make complaints where they wish to do so.

A checklist should be created and given to all children admitted to hospital for mental health treatment to ensure that children have been fully informed of their civil rights (e.g. right to information, etc.).

Children should be consulted in the course of inspections of individual units.

SECTION 3: CHILDREN AND THE CRIMINAL LAW

Best interests of the child: The welfare of young offenders in Ireland

The inclusion of young offenders in any constitutional amendment to protect the welfare of vulnerable young persons would represent a unified welfare approach in Ireland that would ensure that the youth justice system is not simply a subsystem of the general criminal justice system. Such inclusion would serve a dual purpose: not only would it prevent the unnecessary incarceration of young people, but it would also help to create a youth justice system which addresses the causes of youth offending; an innovation which would be in the best interests of the child.

Inter-agency cooperation

Arguably, statutory agencies such as the HSE are not adhering to their duties and regrettably the law is not assisting them to do so. The failure to regulate the exchange of soft information severely compromises the protection of children in the State. The Child Care Act 1991 provides the HSE with very limited powers in non-familial sexual abuse cases. The decision in *M.Q. v Gleeson*⁷ dealt with responsibilities that

⁷ [1998] 4 IR 85.

the HSE has to the alleged abuser when it seeks to make information about him or her known to third parties. The only power to disclose information to third parties that the HSE possesses arises from the wide-ranging duty to protect children which is found in Section 3 of the Child Care Act 1991. In the absence of more specific guidance, the ability of the HSE to justify information sharing is largely based on a questionably broad interpretation of its powers. The Murphy Commission requested that the law be clarified in respect of both the duty to disclose information to relevant third parties and any duties to the alleged abuser.

Court ordered disclosure of confidential records

The Irish courts have not considered in any great detail the problems associated with the disclosure of third-party records such as counselling and medical records relating to the complainant, by the prosecution. In other countries such as England and Canada, where there is no appellate review of decisions to allow trials to proceed, persons with a history of sexual abuse convictions have sought to challenge the lack of proper disclosure of records in order to impugn the fairness of the trial. It is likely that, in light of the reduced numbers of persons seeking prohibition since the decision in *S.H. v. D.P.P.*,⁸ appeals based on the lack of disclosure of such records will become more common.

Ireland urgently requires legislation governing the issue of disclosure. In any discussion regarding potential legislation in this matter, findings of the analysis above regarding other jurisdictions should be considered as well as the need to balance the complainant's privacy with the accused's right to a fair trial.

The Coulsfield Review in Scotland acknowledged the threat to privacy rights as a result of disclosure: “[i]t is therefore fair to say that victims and witnesses have much to lose from an enhanced system of disclosure of information to the accused and his representatives.” The Review also noted that “the accused's right to a fair trial must ultimately take precedence over any other person's right to privacy.” As complainants in Scotland are not entitled to their own legal representation, they have to rely upon the Crown to identify and to defend their privacy interests. A difficulty for complainants recognised in the new Scottish legislation is that complainant's privacy

⁸ [2006] 3 IR 575.

interests are not recognised as a separate entity in the Act but are considered only as one component of the “public interest”.

The European Court of Human Rights (ECtHR) has ruled that the Article 8 (European Convention of Human Rights (ECHR)) interests of complainants “are in principle protected by other, substantive provisions of the Convention”, which implies that Contracting States should organise their criminal proceedings in such a way that those interests are not unjustifiably impacted upon. The Court has also ruled that, in appropriate cases, the interests of the defence should be balanced against those of any witnesses or victims called upon to testify.

Any new statutory framework proposed in respect of disclosure should seek to achieve a balance between the competing interests of the complainant, the public, and the accused in deciding whether non-disclosure is justified. An alignment of the complainant’s privacy interests with the public interest should be sought. One could then argue that the effect of disclosure of personal records is such a powerful disincentive to report sexual offences and to seek counselling/therapy that it seriously prejudices the public interest.

The issue of who would in fact represent a complainant’s privacy interests should also be considered. The D.P.P. may well find that the duties of serving the public interest and representing the complainant’s right to privacy are in irreconcilable conflict. The D.P.P. cannot both serve the public interest and adequately shield the complainant from disclosure applications. Arguably, in the absence of any express statutory rights for advocacy of a child complainant’s interests, and as no guidance is given as to the degree of consideration or protection he or she will be afforded, the right of a child complainant to privacy is seriously undermined.

One option that would recognise the vulnerable position of complainants in these circumstances is to acknowledge that their privacy rights are discrete and distinct from the public interest and therefore justify the appointment of an independent legal adviser who would be a Children’s Advocate. The appointment of a Children’s Advocate is permitted in Canada where it has long been recognised that the disclosure of records in such situations raises serious issues of privacy and equality. Rape complainants are entitled to instruct their own counsel to look after their interests in

applications by the defence for recovery of medical and therapeutic records and other confidential papers such as diaries. Canada accepts that “the values protected by privacy rights will be most directly at stake ... where the maintenance of confidentiality is crucial to a therapeutic, or other trust-like, relationship.”

Like Canadian citizens, Irish citizens have the benefit of a constitutionally protected right to privacy. It follows, therefore, that if the Article 8 rights of complainants are to be fully recognised, they must be provided with independent legal representation to protect their interests.

Recommendations regarding legislation and/or a national protocol for the exchange of information in relation to the investigation and prosecution of cases of abuse

The establishment of a National Protocol for the Exchange of Information in relation to the Investigation and Prosecution of Cases of Abuse would be an important development in child protection. To date, the absence of such a protocol established between the HSE, the D.P.P. and An Garda Síochána has impeded the exchange of information in the investigation and prosecution of cases involving abuse.

Whilst it may be argued that legislation would provide the greatest possibility of success, the effectiveness of protocols in the United Kingdom is noteworthy. There the recently updated *Working Together to Safeguard Children* document provides a comprehensive guidance that is largely complied with and applied consistently across the United Kingdom. The aim of any new legislation and/or protocol should be to provide agreed practice between the parties for the sharing and exchange of information in the investigation of cases of alleged abuse and for the purposes of criminal prosecutions.

When drafting new legislation and/or a new protocol, the HSE, An Garda Síochána and the D.P.P. should be mindful of the current inter-agency frameworks already in existence. New measures must utilise existing frameworks as a foundation to establish a transparent process with clear, unambiguous guidelines for sharing information. An independent review committee must also be made available to ensure that the system is working appropriately and to support transparency.

An effective solution

New legislation and/or a new protocol should supplement the existing policy and legislative tools that already provide guidance on inter-agency work. Measures should also be put in place to correct the existing administrative failings in respect of *Children First* as highlighted above. Thus the measures required for an effective solution can be summarised as follows:

1. New legislation and/or a new national protocol regarding inter-agency cooperation and the exchange of information which should:
 - Be unambiguous;
 - Set out clear criteria to assist in dealing with exchanging soft information;
 - Be transparent;
 - Be such as to ensure accountability;
 - Be designed to be in the best interests of the child.
2. Legislation to place the *Children First Guidelines* on a statutory basis, thereby ensuring a collective duty to report concerns of neglect or abuse of a child.
3. The continuance of joint training to aid collaborative inter-agency workings.
4. Legislation regarding court ordered disclosure that supplements any new legislation and/or protocol regarding inter-agency cooperation.

SECTION 4: TRAFFICKING OF CHILDREN AND PROSTITUTION – A REVIEW

The trafficking of children for any purpose is unacceptable in any modern society. It would appear that one of the main purposes of the trafficking of children is that of sexual exploitation. It is necessary to eradicate the demand for this and this requires the introduction of stringent laws designed to go to the root of the problem. It is recommended that consideration be given to the position in Sweden and Norway, and indeed the United Kingdom, in which the purchase of sexual services has been penalised, with a view to introducing a similar system in this country.

It is also recommended that adequate aftercare support systems be put in place to assist and support children who leave State care to make the transition to becoming

independent members of society. In addition, “out-of-hours” social services supports ought to be made available nationwide.

Legislation needs to be enacted so as to criminalise the grooming of children. In addition, whilst Ireland has signed the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, it should ratify same forthwith.

At present, the European Union has proposed a Directive “on preventing and combating trafficking in human beings, and protecting victims”. Whilst Ireland is legally entitled to opt out of this proposed Directive, it is recommended that it does not do so.

SECTION 1: Youth Homelessness

1.1 Introduction

Youth homelessness is a specific problem that requires specific attention. Obviously, children are more vulnerable than adults and it is in this context that specialised provision must be made for children who become, or are at risk of, becoming homeless. As noted in the *Youth Homelessness Strategy*⁹ (YHS), most young people will have some sort of residence, be it a family home or accommodation provided by the Health Services Executive (HSE), but homeless children and young people are unable to remain there for some reason. Therefore youth homelessness encompasses, not only cases of children sleeping rough because of a lack of residence, but also cases where children have a residence but cannot stay there. The YHS defines homeless children as:

“[t]hose who are sleeping on the streets or in other places not intended for night-time accommodation or not providing safe protection from the elements or those whose usual night-time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the other characteristics of a home and/or intended only for a short stay.”¹⁰

Over the last 20 years, youth homelessness in Ireland has received a greater degree of consideration. In 1991, the responsibility for tackling this issue was placed within the remit of the Health Boards (now the HSE) under the Child Care Act 1991. While this legislative provision was a step forward, there is no statutory framework in place to specify how this responsibility should be fulfilled. A number of policy documents have sought to fill the gaps in the legislation.

1.2 Domestic Legislative Provisions

Section 5 of the Child Care Act 1991 (the ‘1991 Act’) provides that where it appears to the HSE that a child is homeless, it must take the following steps:

- a) Enquire into the child’s circumstances; and

⁹ *Youth Homelessness Strategy* (Department of Health and Children, 2001).

¹⁰ *Ibid.*, at p. 11.

- b) Where it is satisfied that the child has no accommodation to reasonably occupy; and
- c) Unless the child is received into the care of the HSE; then
- d) The HSE shall take reasonable steps to make suitable accommodation available for the child.

Although the 1991 Act does not define the word “homeless”, guidance can be obtained from the wording of the section itself. The HSE has to consider whether the child has no accommodation which he or she can reasonably occupy. This would seem to be a broad concept and would allow for situations where, although there is a home where the child can physically live, the circumstances are such that it would not be safe, or in the child’s best interests, to do so.

This is the sole legal provision dealing specifically with child homelessness. However, Section 2 of the Housing Act 1988 provides a general definition of homelessness. It states that a person is homeless where:

- a) There is no accommodation available which, in the opinion of the housing authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of; or
- b) He is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph a) and he is, in the opinion of the authority, unable to provide accommodation from his own resources.

Under the Housing Act 1988 and the Housing (Miscellaneous Provisions) Act 2009, the responsibility for dealing with homelessness falls upon the local authority. Under the 2009 Act, each housing authority must draw up a homelessness action plan.¹¹ These plans must not only set out measures to prevent people from becoming homeless, but must also detail measures to assist homeless and formerly homeless people. While such plans will obviously impact on children in the context of their family situation, the specific issue of child homelessness on its own is placed within the domain of the HSE.

¹¹ Housing (Miscellaneous Provisions) Act 2009, Chapter 6.

There are a number of other provisions within the 1991 Act which impact on the area of youth homelessness. Under Section 45 of the 1991 Act, where a child in care attains the age of 18, the HSE may continue to assist him or her in a number of ways until he or she reaches the age of 21. Subsection 2 provides that the HSE may arrange accommodation or liaise with the local housing authorities in relation to the housing of children leaving care.¹²

In addition, Section 8 of the 1991 Act requires the HSE to prepare an annual report on the adequacy of childcare and family support services. The section specifically requires consideration to be given to children who are homeless. The most recent Section 8 report available relates to 2008.¹³

1.3 International and Regional Obligations

In addition to the domestic provisions on youth homelessness Ireland also has obligations under international and European law.

1.3.1 International Obligations

There are a number of UN Conventions which impact on this area. Specifically, the UN Convention on the Rights of the Child guarantees a number of rights which are relevant to homeless children. Article 20 of the UN Convention on the Rights of the Child states that:

“[a] child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.”

Furthermore, under Article 27 of the Convention, States Parties acknowledge the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development. While the responsibility of ensuring that the child has such a standard of living is primarily imposed on the child’s parents or those responsible for him or her, the State is required to take appropriate measures in cases

¹² See the Youth Homelessness Strategy Monitoring Committee, *Developing a Leaving and Aftercare Policy: Guidelines for Health Boards* (YHS Monitoring Committee, 2004), developed as part of the implementation of the Youth Homelessness Strategy.

¹³ *Review of Adequacy of Services for Children and Families 2008* (Health Service Executive).

of need to assist in the fulfilment of this responsibility through material assistance, particularly in relation to food, housing and clothing.

This Convention is obviously specific to children; however, similar general rights are also protected under the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 11 guarantees the right to an adequate standard of living, especially in relation to food, clothing and housing. Under this provision, States Parties have to take measures to ensure the realisation of this right.

Ireland has ratified both Conventions; however, neither Convention has been incorporated into domestic law,¹⁴ which means that the rights which are protected therein cannot be enforced through the domestic courts. Furthermore, there is no jurisdiction at the moment for an individual to make a complaint regarding breaches of the Conventions to the Committees of either Treaty. The jurisdiction to petition the Committee on the Rights of the Child does not yet exist. The General Assembly, however, has recently adopted an Optional Protocol to the ICESCR allowing the Committee on Economic Social and Cultural Rights to receive individual complaints.¹⁵ The Irish government has not yet signed this Protocol. However, it still has an international obligation to ensure that it complies with the provisions of these Treaties.

1.3.2 Other International Obligations

There are a number of other international documents which impact on Ireland's responsibility towards homeless children. The European Convention on Human Rights (the ECHR) obviously has a judicial arm which makes it a particularly powerful document. Furthermore, under the European Convention on Human Rights Act 2003, the ECHR has been incorporated into our domestic law at a sub-

¹⁴ The UN Committee on the Rights of the Child criticised Ireland for not having incorporated the Convention into domestic law, in its concluding observations on Ireland's most recent report submitted to the Committee. See UN Committee on the Rights of the Child, *Concluding Observations*, CRC/C/IRL/CO/2, 29 September 2006, at p. 3. Similarly the UN Committee on Economic, Social and Cultural Rights has criticised Ireland for not incorporating the ICESCR into domestic law. See Committee on Economic, Social and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ireland. 05/06/2002. (Concluding Observations/Comments)*, E/C.12/1/Add.77, 5 June 2002, at p. 3.

¹⁵ General Assembly, *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, A/RES/63/117, 10 December 2008.

constitutional level. This essentially means that when construing legislation or rules of law, the judiciary must, in so far as is possible, interpret them in accordance with the ECHR.¹⁶ In addition, organs of the State must carry out their functions in accordance with their obligations under the ECHR.¹⁷ While the Convention itself mainly covers civil and political rights, and a child's right to housing and/or an adequate standard of living would fall within socio-economic rights, there are a number of articles which are relevant because they deal with questions of home, housing and the treatment of a child.

Article 8 of the ECHR acknowledges that everyone has the right to respect for their private and family life and their home and correspondence, and it mandates that the State shall only interfere with these rights in certain circumstances. The concept of "home" has been given a very wide interpretation by the European Court of Human Rights (the ECt.HR).¹⁸ However, Article 8 does assume the existence of some form of home which the State may have interfered with. As such, therefore, it seems to be of no great benefit to homeless children unless claiming homelessness as a result of unlawful interference with one's home. The ECt.HR has, however, accepted that positive obligations are created by this article.¹⁹ Specifically, there have been a number of cases in which it has been held that while Article 8 does not require the State to provide housing for every person, a failure or refusal to provide assistance to severely disabled persons could come under Article 8.²⁰ This principle could be extended to include failure to provide housing or adequate housing for children.

Article 3 of the ECHR could have greater potential for protecting homeless children. It states that "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment". It could be argued that failure to provide children with adequate housing or living conditions constitutes inhuman or degrading treatment. The Court has discussed, extensively, the definition of both inhuman treatment and degrading treatment. For treatment to be considered inhuman, it must reach a minimum level of severity and be "premeditated ... applied for hours at a stretch and

¹⁶ European Convention on Human Rights Act 2003, Section 2.

¹⁷ *Ibid.*, Section 3.

¹⁸ It is not limited to the meaning given to a "home" under domestic law: *Chapman v UK* (2001) 33 EHRR 399.

¹⁹ *Moldovan v Romania* (Apps. 41138/98 and 64320/01), at para. 93.

²⁰ See *Botta v Italy* (1998) 26 EHRR 241 and *Marzari v Italy* (1999) 28 EHRR 175.

[have] caused either actual bodily injury or intense physical and mental suffering.”²¹ It is suggested that it would be very unlikely for the Court to hold a failure by the State to provide housing or adequate housing for a child to be inhuman treatment. Degrading treatment must have been such that it aroused in the victim “feelings of fear, anguish and inferiority capable of humiliating and debasing them”.²² It is more likely that the Court would make a finding of degrading treatment in relation to State failures.

In *R (Limbuella) v Secretary of State*,²³ it was held in the House of Lords that the State had a positive duty to provide assistance to a destitute and homeless asylum seeker. It was held that this obligation arose when

“it appears on a fair and objective assessment of all relevant facts and circumstances that an individual applicant faces an imminent prospect of serious suffering caused or materially aggravated by denial of shelter, food, or the most basic necessities of life.”²⁴

While this is an English decision, it is based on the principles of Article 3 of the ECHR. It is suggested that this principle can be applied to the provision of assistance for homeless children and that failure to so provide would constitute a breach of Article 3.

Under the recent Lisbon Treaty, the Charter of Fundamental Rights is now applicable to European member states.²⁵ The Charter applies to the actions of European institutions. It also applies to European Union States when implementing or exercising powers under European Union law. The first article of the Charter requires that human dignity be respected and protected. Similar articles to those found under Articles 3 and 8 of the ECHR are to be found in Articles 4 and 7 of the Charter respectively. Article 24 is a specific provision on the rights of the child. It states that children have the right to such protection and care as is necessary for their well-being and that in actions relating to children, the best interests of the child must be the primary consideration. Article 34(3) also acknowledges and respects the right to

²¹ *T and V v United Kingdom* (2000) 30 EHRR 121, at para. 71.

²² *Ibid.*

²³ [2005] UKHL 66.

²⁴ *Ibid.*, at para. 8.

²⁵ The Treaty of Lisbon gives the Charter the same legal effect as European Treaties.

social and housing assistance to ensure a decent existence for all those who lack sufficient resources.

The European Social Charter also impacts on this area. It is a Council of Europe Treaty and has been signed and ratified by Ireland. Under Article 7, children are guaranteed the right to a special protection against the physical and moral hazards to which they are exposed. Children are also entitled to appropriate social, legal and economic protection²⁶ and such protection is also guaranteed to the family as a whole under Article 16. There is also specific provision under Article 31 which requires State Parties to take measures to promote access to adequate housing and prevent and reduce homelessness with a view to its elimination.

Under the Social Charter, Ireland must submit a National Report each year on how the provisions of the Charter are being implemented. Furthermore, there is a collective complaints procedure under the Charter whereby certain international organisations can register a complaint against a country with the European Committee on Social Rights. There have been a number of complaints upheld in relation to failure to provide the Roma community with adequate housing.²⁷ In *International Movement ATD Fourth World (ADT) v France*²⁸ a complaint was upheld against France under Article 31 for failure to provide sufficient affordable housing. Furthermore, in *FEANTSA v France*²⁹ another complaint against France under this provision was upheld. It was noted by the Committee, *inter alia*, that the measures to tackle homelessness were insufficient. Such failure on the part of the French authorities derived from a lack of the data which would have helped them to actually understand the nature and scope of the problem of homelessness. Furthermore, it was found that there was insufficient emergency accommodation. A recent decision handed down by the Committee found a breach of Article 31(2) where children who were unlawfully present in a territory were not given adequate shelter. In *Defence of Children International v The Netherlands*³⁰ the

²⁶ Article 17 of the European Social Charter, Council of Europe, *European Social Charter* (with Protocols and 1996 revisions)
http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/TreatiesIndex_en.asp,
last visited 18 January 2011.

²⁷ See for example: *European Roma Rights Centre v Bulgaria*, 31/2005; *European Roma Rights Centre v Italy*, 27/2004; *European Roma Rights Centre v Greece*, 15/2003.

²⁸ European Committee of Social Rights, 33/2006.

²⁹ European Committee of Social Rights, 39/2006. See also *FEANTSA v Slovenia*, 53/2008.

³⁰ European Committee of Social Rights, 47/2008.

Committee held that Article 31(2) was aimed at particularly vulnerable people and where a child was unlawfully within the jurisdiction, it was the responsibility of the State to provide adequate shelter for as long as the child remained within the jurisdiction.

1.4 Domestic Policy Documents

There is a large volume of policy documents which propose to expand the domestic and international obligations of Ireland in the area of youth homelessness. While these documents are important and provide a guide to service providers, they are not legally binding.

1.4.1 Youth Homelessness Strategy

The core policy document is the YHS.³¹ The YHS aims to reduce and, if possible eliminate, youth homelessness through preventive strategies and to ensure that where a child becomes homeless, he or she benefits from a range of services that will integrate the child back into the community as soon as possible. It relied heavily on the findings of the recommendations made in the *Report of the Forum on Youth Homelessness*.³² This Report found that a greater level of coordination was needed in the delivery of services to homeless and out of home children.³³ In addition, it was stated that greater access to services was necessary. Appropriate care plans for each child coming into contact with the Homeless Service were suggested and also the provision of appropriate accommodation was identified as a goal. Specific attention was paid to creating residential care for substance abusers, those requiring medical care and young homeless Travellers. Education and training were also noted as being central and it was recommended that specific programmes be drawn up to address the needs of the young homeless community.

The YHS is divided into three thematic areas: preventive measures, responsive services, and planning and administrative supports. The preventive measures, in the

³¹ *Youth Homelessness Strategy* (Department of Health and Children, 2001).

³² *Report of the Forum on Youth Homelessness* (Northern Area Health Board, 2000).

³³ Specifically, it was suggested that one authority be designated to have statutory responsibility for the delivery of services to homeless and out of home children and young people between the ages of 12 and 20. It was also recommended that an Independent Board be established to ensure planning, delivery and supervision of the services.

YHS focus on strengthening family support, schools, and community and aftercare services provided by the HSE, related government departments and also from voluntary agencies. So as to ensure the implementation of preventive measures, family support services should target children and families at risk of becoming homeless. The strategy includes a statement that an out-of-hours emergency service for children in crisis would be made available. The document also contains an Aftercare Protocol, which describes aftercare as “an integral part of the process” and “not an optional extra”.³⁴

Where the preventive measures fail, the strategy provides that supports will be in place to protect homeless children. Emergency accommodation will be made available for the homeless child, but it should not become a long-term solution. It should be provided on an emergency basis and for a period sufficient to allow an assessment of the needs of the homeless child. Where the child cannot return home, suitable longer-term accommodation must be provided. Although services would vary between rural and urban areas, accommodation would take the form of supported lodging arrangements, foster care, residential accommodation, semi-independent living arrangements and transitional accommodation. Where children have been placed in longer-term accommodation, efforts should be made to ensure linkages with educational and training services. Other supports, including those based on the child’s health and recreational needs, should also be provided to ensure reintegration into the community as soon as possible. A case management worker should be in place to ensure that each child is provided with and accesses such supports.

The final element of the YHS is to ensure that proper planning and administrative supports are in place. Responsibility for coordination of the strategy is placed on the Health Boards (now the HSE) in accordance with Section 5 of the 1991 Act and this includes liaising with other stakeholders in the statutory and voluntary sector. Information on services for homeless children must be made available to ensure ease of access. Each Health Board (now the HSE) was required under the YHS to establish a Youth Homeless Services Forum. Finally the YHS required that effective

³⁴ *Youth Homelessness Strategy*, (Department of Health and Children, 2001), at p. 27.

information systems on youth homelessness be developed including a database accessible to both statutory and voluntary stakeholders.

1.4.2 General Policy Documents on Homelessness

In addition to the YHS, there are a number of policy documents dealing with the general issue of homelessness which are relevant to youth homelessness. In 2000, the Department of Environment and Local Government published *Homelessness: An Integrated Strategy*.³⁵ This document recognises that an inter-departmental approach is needed to tackle homelessness. In addition, it acknowledges that the provision of housing is not sufficient to prevent and deal with homelessness but that employment, education, training, welfare and healthcare are also central to any long-term solution.

This was followed in 2002 by the *Homeless Preventative Strategy*.³⁶ This document incorporates targeted prevention strategies aimed at ensuring those who leave State care – custodial, health-related or welfare-related – do not become homeless. While this document does impact on youth homelessness, it specifically states that, in the main, its focus is on the issue of adult homelessness. Chapters 3, 6 and 7, however, do deal with issues which directly relate to youth homelessness. Chapter 3 details the strategy for young offenders after their release. It observes that releases for young offenders are planned releases and as such do not present the same difficulties as releases of adult offenders. It was noted that pre-release units were in operation in all centres except for Trinity House and Oberstown; however such units were in the process of being set up and staffed when this document was published. Chapter 6 deals with young people who leave care. While, strictly speaking, once a person attains the age of 18 they are no longer a child, under Section 45 of the 1991 Act, the HSE may continue to assist a child up until the age of 21 years, or until the child has finished education. The YHS also includes an Aftercare Protocol³⁷ which is referred to in Chapter 6. Chapter 7 emphasises the importance of education in preventing both youth and adult homelessness.

³⁵ *Homelessness: An Integrated Strategy* (Department of Environment and Local Government, 2000).

³⁶ *Homeless Preventative Strategy* (Department of Environment and Local Government, 2002).

³⁷ *Youth Homelessness Strategy* (Department of Health and Children, 2001), at p. 27.

The Department of the Environment and Local Government sought to build upon these two documents in *The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008–2013*.³⁸ This document was drawn up following a review of the previous strategies. It sets out three core objectives: eliminating long-term occupation of emergency homeless facilities, eliminating the need to sleep rough and preventing the occurrence of homelessness as far as possible.

1.4.3 Other Policy Documents which Impact on Youth Homelessness

There are a number of other general policy documents which impact on youth homelessness. The objectives of the *National Children's Strategy* (2000) fed into the drawing up of the YHS. Specifically Objective C of the NCS requires that children be given the support necessary to enjoy optimum physical, mental and emotional well-being. Objective G states that children will be provided with the financial supports necessary to eliminate child poverty. Finally, Objective H is the objective most relevant to youth homelessness. It maintains that children will have access to accommodation appropriate to their needs.

The *Children First Guidelines* provide an action framework for Child and Family Social Services dealing with homeless children.³⁹ It must be established how the child came to be homeless and contact must be made with the child's parents or carers to ascertain their circumstances and the child's situation.⁴⁰ An assessment of the risks of returning the child to his or her parents must be made. If it is in the child's best interests to be reunited with his or her parents, it must then be considered if the parents are willing and able to take the child back and if the child wishes and is willing to return to the family home.⁴¹ Where the child is not to be returned home, efforts must be made to identify a temporary accommodation placement with a family

³⁸ *The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008–2013* (Department of Environment and Local Government, 2008).

³⁹ While the *Guidelines* have been reviewed and amended recently, the newly amended *Guidelines* are not yet operational. See also *Children First National Guidelines for the Protection and Welfare of Children* (Department of Health and Children, 1999).

⁴⁰ The *Revised Guidelines* (2010) do not require that contact be made with the child's parents or carers as soon as possible but rather requires that an assessment of the potential for the child to return to the family home be made, including whether such a return would require family support.

⁴¹ The *Revised Guidelines* (2010) also require the child's physical, social and psychological well-being, including the need for medical treatment or drug/alcohol treatment, to be assessed.

member which is acceptable to both the child and the parents. Where this cannot be achieved, the HSE has three options:

1. It can seek an Emergency Care Order under the 1991 Act if circumstances warrant it.
2. The child may be taken into the voluntary care of the HSE.
3. Finally, if grounds for receiving the child into care are unclear or non-existent, the HSE must provide accommodation which is suitable to the child's needs.

Such accommodation should be merely temporary enough to allow a full assessment of the child's needs to be carried out. The revised 2010 *Children First Guidelines* do not include the recommendation from the previous version that all Health Boards (or local health offices) operate an out-of-hours service to facilitate children who present outside of normal office hours. Failure to operate such a system presents obvious difficulties, especially in urban areas, and can result in children, who are in need of accommodation, sleeping rough.

1.5 Statistics on Youth Homelessness in Ireland

It is difficult to obtain an up-to-date and exact figure of the number of homeless children in Ireland as, obviously, there will be children who escape the attention of both the HSE and voluntary bodies. In the YHS in 2001, the national figure for homeless children was given as 588. The *Analysis of the Interim Child Care Dataset* in 2004 placed the figure at 495.⁴² The most recent report of the HSE on the adequacy of services for children and families in 2008⁴³ gives a figure of 234 children who “appear”⁴⁴ to be homeless, which is a sizeable drop from the figures given in 2001 and 2004. However, it would seem, when figures from other sources are taken into account, that the HSE almost certainly underestimates the numbers of young people who are homeless or out of home. In 2008, the Homeless Agency conducted a survey of adult homelessness in Dublin.⁴⁵ While it specifically states that youth homelessness was not within its remit, households which were receiving homeless services were

⁴² *Analysis of Child Care Interim Dataset* (Office of the Minister for Children and Youth Affairs, Department of Health and Children, 2004).

⁴³ *Review of Adequacy of Services for Children and Families* (Health Service Executive, 2008).

⁴⁴ What is meant by children appearing to be homeless is not explained in the report.

⁴⁵ *Counted In, 2008: a report on the extent of homelessness in Dublin* (Homeless Agency, 2008).

asked to give information to the Agency on any children of the family, whether residing with them or not. A total of 249 households reported having one or more children residing with them in homeless services accommodation.⁴⁶ This would indicate that at the very least, there were 249 children homeless in the Dublin region alone in 2008.⁴⁷ This figure does not include the 330 households who indicated that they had children who were not residing with them in the homeless accommodation.

Furthermore, Mayock and Carr note that in 2006, 136 children presented as homeless in the HSE Southern Area.⁴⁸ Given that the Dublin region has traditionally had the highest incidence of youth homelessness, it is reasonable to assume that the figure for that area would be at least the equivalent of if not higher than that of the HSE Southern Area. Without official or reliable up-to-date data on each of the HSE regions, however, this must remain mere speculation. Nonetheless, it appears to be accepted that the number of homeless children has declined in the last 10 years.

1.6 Children at Risk of Becoming Homeless

Regardless of the exact number of children who are homeless or “out of home”, it is clear that there are a number of categories of children who are at a greater risk than others of becoming homeless and these children must be given special attention. It is generally accepted that once a child becomes homeless, that way of life can become entrenched very quickly, making it much more difficult for the child to break out of the circle of homelessness.⁴⁹ Therefore, the best way of tackling youth homelessness is to prevent children from becoming homeless. Mayock and Carr note that:

“most homeless youths have a history of prior adversity that might be classified for a range of potentially negative outcomes ... Nonetheless, research focusing specifically on youth

⁴⁶ Ibid., at p. 33. It was noted, however, that an error on the form distributed by the Homeless Agency meant that the age of the child was not provided by the households so a large proportion of the “children” could have reached the age of 18.

⁴⁷ The Survey stated that the 249 households who reported having one or more children residing with them accounted for 576 child dependants; however, not all of these children were residing with the parents at the time. While this means that the exact figure cannot be determined, these figures must still lead to the conclusion that the HSE 2008 figure of 234 homeless children throughout the country is underestimating the problem.

⁴⁸ Paula Mayock, and Nicola Carr, *Not Just Homelessness ... A Study of ‘Out of Home’ Young People in Cork City* (Health Service Executive South, 2008), at p. 5.

⁴⁹ *Child Homelessness in Europe: An Overview of Emerging Trends* (FEANTSA, 2007), at p. 24.

homelessness has identified a range of factors associated with increased likelihood of homelessness among the young.”⁵⁰

In every report there are a number of key indicators identified:

1. *Difficulties, instability, or abuse within the family home:*

This is generally reported as being experienced by children prior to leaving home. Mayock and Vekić, in their study of youth homelessness in Dublin, discovered a high level of instability in the family homes of the children interviewed, including frequent moves, marital discord, parental alcohol or drug addiction, instances of physical abuse, and emotional and psychological abuse. While these issues were present prior to the child leaving home, it was noted that the actual leaving of the family home was generally preceded by one specific incident.⁵¹

2. *History of Care:*⁵²

This factor appears consistently in histories of homeless children. In Mayock and Carr’s study of youth homelessness in Cork, 20 out of 37 children had been involved with the care system.⁵³ In Mayock and Vekić’s study of youth homelessness in Dublin, 40% of the children involved had been in care.⁵⁴ Particular problems arose when the children turned 18 and were leaving care although, as Mayock and Vekić noted in their Dublin study, there was a risk of homelessness in some cases well before leaving care.⁵⁵

3. *Addiction Problems and Problem Behaviour:*

It is not always the case that addiction problems precede homelessness; however, in the *Report of the Forum on Youth Homelessness*⁵⁶ it was noted that in a survey of young homeless in Clondalkin 50% of respondents said that drug use was a factor in becoming homeless.⁵⁷ In contrast, in *Understanding Youth Homelessness in Dublin*

⁵⁰ Paula Mayock, and Nicola Carr, *Not Just Homelessness ... A Study of ‘Out of Home’ Young People in Cork City* (Health Service Executive South, 2008), at p. 14.

⁵¹ P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 15. See also Paula Mayock, and Nicola Carr, *Not Just Homelessness ... A Study of ‘Out of Home’ Young People in Cork City* (Health Service Executive South, 2008), at p. 43.

⁵² In an article in the *Irish Times*, 13 January 2009, Focus Ireland was quoted as saying that it estimated two-thirds of children leaving State care would experience homelessness within two years.

⁵³ Paula Mayock, and Nicola Carr, *Not Just Homelessness ... A Study of ‘Out of Home’ Young People in Cork City* (Health Service Executive South, 2008), at p. 37.

⁵⁴ P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 14.

⁵⁵ *Ibid.*, at p. 15.

⁵⁶ *Report of the Forum on Youth Homelessness* (Northern Area Health Board, 2000).

⁵⁷ *Ibid.*, at p. 35.

City, Mayock and Vekić note that the children who took part in the study did not attribute their homelessness to drug use even though a number of them had begun taking drugs prior to leaving home. It is significant, however, that the study found that for nearly all of the children, drug use increased upon becoming homeless, leading to unsafe practices and serious health problems.⁵⁸ The problematic behaviour in some instances can be tied in with addiction problems and/or with difficulties or conflict at home.

3. *Poverty and Household Instability:*

Consistent instability in living conditions was acknowledged by Mayock and Vekić as being one of the pathways into homelessness.⁵⁹ Combined with poverty, this would certainly give rise to very difficult living conditions. As noted above, the Homeless Agency found that 249 households in Dublin had children living with them in homeless accommodation. This is one of the key areas where the HSE must liaise with the local authorities regarding the provision of social housing.

4. *Other Factors:*

Other factors which have been identified as contributing to youth homelessness are a low level of interaction with the education system, and poor physical and/or mental health.

While none of the above indicators on their own can be seen as the sole reason for a child becoming homeless, they are nonetheless factors which should inform the implementation of the prevention measures under the YHS.

1.7 The Current System

As noted above, the current system is based on legislation and policy documents. There is very little information readily available as to the actual process that is initiated when a child presents to the HSE requiring accommodation. While it is mentioned in a number of reports that when children require accommodation after normal office hours,⁶⁰ they should present to a Garda Station from which contact will

⁵⁸ P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 28.

⁵⁹ *Ibid.*, at p. 15.

⁶⁰ Even the information on the times of the out-of-hours service is unclear. P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 6, state that a child must wait until 8pm

be made with a social worker, this information is not as accessible as it should or could be. In addition, there are a number of problems with such a set-up and it has been strongly criticised in the past.⁶¹ Requiring children who are young and vulnerable to make their way to a Garda Station in the evening or at night is not the safest way of providing for these children's needs. In addition, it has been pointed out that for children who have had no prior contact with the Gardaí, having to spend part of their first night out of home in a Garda Station will be traumatic.⁶² The HSE also operates a specific crisis intervention service in the areas of Dublin, Kildare and Wicklow. The HSE describes it as “an inter-agency partnership whereby statutory and voluntary services work closely to ensure that there is a responsive and protective service available to young people”⁶³ and includes an out-of-hours social work service, day support service and emergency/residential services.

According to the *Children First Guidelines*, once contact has been made with a social worker, there is an obligation, if it is possible and desirable, to reunite a child with its parents/guardians. If this cannot be done, efforts should be made to place the child with a relative and if this is not possible, the HSE can apply for an emergency care order, take the child into voluntary care and/or provide suitable accommodation. While these guidelines are reasonably comprehensive, not all of these actions can be carried out as soon as the child presents. Therefore suitable emergency accommodation must be provided. There have been reports of shortages of social workers and problems with the HSE out-of-hours service.⁶⁴ In addition, the Ombudsman for Children noted that her Office had received complaints regarding difficulties homeless children had in accessing the out-of-hours service and, more

to present at a Garda Station to avail of the out-of-hours service; however, on a number of HSE area websites, it is advised that the Gardaí should be contacted by a child or a concerned adult after 5pm.

⁶¹ See for example, the *Youth Homelessness Strategy* (Department of Health and Children, 2001) at p. 16; Paula Mayock, Mary Louise Corr and Eoin O'Sullivan, *Young People's Homeless Pathways* (Dublin: Homeless Agency) 2008, at p. 164.

⁶² P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (The Stationery Office, 2006), at p. 16.

⁶³ *Review of Adequacy of Services for Children and Families* (Health Service Executive, 2008), at p. 38.

⁶⁴ See for example, “Gardaí criticise HSE services after boy forced to stay in station”, the *Irish Independent*, 21 July 2008; Van Turnhout, *Saving Childhood Ryan*, Speech of Chief Executive of Children's Rights Alliance, 20 May 2010, Jillian Van Turnhout, launch of the Saving Childhood Ryan campaign www.savingchildhoodryan.ie/Jillian%20van%20Turnhout,%20CRA%20speech.pdf last visited 19 January 2011. Also available on You Tube http://www.youtube.com/watch?v=HuQTQQiJ_8 last visited 19 January 2011; “Money dictates standards of care for homeless children”, the *Irish Examiner*, 23 May 2009.

importantly, in accessing placements.⁶⁵ It is difficult to obtain accurate data as to the number of beds available for such emergency placements as both the HSE and voluntary services provide these facilities. Urban areas experience a greater need for such facilities; however, rural areas must have some access to emergency accommodation also to ensure that the HSE fulfils its obligations under the 1991 Act.

Once the short-term needs of the child have been addressed, a social worker must assess the medium- and longer-term needs of the child. If the child is being taken into care (either through an emergency care order or voluntary care) there is a well-established framework in place within which the HSE operates. If, however, the child is not being taken into the care of the HSE and is not being returned to his or her parents/guardians, there is little information readily available as to the process which will then take place. The child will not be subject to the normal regulations, care plans and aftercare plans which a child in care will benefit from. It would also appear that if the child is accessing the out-of-hours facilities when he or she turns 18 that there is no provision for that young adult to access aftercare facilities. This is because a child in the out-of-hours service is not automatically in the care of the HSE.⁶⁶

The YHS states that emergency accommodation must only be the entry point into the service and must not become a more permanent routine for the child. While this is the stated objective, a number of sources claim that this is not always how the service operates. In the 2009 Report of the Ombudsman for Children⁶⁷ it was noted that following some investigation, the Office discovered that some children were availing of the out-of-hours service “for extended periods of time either continuously or intermittently”.⁶⁸ Furthermore, there was some evidence before the Office of social workers having difficulty in obtaining a placement for a child because of unavailability or long waiting lists and this, therefore, also resulted in the child accessing the out-of-hours service for prolonged periods of time.

⁶⁵ *Annual Report 2009* (Ombudsman for Children’s Office, 2009).

⁶⁶ *Ibid.*, at p. 27.

⁶⁷ *Ibid.*, at pp. 26 and 27.

⁶⁸ *Ibid.*

1.8 Best Practice

It is difficult to identify one model of tackling youth homelessness as each region within each country will face different challenges. FEANTSA⁶⁹ has, however, developed a homelessness policy which encompasses 10 approaches. While this policy is not aimed solely at youth homelessness, the approaches identified, if properly integrated, could be used to tackle and eliminate youth homelessness in Ireland. The 10 approaches are as follows:

1. Evidence-based approach: focuses on ensuring that the problem of homelessness is understood through regular monitoring of trends and analysis of information, particularly relating to the effectiveness of homelessness policies.
2. Comprehensive approach: centres on preventing homelessness and, where persons have become homeless, provision of emergency accommodation and reintegration into the community.
3. Multidimensional approach: involves tackling homelessness using education, housing, health and employment. This is achieved through the cooperation of agencies – both State and voluntary.
4. Rights-based approach: emphasises the right to housing as a fundamental right both under international treaties and domestic legislation. For such an approach to work, the right to housing must be enforceable.
5. Participatory approach: requires the input of service providers (from both the State sector and the voluntary sector), State departments and homeless persons who are using the services provided. The aim is to learn from consultation with each of these stakeholders on whether the homeless strategy is achieving its aims.
6. Statutory approach: uses the introduction and implementation of legislation to ensure that the homeless strategy can be executed consistently, and can be monitored effectively.

⁶⁹ Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri.

7. Sustainable approach: mingles the three elements of adequate financial resources, political will and public support.
8. Needs-based approach: makes the needs of the individual homeless person the centre of all approaches not the needs of the organisation. This can be achieved through consistently obtaining information on homeless trends and ensuring that homeless policies are updated regularly.
9. Pragmatic approach: sets realistic and obtainable goals within an appropriate time-frame (which should include short-, medium- and long-term goals). Such goals are to be derived from thorough research on the state of homelessness in the country (and each region) and the needs of homeless persons.
10. Bottom-up approach: direction of policy responses to homelessness at a local level. These policy responses should derive from the national policy on homelessness but should entail local services having greater responsibility in terms of providing for homeless persons in their specific area and also co-ordinating between all stakeholders.

Obviously, there will be significant cross-overs between the 10 approaches listed above, and Ireland is following quite a number of them, but improvements can be made.

1.9 Recommendations

1.9.1 Comprehensive review of the coordination, implementation and continued relevance of the Youth Homelessness Strategy

Youth homelessness is a complex and multifaceted problem, and while a number of recommendations are made below to improve approaches aimed at preventing and tackling youth homelessness, the most important recommendation that can be made is that a full and comprehensive review of the coordination and implementation of the YHS must be carried out. This review must seek to ascertain the manner in which the YHS has been implemented throughout the HSE regions. In addition, it must include an analysis of the continuing relevance of each of the objectives of the YHS. The

manner in which each child is dealt with under the YHS should be assessed to ensure that the interventions being made are effective.

1.9.2 Greater coordination between youth homeless providers

It is essential that there is coordination between youth homeless providers and also between the HSE and other stakeholders such as the local authority, local education representatives and local health representatives. This was a recommendation first made in the *Report of the Forum on Youth Homelessness*.⁷⁰ Adult and youth homeless strategies in each region should complement each other. While the HSE has primary responsibility for youth homelessness, it should also have regard to the fact that policies have been drawn up to tackle adult homelessness which will impact on youth homelessness. In addition, the HSE should liaise with the local authority regarding the homelessness action plan for the area to ensure proper provision for children who are part of a homeless family.

1.9.3 Strengthening of statutory framework regarding youth homelessness

While the Child Care Act 1991 places the issue of youth homelessness within the remit of the HSE, there is no statutory framework to stipulate the legal contents of this responsibility. For this provision to be as effective as possible, it should allow for the Minister for Children to make regulations regarding the implementation of this responsibility under the YHS. In addition, it should be possible for children who have not received the appropriate provision under Section 5 of the 1991 Act to seek redress through the courts. This would, most likely, require the legislature to specifically empower such an action as otherwise any action taken by a child would risk being dismissed as being outside the scope of the courts' power under the separation of powers.

⁷⁰ *Report of the Forum on Youth Homelessness* (Northern Area Health Board, 2000), at p. 87.

1.9.4 Provision of comprehensive, up-to-date information on youth homelessness

This is essential to tackling the issue of youth homelessness.⁷¹ While the Report on the *Review of Adequacy of Children and Family Services* provides comprehensive data on children coming into contact with the HSE, information from voluntary organisations must also be considered for a complete picture of youth homelessness. The YHS stated that a database which permitted both State and voluntary sectors access would be established. This has not been done and it would be a valuable resource, especially if State and voluntary sector organisations were allowed, not only to access it, but also to log data onto it. Important studies have been carried out over the past 10 years which should be fed into improving the YHS and ensuring that prevention strategies and emergency responses are as effective as possible.⁷²

1.9.5 Remove the age limit of 18 on the provision by the HSE of homeless services and aftercare services

Under the current legislative and policy framework, once a child attains the age of 18 he or she is no longer the responsibility of the HSE. This strict cut-off point is problematic and can lead to young adults becoming more entrenched in homelessness. In addition, where a homeless child comes to the attention of the HSE and is taken into care, that child has the benefit of care plans and aftercare plans when he or she turns 18, whereas a homeless child who is not taken into the care of the HSE is not entitled to any aftercare plan. It is recommended that all homeless children who turn 18 while homeless should be entitled to aftercare support and benefit from the aftercare protocol. To ensure that this recommendation is given as much strength as possible, it is further recommended that Section 45 of the Child Care Act 1991 (which

⁷¹ The UN Committee on the Rights of the Child criticised Ireland's collection of data on children and their well-being, and recommended that measures be taken to increase the systematic and comprehensive collection of such data. See UN Committee on the Rights of the Child, *Concluding Observations*, CRC/C/IRL/CO/2, 29 September 2006, at p. 4.

⁷² See for example, P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (Dublin: The Stationery Office, 2006); Paula Mayock and Nicola Carr, *Not Just Homelessness ... A Study of 'Out of Home' Young People in Cork City* (Health Service Executive South, 2008); Paula Mayock, Mary Louise Corr and Eoin O'Sullivan, *Young People's Homeless Pathways* (Homeless Agency, 2008); *Child Homelessness in Europe – An Overview of Emerging Trends* (FEANTSA, 2007).

allows for the provision of aftercare to a young adult who had been in the care of the HSE when he or she turned 18) be amended to include provision of aftercare to a young adult who had been homeless as a child.

1.9.6 Coordination between local authorities and the HSE in tackling homelessness through the provision of social housing

As noted above, there are a significant number of homeless children who are part of a homeless family. This problem requires coordination of effort between the HSE and the local authority to ensure that the problem is comprehensively tackled. Under the Housing (Miscellaneous) Provisions Act 2009, each local authority has to devise a homelessness action plan. These plans should be devised in conjunction with local health offices, whose staff have knowledge of the issue of youth homelessness in the area.

1.9.7 Provision of a 24 hour ‘out-of-hours’ social work service and the discontinuance of the use of Garda Stations as part of the out-of-hours service

Recommendations for a 24 hour “out-of-hours” social work service have been made a number of times in the past.⁷³ While it is clear that this would involve a significant increase in the number of social workers employed by the HSE, it is a basic service to which homeless children (and indeed other children who require HSE care out of office hours) are entitled. If such a service is not going to be set up, an alternative mechanism should be found. It is not appropriate or safe to require vulnerable children to attend at Garda stations in the evening or night to obtain help from the HSE. Furthermore, Gardaí are not social workers or counsellors and are not necessarily trained to deal with such a situation.

⁷³ See for example, *Annual Report 2009* (Ombudsman for Children’s Office, 2009); “Emergency doctors call for HSE to provide 24 hour social work cover”, *The Irish Examiner*, 12 March 2009; numerous calls for such a service from the Children’s Rights Alliance, the ISPCC, Barnardos, the Association of Garda Sergeants and Inspectors, and the UN Committee on the Rights of the Child, *Concluding Observations*, CRC/C/IRL/CO/2, 29 September 2006, at p. 7.

1.9.8 Separation of newly homeless children from those entrenched in homelessness

A number of reports have noted the negative consequences of placing a recently homeless child in an environment where there he or she is constantly mixing with young people who have been homeless for a greater period of time. It shrinks the social pool of the recently homeless child and increases the likelihood that the child will become embedded in the culture of homelessness.⁷⁴ It is recommended that, in so far as possible, children who are newly homeless should not be placed in accommodation where they would be continually mixing with children who have been experiencing homelessness for longer periods of time. While it is acknowledged that this recommendation might be difficult to fulfil in all areas, it would have the greatest impact in urban areas where there are greater numbers of homeless children. It is therefore suggested that the recommendation be targeted in those areas.

1.9.9 Easier access to information for children

It is recommended that efforts should be made to provide a greater degree of access to information on homeless services to children. This could be done by publicising and operating a Freephone number which would have an automated service detailing facilities in each area, and also through the setting up of a website with similar information. Coordination of efforts with schools is also essential, not just to provide children with information on homeless services but also to ensure that they understand the process which will be initiated once a child is homeless.

1.9.10 *Children First Guidelines* to include provision regarding out-of-hours service

The *Revised Children First Guidelines* do not include any reference to an out-of-hours social work service. It is essential that such a service be provided and it is recommended that the *Revised Guidelines* be amended before becoming operational to ensure that they include a requirement for such a service.

⁷⁴ See for example, P. Mayock and K. Vekić, *Understanding Youth Homelessness in Dublin City: Key Findings from the First Phase of a Longitudinal Cohort Study* (Dublin: The Stationery Office, 2006), at p. 24; Paula Mayock, Mary Louise Corr and Eoin O'Sullivan, *Young People's Homeless Pathways* (Homeless Agency, 2008), at p. 155.

SECTION 2: Right of Children with Mental Health Difficulties to be Heard

2.1 Introduction

The purpose of this section is to examine the current situation vis-à-vis the right of children with mental health difficulties to be heard. Children with mental health difficulties are in a unique position. Compared to adults with similar difficulties, not only do such children have less developed capacities because of their youth, but they also lack the power to exercise their own legal rights for many purposes, as it is assumed that it is appropriate that adults do so on their behalf. Mental health difficulties combined with these factors leave children in a particularly vulnerable position. Therefore it seems vital to examine the right of this particular group of children to be heard. There are crucial issues in the Irish system relating to service provision, most notably the lack of inpatient facilities for adolescents and the admission of patients under the age of 18 to adult wards.⁷⁵ That said, this area has been given significant consideration and reform is ongoing.⁷⁶ The right to be heard and due process rights of children with mental health difficulties is a major focus of this Report. Irish practice will be analysed and comparisons will be made with legislation and practice in England and Wales. The jurisprudence of the ECt.HR will be considered and recommendations will be made.

The right of children to be heard is enshrined in the UNCRC as well as in the national law of some states. The provision as protected within the UNCRC recognises that, for

⁷⁵ The lack of appropriate provision for children with mental health difficulties in Ireland is well documented. See for example, Carl O'Brien, "155 Children placed in Adult Psychiatric Hospitals", *The Irish Times*, 1 March 2010; Patrick Devitt, "Mental Health Services still do not Reflect New Policies", *The Irish Times*, 15 May 2009; Ursula Kil Kelly, *Children's Rights in Ireland* (Tottel, 2008), at p. 433; Office of the Ombudsman for Children Press Release, "Mental Health Services for Children remain Inadequate, Stigma Prevails", 18 December 2007, available at <http://www.oco.ie/whats-new/media/press-release-archive/mental-health-services-for-children-remain-inadequate-stigma-prevails.html>, last accessed 2 August 2010; UN Committee on the Rights of the Child, *Concluding Observations*, CRC/C/IRL/CO/2, 29 September 2006, at para. 46.

⁷⁶ See Mental Health Commission, *Code of Practice Relating to Admission of Children under the Mental Health Act 2001: Addendum* (Mental Health Commission, 2009), at p. 3, discussed further below.

many purposes, decisions (including judicial decisions) will be made on behalf of children by adults, because of their status as minors. It further recognises that, despite this status, children can have well-developed opinions and views based on knowledge of their own environment, and therefore should have a right to contribute to those decisions. The Convention holds that the level of that contribution, ranging from simply being informed about the process to making the decision, will depend on the age and maturity of the child. The right to be heard is directly linked with the category of rights which relate to due process: for example the right to a fair trial, the right to information and a number of other rights which are enshrined in the ECHR and other texts at international, national and regional level. Due process rights are “fundamental procedural legal safeguards to which every citizen has an absolute right when a state or court purports to take a decision that could affect any right of that citizen”.⁷⁷ The most basic right under the due process doctrine is the right to be given an opportunity to be heard.⁷⁸

It is undeniable that, as children are for some purposes a distinct social and legal category, there will be legal matters which pertain to this group which do not apply to adults. For example, children may be taken into the care of the State if they experience abuse or neglect at home, and this is generally not the case for adults. Unlike most adults, some children (e.g. babies) obviously do not have the capacity to instruct counsel. Therefore the matter of due process rights for children raises a number of complex issues. Nevertheless, restrictions placed on such rights for children should only be those that are necessary and proportionate in accordance with their status as minors, in line with non-discrimination legislation.⁷⁹ Such legislation is in existence in many States, and enshrines the principle of proportionality: the principle that distinctions in legal rights should have a “reasonable relationship of

⁷⁷ *Duhaime's Law Dictionary* (2009), available at <http://duhaime.org/legaldictionary.aspx>, last visited 2 April 2010.

⁷⁸ *Ibid.*

⁷⁹ For example, the Equal Status Act 2000 in the Republic of Ireland. It is also of note that the Charter of Fundamental Rights of the European Union (2010) Chapter III relates to equality and Article 21(1) holds that “[a]ny discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.” <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0389:0403:EN:PDF>, last visited 19 January 2011.

proportionality between the means employed and the aim sought to be realised”.⁸⁰ Therefore, in circumstances where children have the desire and the capacity to be heard and contribute to decision-making affecting them, there presumably exists an obligation to facilitate them to do so, to the extent that adults enjoy that right.⁸¹ Nowhere is this more important than in situations which relate to deprivation of liberty and physical integrity: for example, detention and treatment on mental health grounds.

The high levels of mental health difficulties of young people in Ireland indicate the need for excellence in mental health services. The most reliable estimate indicates that one in five young people in Ireland experience serious emotional distress at any one time.⁸² Ireland has one of the highest rates of youth suicide in the European Union, at 15.7 per 100,000 of 15–24 year olds.⁸³ It is highly problematic, and well documented, that many young people with significant mental health problems frequently do not come to the attention of the healthcare services⁸⁴ and that there is a significant shortage of services available for young people in this regard.⁸⁵ However, a number of children and young people do receive services and in some situations are admitted to psychiatric institutions for mental health treatment.⁸⁶ As in the general medical arena, the admission and treatment of children with mental health difficulties raises a number of issues relating to their status as minors.

⁸⁰ ‘Belgian Linguistic’ case of the European Court of Human Rights, (No. 2) (1968), Series A, No. 6 (1979–80) 1 EHRR 252, at para. 10.

⁸¹ This point is already recognised in the area of criminal law, where children accused of infringing the law will usually be accorded legal representation in situations where adults would be accorded such representation.

⁸² Irish College of Psychiatrists, *A Better Future Now: Position Statement on Psychiatric Services for Children and Adolescents in Ireland* – Occasional Paper OP60 (Irish College of Psychiatrists, 2005), cited in T. Bates et al., *Somewhere To Turn To, Someone To Talk To* (Dublin: Headstrong, The National Centre for Youth Mental Health, 2009).

⁸³ National Office for Suicide Prevention, *National Office for Suicide Prevention Annual Report 2006* (National Office for Suicide Prevention, Health Service Executive, 2007), at p. 1.

⁸⁴ C. Sullivan, E. Arensman, H.S. Keeley, P. Corcoran and I.J. Perry, *Young People’s Mental Health: A report of the findings from the Lifestyle and Coping Survey*, (National Suicide Foundation, Cork, 2004).

⁸⁵ See above note 75.

⁸⁶ The Mental Health Commission was notified of a total of 365 admissions of children to approved centres in 2009, of which 10 were “involuntary” admissions (i.e. parents or guardians did not consent or could not be located). Mental Health Commission, *Annual Report 2009* (Mental Health Commission, 2009), at p. 43.

2.2 Mental Health Act 2001

The Mental Health Act 2001 (the 2001 Act), commenced in 2006, reforms a legislative framework which was “outdated and lacking in focus on the rights of mental health service users”⁸⁷ and which failed to comply with international standards such as those enshrined in the ECHR and the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care (1991).⁸⁸ The 2001 Act addresses the circumstances in which persons with a “mental disorder” can be admitted, detained and treated involuntarily in “approved centres”,⁸⁹ as well as the maintenance of quality standards of care and treatment, including regular inspection and adequate regulation. The 2001 Act defines the term “mental disorder” as: “a mental illness, severe dementia or significant intellectual disability where, because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons; or because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition, or would prevent the administration of appropriate treatment that could be given only by such admission, and the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.”⁹⁰

2.3 Children and Capacity to Consent to Medical Treatment

The 2001 Act operates in a context of uncertainty as regards children and medical consent. The Law Society of Ireland refers to Irish law as “less than clear” on the matter.⁹¹ The Medical Council Guidelines state:

“If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be

⁸⁷ Jenny Bulbulia, ‘The Mental Health Act 2001’, *Bar Review*, vol. 10 (2005), 8–24.

⁸⁸ The 2001 Act replaces the majority of the provisions of the Mental Treatment Act 1945 as well as replacing the Mental Treatment Act 1953; the Mental Treatment Act (Detention in Approved Institutions) Act 1961; the Mental Treatment Act 1961 and the Health (Mental Services) Act 1981.

⁸⁹ An approved centre is one which is on the Register of Approved Centres established by the Mental Health Commission under Section 63(1) of the Mental Health Act 2001.

⁹⁰ Mental Health Act 2001, Section 3(1).

⁹¹ Law Society of Ireland, *Rights-Based Child Law: The Case for Reform, A report by the Law Society’s Law Reform Committee* (Law Society of Ireland, 2006), at p. 199.

had to the wishes of the child. The doctor must never assume that it is safe to ignore the parental/guardian interest.”⁹²

Kilkelly notes the fact that this advice fails to outline that there actually exists an obligation to obtain the consent of children 16 years and over under Section 23 of the Non-Fatal Offences Against the Person Act 1997, and that the guidance appears to deal at once with the need to explain a proposed procedure to the child and the need to respect children’s wishes where parents’ consent is required, as well as the need to consider parental interests where the child has the capacity to consent.⁹³ This highlights the distinct lack of clarity in the area. More recent guidance from the Medical Council on the capacity of children to consent does note that “[p]atients aged 16 years and over are entitled by law to give their own consent to surgical, medical or dental treatment.”⁹⁴ As regards children under 16, the most recent guidance of the Medical Council briefly states that, where the patient is under the age of 16 years, it is usual that the parents will be asked to give their consent to medical treatment on the patient’s behalf, but that in exceptional circumstances, a patient under 16 may seek to make a healthcare decision on their own without the knowledge or consent of their parents. The Council advises professionals that “[i]n such cases you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient’s best interests.”⁹⁵ The fact that legislation which pertains to children with mental disorders conflicts with other legislation (as outlined below) is not noted by the guidance.

2.4 Children and the Mental Health Act 2001

The situation of children with mental health difficulties is dealt with to some extent in the 2001 Act; however, the uncertainty surrounding children and medical consent poses significant problems. Under the Mental Treatment Act 1945, services were targeted at children (defined as those under 16 years) and adults (those 18 years and older). This created a lacuna in service provision for young people aged between 16

⁹² Medical Council, *A Guide to Ethical Conduct and Behaviour* (6 edn) (Medical Council, 2004), at para. 18.3.

⁹³ Ursula Kilkelly, *Children’s Rights in Ireland* (Tottel, 2008), at p. 444.

⁹⁴ Medical Council, *A Guide to Ethical Conduct and Behaviour* (7 edn) (Medical Council, 2009), at p. 41.

⁹⁵ *Ibid.*

and 17 years, who were treated in the general adult services by psychiatrists trained in the treatment of adults. The Law Reform Commission states that:

“This situation was criticised because the specific needs of the adolescent population were not met. General adult psychiatrists do not have the training to deal with developmental or conduct disorders. Furthermore, adult services lack the necessary multidisciplinary input which centres on family, school and social interventions.”⁹⁶

There was an attempt made through the 2001 Act to resolve this problem by extending child services to young people up to the age of 18 years. The legislation acknowledged that adolescents have particular needs which may not be met in the context of adult psychiatry, and it focused attention on the issue of treatment for young people aged between 16 and 17 years.⁹⁷ Recent improvements in the area of treatment of adolescents are evident. The Independent Monitoring Group reports annually on the implementation of the policies contained in *A Vision for Change*, a model of mental health service provision for Ireland. The first annual report of the Group, which covered the period to the end of January 2007, noted particular failings in the provision of child and adolescent services. The second report stated “that by and large the recommendations in its first report were not addressed in 2007”⁹⁸ and that there had been little progress in the development of mental health teams to serve the particular needs of children and adolescents, or in the provision of additional inpatient beds.⁹⁹ However, the third¹⁰⁰ report notes improvements in relation to provision of such services as does the fourth.¹⁰¹ There is currently a burgeoning awareness of the problem of the admission of children to adult units and an impetus to effect change. An addendum to the Mental Health Commission, *Code of Practice relating to Admission of Children under the Mental Health Act* directs that:

- No child under 16 years is to be admitted to an adult unit in an approved centre from 1 July 2009;

⁹⁶ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 177.

⁹⁷ *Ibid.*

⁹⁸ A Vision for Change Monitoring Group, *A Vision for Change – The Report of the Expert Group on Mental Health Policy: Third Annual Report on Implementation 2008* (Department of Health and Children, 2009), at p. 6.

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*, at p. 3.

¹⁰¹ A Vision for Change Monitoring Group, *A Vision for Change – the Report of the Expert Group on Mental Health Policy: Fourth Annual Report on Implementation 2009* (Department of Health and Children, 2010), at p. 4.

- No child under 17 years is to be admitted to an adult unit in an approved centre from 1 December 2010; and
- No child under 18 years is to be admitted to an adult unit in an approved centre from 1 December 2011.¹⁰²

If in exceptional circumstances the admission of a child to an adult unit in an approved centre occurs in contravention of these principles, the approved centre has an obligation to submit a report on the matter to the Mental Health Commission outlining why the admission has occurred.¹⁰³ Increasing the level of provision of child and adolescent mental health services has greatly improved the matter of providing for the needs of children with mental health difficulties. The HSE outlines in a recent report the increases made in beds available for such children:

“In 2008 the capacity of the HSE child and adolescent inpatient units (Warrenstown, Dublin and St. Anne’s, Galway) increased to a total of 16 beds, operating on a fulltime 7 day basis. In 2009 the opening of two new units at St. Vincent’s Hospital, Fairview, Dublin and St. Stephen’s Hospital, Cork increased this number to a total of 30 beds. Work is progressing on the 2 new 20 bed units at Merlin Park Hospital, Galway and Bessboro, Cork and both are due to open in 2010.”¹⁰⁴

The taking of these steps towards improvement constitutes a very positive development, considering that there had previously been such a failure to provide the facilities for the care of children in need of mental health treatment. However, it seems that the relevant authorities have not yet given the matter of consent and deprivation of liberty the careful consideration which it deserves. For example, while the matter of service provision for children is considered in *A Vision for Change*, there is no reference to the issues relating to children and consent to treatment.¹⁰⁵ This seems particularly surprising as detention of children in psychiatric units is a deprivation of liberty issue. The Irish College of Psychiatrists notes that:

“The new Mental Health Act is essentially an involuntary detention Act and correctly is an attempt to address civil liberties and civil rights issues and professional standards in relation to this population. It is, therefore, imperative that all citizens are treated equitably...”¹⁰⁶

¹⁰² See Mental Health Commission, *Code of Practice Relating to Admission of Children under the Mental Health Act: Addendum* (Mental Health Commission, 2009), at p. 3.

¹⁰³ Ibid.

¹⁰⁴ Health Research Board, *Child and Adolescent Mental Health Services: First Annual Report* (Health Research Board, 2008), at p. 5.

¹⁰⁵ Report of the Expert Group on Mental Health Policy, *A Vision for Change*, (Dublin, 2006).

¹⁰⁶ The Irish College of Psychiatrists, *Comments on Mental Health Act 2001* (Dublin, 2001), at p. 8. Available at <http://www.irishpsychiatry.com/comments.html>, last visited 12 August 2010.

This makes it all the more unfortunate that the right of children to be heard is neglected in the 2001 Act. The matter of consent to medical treatment is the most notable issue that arises from the position of children's rights and interests in the 2001 Act. Parents exercise rights on behalf of their children for many purposes until the age of majority (18 years in Ireland). However, there exist significant exceptions to this. For example, Section 23 of the Non-Fatal Offences Against the Person Act 1997 stipulates that:

“The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian.”

Therefore individuals aged 16 years and over are to be considered competent to consent to treatment. Arguably, the most pertinent issue which exists in relation to the due process rights of children with mental health difficulties, is that some children may be resistant to admission to hospital. Where adults¹⁰⁷ refuse to consent to admission to a psychiatric hospital (referred to as “involuntary”¹⁰⁸ patients), they have a number of due process rights under the 2001 Act. Such persons must be provided with notice in writing outlining, amongst other things, that he or she is entitled to legal representation,¹⁰⁹ that he or she will have his or her detention reviewed by a tribunal,¹¹⁰ and he or she is entitled to appeal to the Circuit Court against a decision of a tribunal if he or she is the subject of a renewal order.¹¹¹ Following the receipt by the Mental Health Commission of a copy of an admission order or a renewal order, the Commission must, as soon as possible, refer the matter to a tribunal;¹¹² assign a legal representative to represent the patient concerned (unless he or she proposes to engage one);¹¹³ direct a consultant psychiatrist to establish whether admission is in the interests of the patient and whether the patient is suffering from a mental disorder; and

¹⁰⁷ Held to be persons over the age of 18 years in the Mental Health Act 2001, Section 2(1). This is considered further below.

¹⁰⁸ See Mental Health Act 2001, Part 2, “Involuntary admission of persons to approved centres”.

¹⁰⁹ Section 16 (2)(b).

¹¹⁰ Section 16 (2)(e).

¹¹¹ Section 16 (2)(f).

¹¹² Section 17 (1)(a).

¹¹³ Section 17 (1)(b).

make a report to the tribunal to which the matter has been referred and provide a copy of the report to the legal representative of the patient.¹¹⁴

A voluntary patient is defined by the 2001 Act as “a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order”.¹¹⁵ The Law Reform Commission points out that the definition in the 2001 Act is a negative one, centred not on what a voluntary patient is, but rather on what a voluntary patient is not.¹¹⁶ A voluntary patient is not the subject of an admission (or renewal) order and therefore is not suffering from a mental disorder. Such a patient is accordingly treated as having the capacity to consent voluntarily to detention and treatment.¹¹⁷ The Commission submits, therefore, “that a voluntary admission must necessarily contain an element of choice and voluntariness on behalf of the patient to consent to detention and treatment”.¹¹⁸ It seems highly problematic, then, that the Department of Health and Children states that the majority of children receiving inpatient treatment for mental health difficulties will be admitted on a voluntary basis, meaning that such admissions will be made at the request of the child’s parent(s) or guardian(s).¹¹⁹ Consequently, a child is referred to as an “involuntary patient” only where the parents of that child fail to consent to or withdraw consent to admission or treatment.

This raises a number of troubling issues. Firstly, as the Law Reform Commission notes, “voluntary” admission must involve choice and voluntariness on the part of the patient. Bearing this in mind, it is difficult to argue that a child who resists admission can be said to be present in hospital on a voluntary basis, even where parents have consented to admission. Such an assertion is in distinct opposition to conceptions

¹¹⁴ Section 17 (1)(c).

¹¹⁵ Section 2 (1).

¹¹⁶ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 185.

¹¹⁷ *Ibid.*, at p. 188.

¹¹⁸ *Ibid.* The definition of “consent” in Section 56 of The Mental Health Act 2001 also refers to a level of voluntariness, involving consent obtained freely without threats or inducements, where the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment, and where the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

¹¹⁹ Department of Health and Children, *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Stationery Office, 2007), at p. 19.

within current international human rights texts and elsewhere¹²⁰ of children as individual human beings who hold rights distinct from those of their parents.¹²¹ Secondly, as the Law Reform Committee of the Law Society of Ireland has pointed out, where a child cannot “consent” to medical treatment as such,¹²² it would seem that he or she is necessarily not a “voluntary” patient, and should therefore be regarded as an involuntary patient.¹²³ The Law Reform Commission adds that, since the Mental Health Commission specifies that children over 16 can be detained for treatment on the basis of parental consent, “it would appear that the child would not have the right to leave as such” and that the term “voluntary” is not appropriate for this category of patient.¹²⁴ Finally, the consent to treatment of children of 16 years and over is held by the Non-Fatal Offences Against the Person Act 1997 to be as effective as it would be if the child were of full age, rendering consent from his or her parent or guardian unnecessary for individuals of this age. This is an anomaly which is in urgent need of consideration and clarification by the relevant authorities.

Where it appears to the HSE that a child is suffering from a mental disorder which is unlikely to be treated except through the making of an order and where parents or guardians refuse to consent to treatment (or cannot be located), the HSE may make an application to the District Court for an order authorising the detention of the child in an approved centre.¹²⁵ Therefore it is unlikely that children will be denied treatment because of the failure of a responsible adult to consent. The matter of greater concern is that children may be treated without giving their own consent because the consent of parents or guardians has been obtained and that, unlike in the case of adults, there can be no recourse to review of a decision. No Irish case law exists on the matter of the legal status of the refusal of a minor to medical treatment; legal consideration of

¹²⁰ For example, in the United Kingdom, legislation and policy has evolved to the point where they operate on the basis of parental “rights and responsibilities” as opposed to viewing children as appendages of adults.

¹²¹ For example, the *Convention on the Rights of the Child*, which notes the pivotal position of the family in children’s lives (e.g. in Article 5), but also the notion of children as rights holders.

¹²² Individuals under the age of 18 years are considered to be children in the Mental Health Act 2001 (Section 2(1)) but under 16 years in the Non-Fatal Offences Against the Person Act 1997(Section 23). This anomaly is discussed further below.

¹²³ Law Society of Ireland, *Rights-Based Child Law: The Case for Reform, A report by the Law Society’s Law Reform Committee* (Law Society of Ireland, 2006), at p. 208.

¹²⁴ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 189.

¹²⁵ Mental Health Act 2001, Section 25.

the refusal of treatment concentrates on the legality of a decision by a terminally ill adult patient to refuse life-sustaining treatment.¹²⁶

Another significant issue is the fact that the continued administration of treatment to children negates the need for renewed consent for the purposes of different aspects of treatment.¹²⁷ This situation is, of course, notwithstanding the fact that consent is not sought from the child himself or herself in any case. Nevertheless, Section 61 of the 2001 Act stipulates that, where medicine has been administered to a child detained under Section 25 for the purposes of ameliorating his or her mental disorder for a continuous period of three months, administration of that medicine shall only be continued with the approval of two psychiatrists. Section 61 is similar to Section 60, which provides for such a review in the situation where an adult patient is unable or unwilling to give such consent to continued administration of medication. A review of the operation of the 2001 Act by the Department of Health and Children notes that the process for the detention of a child under Section 25 is quite different to the involuntary admission of an adult and this is not correctly reflected in Section 61. The report goes on to state that “[t]he Minister accepts that there appears to be a drafting error in this section which requires to be amended. This amendment will be made as soon as a suitable opportunity arises.”¹²⁸ Such an amendment has yet to be made and the nature of the intended amendment is unclear. What is clear is that the ongoing provision of medication to children raises serious concerns about the assumption that consent is not relevant to children. Kilkelly states that “[i]n this way, the Mental Health Act appears to allow the consultant psychiatrist unrestricted decision-making powers in this area.”¹²⁹ This is an area which is in urgent need of clarification and reform.

2.5 Capacity to Refuse Treatment

The Law Reform Commission states that the ambiguity around the rights of minors to consent to medical treatment is “even more pronounced” in relation to the capacity to

¹²⁶ See for example, *Fitzpatrick v FK*, [2008] ILRM 68; *Fitzpatrick v FK* (No 2), [2008] IEHC 104.

¹²⁷ See below for consideration of this matter in the legislation of England and Wales.

¹²⁸ Department of Health and Children, *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Stationery Office, 2007), at p. 28.

¹²⁹ Ursula Kilkelly, *Children’s Rights in Ireland* (Tottel, 2009), at p. 436.

refuse medical treatment.¹³⁰ In *A Guide to Ethical Conduct and Behaviour* the Medical Council holds that:

“A refusal of treatment by a patient between 16 and 18 years, which is against medical advice and parental wishes, is of uncertain legal validity. In this event, you should consider seeking legal advice before acting on such a decision.”¹³¹

According to this guidance, it seems that a 16 year old may consent to medical treatment¹³² but a refusal of medical treatment would still require recourse to legal advice. This guidance is problematic as it leaves a number of matters unclarified. It does not consider the fact that medical advice and parental wishes may differ or the potential consequences of such differences. Furthermore, as the Law Reform Commission notes, no distinction is drawn by the Council between essential or life-sustaining treatments and other treatments which are less urgent.¹³³

Section 23 of the Non-Fatal Offences Against the Person Act 1997 refers only to the capacity of a minor who has attained 16 years to consent to treatment. Crucially, however, the legislation specifies that such consent is “as effective as it would be if he or she had attained full age”. This is significant because the refusal to consent of an adult is treated as deriving from the capacity to consent,¹³⁴ which means that, logically, the same must apply to the situation of a minor who has attained 16 years of age. The Law Reform Commission calls for clearer guidance on this point, as this theory is not determinative of the current legal situation, but merely contributes to the body of opinion surrounding the right of a minor to refuse medical treatment.¹³⁵

2.6 Lack of Mental Health Tribunal for Children

As noted above, the 2001 Act provides for the establishment of Mental Health Tribunals. These are independent tribunals which are established by the Mental Health Commission in order to review and affirm or revoke decisions which are made

¹³⁰ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 130.

¹³¹ Medical Council, *A Guide to Ethical Conduct and Behaviour* (7 edn) (Medical Council, 2009), at p. 41.

¹³² *Ibid.* The Medical Council holds in the previous paragraph that “[p]atients aged 16 years and over are entitled by law to give their own consent to surgical, medical or dental treatment.”

¹³³ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 130.

¹³⁴ The Supreme Court opined in *Re a Ward of Court (No2)* [1996] 2 IR 79, at 129 that the corollary to the right to consent to treatment is the right to refuse treatment.

¹³⁵ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at p. 131.

under the 2001 Act. Such decisions include, for example, decisions to involuntarily admit patients or to carry out certain methods of treatment. An individual affected by such a decision under the 2001 Act is entitled to be informed of their rights before the tribunal is held, and to be heard by and legally represented at the tribunal.¹³⁶ A Mental Health Tribunal consists of a consultant psychiatrist, a legal professional and a lay person.¹³⁷ The Mental Health Commission notes that through the tribunals “[t]he important safeguards recognised and enshrined in international protocols are now provided for in Irish law.” However, such safeguards are not available to children who refuse to or are unable to consent to admission and treatment. No mechanism exists for any person under 18 years of age in this situation to appeal or seek a review of detention or treatment.

The Law Reform Commission points out that the 2001 Act has relied heavily on the provisions of the Child Care Act 1991.¹³⁸ The 1991 Act recognises the District Court as the ultimate guardian of the child. Consequently, Section 25 of the 2001 Act stipulates that the review of the “involuntary” admission of children (i.e. where a parent or guardian of the child has not provided consent) is to be performed by the court. The District Court will undoubtedly endeavour to act in the best interests of the child; however, a number of problems arise. Despite the assertion by the HSE that children’s rights are provided for under the 2001 Act by virtue of the provisions of the 1991 Act,¹³⁹ children are not generally made party to proceedings in the District Court, and are rarely provided with legal representation, or independent representation of any kind.¹⁴⁰ The Law Reform Commission states that, although certain provisions of the 1991 Act, as incorporated into Section 25 of the 2001 Act, provide for the views of children to be heard in proceedings, they are essentially weak provisions.¹⁴¹ This clearly fails to reach the standard of due process rights set for adults through the

¹³⁶ Mental Health Commission, *Reference Guide Mental Health Act 2001: Part Two – Children* (Mental Health Commission, 2005), at p. 3.

¹³⁷ Law Reform Commission, *Children and the Law: Medical Treatment* (LRC, 2009), at pp. 197–8.

¹³⁸ *Ibid.*, at p. 197.

¹³⁹ Department of Health and Children, *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Stationery Office, 2007), at p. 20.

¹⁴⁰ See for example, Capita Consulting Ireland and Nuffield Institute for Health, *Review of the Guardian Ad Litem Service* (National Children’s Office, 2004); Aoife Daly, ‘Limited Guidance: The Provision of Guardian *ad litem* Services in Irish Family Law’, *Irish Journal of Family Law*, vol. 13(1) (2010), 8–11.

¹⁴¹ Law Reform Commission, *Children and the Law: Medical Treatment* (Stationery Office, 2009), at p. 197.

establishment of Mental Health Tribunals. Moreover, children and young people will undoubtedly benefit from a multidisciplinary approach, and the input from different members of a Tribunal would arguably better suit their needs. Thus the Tribunal may be a more appropriate context in which to discuss the admission and treatment of a child with mental health difficulties, rather than the formal setting of the court.¹⁴²

2.7 Capacity to Consent

It is useful to consider briefly the substance of the matter of capacity to consent and how this may relate to individuals under the age of 18 years. Whilst capacity to consent to treatment is undoubtedly a difficult area, some guidance in Ireland does exist. In *Fitzpatrick v FK (No 2)*,¹⁴³ the Court was called upon to determine whether a life-saving blood transfusion had been lawfully given to a patient who had refused it. In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment, Laffoy J. cited Lord Donaldson in *Re T (refusal of medical treatment)*,¹⁴⁴ who maintained that the test is:

“[W]hether the patient’s cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.”

If the matter of “impairment” was taken from this definition, it could well provide a basis for determining whether a child under the age of 16 years has the capacity to consent in respect of the provisions of the 2001 Act. Whilst adults are frequently preoccupied with categorising children on the basis of age, in actual fact it is extremely difficult, and arguably unhelpful in many cases, to make such generalisations.¹⁴⁵ It is arguable that the issue of medical consent for children under 16 years should not be determined by an arbitrary factor such as age, but rather on the maturity of the individual child, to be determined on a case by case basis by individual professionals. This would protect an immature child from making unwise

¹⁴² Ibid., at p. 198 and The Irish College of Psychiatrists, *Comments on Mental Health Act 2001* (Irish College of Psychiatrists, 2001), at p. 7. Available at <http://www.irishpsychiatry.com/comments.html> last visited 12 August 2010.

¹⁴³ *Fitzpatrick v FK (No 2)*, [2008] IEHC 104.

¹⁴⁴ [1992] 4 All ER 649.

¹⁴⁵ See for example, Gerison Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre, 2005), at p. 24; Sheila Greene, ‘Children as social actors’; paper presented at the Public Conference, *Achieving Rights-Based Child Law*, organised by the Irish Human Rights Commission and Law Society of Ireland in Dublin on 14 October 2006, at p. 4.

decisions, yet enable a mature child of a similar age to make decisions about his or her own health.¹⁴⁶

It is worth noting that amendments to the laws of England and Wales to allow for additional safeguards for incapacitated patients include those made under the Mental Capacity Act 2007.¹⁴⁷ The Act affects people who may lack capacity to make certain decisions, including those with mental health problems. It clarifies who can take decisions in which situations and how they should go about this and also enables people to plan ahead for a time when they may lack capacity. The Act covers major decisions about a number of matters, including healthcare treatment where the person lacks capacity to make the decisions themselves. Most of the Act applies to children aged 16–17 years, who may lack capacity to make certain decisions.

It is arguable that, in order to attain consistency between the Non-Fatal Offences Against the Person Act 1997 and the 2001 Act, decisions made under the 2001 Act regarding treatment of children aged 16 years and over should be automatically subject to a Mental Health Tribunal. This would give recognition to the fact that children in this age group have a decision-making level very similar to that of adults. Children aged below 16 years also have much to contribute to decision-making affecting their lives. This has been recognised in other jurisdictions. It must also be acknowledged that whilst the vast majority of parents and professionals will act in the best interests of the children in their care, a few may not, and safeguards ought to be in place against the latter possibility.¹⁴⁸ For this reason, it is unacceptable to provide significant safeguards for adults who lack capacity but to not extend them to children in the same situation. Although such an extension will require some additional resources, most children admitted are aged between 16 and 17 years and therefore would not fall into the category outlined above. Furthermore, lack of resources would not be an acceptable reason for any other group of individuals, such as women or non-

¹⁴⁶ Consider, for example, the notion of *Gillick* competence in the UK. See further below.

¹⁴⁷ As a response to *HL v UK*, 45508/99 (2004) ECHR 471, in which the ECtHR held that “incapacitated compliant patients” in the mental health context should receive protections similar to those of involuntary patients in order to guard against unlawful detention.

¹⁴⁸ See Geoffrey Shannon, *Third Report of the Special Rapporteur on Child Protection* (Geoffrey Shannon, 2009) for an analysis of the Ryan Report on the abuses perpetrated systematically in State institutions, as well as an analysis of the abuses which have occurred within the family context.

Irish nationals to be left in such a vulnerable position. Neither should it be for children, who arguably need it all the more because of their particular vulnerability.

In Ireland, the Scheme of the Mental Capacity Bill was published in 2008.¹⁴⁹ The Bill proposes to reform the existing Wards of Court system and to replace the Lunacy Regulation (Ireland) Act 1971, which currently applies to the area of incapacitated adults. The Bill proposes to provide increased protection to adults who may lack capacity to make decisions. The Irish Human Rights Commission have called for an amendment of the definition of a “voluntary” patient in the 2001 Act to include only those persons who have the capacity to make a decision to enter care. The Commission has also advised that ideally such an amendment should be contemporaneous with the enactment of a comprehensive Mental Capacity Bill.¹⁵⁰ Like the Mental Capacity Act 2007 of England and Wales, such a Mental Capacity Bill could include those aged 16 years and over. This would provide further clarification of the legal situation of young people with mental health difficulties.

2.8 Admission and Treatment in England and Wales

Until recently practice in England and Wales was similar to current practice in Ireland: children could be admitted to a psychiatric hospital informally by a parent or guardian. In 2002, the Department of Health issued a consultation document which proposed giving young people aged 16 years and over a greater say in medical decisions affecting them and greater protections to those under 16 years who were refusing or resisting treatment. Section 131 of the Mental Health Act 1983 was then amended by Section 43 of the Mental Health Act 2007 in order to end the informal admission of those aged between 16 and 17 years on the ground of the consent of a parent or guardian. The 2008 *Code of Practice on the Mental Health Act 1983* gives detailed guidance on the admission and treatment of children under mental health

¹⁴⁹ See generally Peter Leonard and Martin McLaughlin, ‘Capacity legislation for Ireland: filling the legislative gaps’, *Ir J Psych Med* 26(4) (2009), 165–168.

¹⁵⁰ Irish Human Rights Commission Press Release, “IHRC calls for Mental Capacity Legislation and Review of Mental Health Act 2001 to Protect Rights of Incapacitated Persons and Wards of Court”, 15 February 2010. Available at <http://www.ihrc.ie/newsevents/press/2010/02/>, last visited 12 August 2010.

legislation.¹⁵¹ The views and capacities of children are given prominence in the Code, which states that:

“The law about admission and treatment of young people aged 16 or 17 differs from that for children under 16. But in both cases, whether they are capable of consenting to what is proposed is of central importance.”

Section 131 of the Mental Health Act 1983 provides that where a patient who is 16 or 17 years old has capacity (under the Mental Capacity Act) to consent to admission to hospital for the purpose of treatment, he or she may consent or refuse consent to admission, regardless of the consent of a parent or guardian. This means that if such a young person consents to being admitted for treatment, the individual can be treated as an informal patient in accordance with Section 131, even if a parent or guardian refuses consent.¹⁵²

Where a patient is 16 or 17 years old and has the capacity but does not consent (e.g. if the individual is overwhelmed by the implications of such a decision) or refuses to consent, a parent or guardian cannot consent on behalf of the patient. Professionals are advised under these circumstances to consider whether the patient satisfies all the criteria for detention under the Mental Health Act. If this is not the case, but the professional submits that treatment in hospital is thought to be in the patient’s best interests, the Code advises that it may be necessary to seek authorisation from the courts.¹⁵³ Where such a young person is admitted informally, professionals must decide whether the matter relating to the treatment required falls within the “zone of parental control”. This will depend on a number of criteria, for example the severity of the treatment and whether there is any reason to believe that the parent may not act in the best interests of the child.¹⁵⁴

Where the young person aged 16 or 17 years lacks capacity, Section 131 of the Act does not apply. Where a deprivation of liberty is involved, admission of a 16 or 17 year old cannot be authorised under the Mental Capacity Act, and a parent or guardian

¹⁵¹ Department of Health, *Code of Practice Mental Health Act 1983* (Department of Health, 2008), see pp. 326–354.

¹⁵² *Ibid.*, at p. 334.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*, at p. 239. See further National Institute for Mental Health in England, *The Legal Aspects of the Care and Treatment of Children and Young People with a Mental Disorder: A Guide for Professionals*, (National Institute for Mental Health in England, 2009).

can consent to admission where the matter is within the zone of parental control. If the matter is outside the zone of parental control, then professionals are again advised to consider whether the patient satisfies all the criteria for detention under the Mental Health Act. If not, the Code advises that it may again be necessary in this situation to seek authorisation from the courts.

Children who are under 16 years and deemed to be *Gillick* competent¹⁵⁵ may consent to informal admission. Consent from a parent or guardian is not required in this context. The capacity of a patient to consent should be reassessed in relation to every decision which needs to be made, as it is the view expressed in the Code that “[a] child may have the competence to consent to some interventions but not others,”¹⁵⁶ and also because a mental disorder may cause a child’s mental state to fluctuate significantly.¹⁵⁷ Crucially, children and young people who are detained under the Mental Health Act have the same rights as adult patients to apply to a tribunal which has the power to discharge patients from detention.¹⁵⁸ The Code emphasises that children are to be given assistance at an early stage in order to get access to legal representation for this purpose.¹⁵⁹

2.9 Advocacy, Complaints and Inspections

There is a distinct lack of advocacy services for children in Ireland. The Ombudsman for Children has highlighted the absence of effective advocacy mechanisms for the purpose of representing children and their rights, and to monitor services designed to meet their needs, as a significant obstacle to the implementation of children’s rights.¹⁶⁰ She emphasises that the establishment of independent and effective complaints mechanisms, as well as systems to ensure that the highest children’s rights standards are secured in children’s services, are of vital importance. Such mechanisms are necessary to ensure full protection of the rights of children who are particularly

¹⁵⁵ In the 1985 case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402, discussed in my first report, it was held by the House of Lords that a child may consent to medical treatment if he or she is under 16 years of age but is *Gillick* competent (i.e. has reached a certain level of maturity and understanding).

¹⁵⁶ Department of Health, *Code of Practice Mental Health Act 1983* (Department of Health, 2008), at p. 337.

¹⁵⁷ *Ibid.*, at p. 338.

¹⁵⁸ *Ibid.*, at p. 346.

¹⁵⁹ *Ibid.*

¹⁶⁰ Ursula Kilkelly, *Barriers to the Realisation of Children's Rights in Ireland* (Ombudsman for Children, 2007).

vulnerable, such as children who are very young, sick, in residential care or at risk. Children with mental health difficulties certainly fall into this category. Whilst organisations such as the ISPCC, Barnardos and Headstrong (The National Youth Centre for Mental Health)¹⁶¹ provide some level of community advocacy, no provision exists for advocacy services for children detained in mental health institutions; of the three inspection reports conducted on child and adolescent units in 2009, two noted the absence of an advocacy service for children in such units. The Report of the Inspector of Mental Health Services 2009 on St. Joseph's Adolescent Inpatient Unit, for example, notes that "[t]here was no national advocacy agency for children and information could not be provided."¹⁶² The lack of advocacy services seems all the more inadequate when one considers that children who are unable or unwilling to consent to detention and treatment for a mental disorder, unlike adults, have no right to a review of a decision.

The Mental Health Commission stipulates that if a child is admitted to an adult ward, staff must indicate, as part of their report to the Commission on the admission, if provisions exist "to ensure the right of the child to have his/her views heard", if the child had his or her rights explained (with a report of the level of understanding assumed by any explanation given)¹⁶³ and if the child had access to an age-appropriate advocacy service.¹⁶⁴ This constitutes a positive approach, as such questions recognise that children should be heard and informed. However, as no advocacy service for children admitted for mental health treatment appears to exist, it is unclear how a unit could perform well in relation to the last question. Moreover, such a checklist should be mandatory for all institutions admitting children for mental health treatment, and not just in cases where children happen to be admitted to adult units.

¹⁶¹ See further <http://www.headstrong.ie/>.

¹⁶² Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – St. Anne's Child and Family Centre*, (Mental Health Commission, 2009), at p. 19. See also Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – Warrenstown Child and Adolescent In-Patient Unit* (Dublin, 2009), at p. 19. The final report inexplicably fails to mention this, highlighting the need for greater consistency across such reports. See Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – St. Joseph's Adolescent Inpatient Unit, St. Vincent's Hospital, Fairview* (Mental Health Commission, 2009).

¹⁶³ Mental Health Commission, *Code of Practice Relating to Admission of Children under the Mental Health Act 2001* (Mental Health Commission, 2006), at p. 12.

¹⁶⁴ *Ibid.*, at p. 8.

Another important point as regards the right of children to be heard relates to the availability and accessibility of complaints mechanisms. The Ombudsman for Children draws attention to the many expressions of concern over the general lack of accountability of the Department of Health and Children for its maintenance of healthcare services for children. Moreover, she highlights the extent to which the HSE operates as, and is viewed as, an unaccountable, independent entity, citing the high level of complaints to the Office of the Ombudsman for Children in relation to this body.¹⁶⁵ The Irish Social Services Inspectorate states, for example, that not all HSE areas have a specific complaints policy for children in foster care, and that the complaints policies devised by a number of residential facilities requires revision,¹⁶⁶ indicating that complaints and advocacy services for vulnerable children are generally quite poor within the HSE. Although the Ombudsman for Children has a function to investigate complaints against public bodies in certain circumstances, there are limits to the remit of the Office. The Ombudsman cannot, for example, investigate complaints about action taken by or on behalf of a public body, school or voluntary hospital if the action relates to the administration of the law on asylum, immigration, naturalisation or citizenship.¹⁶⁷ The Ombudsman has expressed concern to both the Oireachtas and the Committee on the Rights of the Child regarding the impact of the limitations on the children affected.¹⁶⁸ Moreover, in the context of children admitted for mental health treatment, a much more targeted and specific service is necessary. The Mental Health Commission outlines in its annual report how it has put Access Officers in place in order to provide assistance and guidance for people with disabilities in accessing procedures in relation to the making and investigation of complaints. Training of Access Officers was carried out in 2009.¹⁶⁹ It is arguable that

¹⁶⁵ Ursula Kilkelly, *Barriers to the Realisation of Children's Rights in Ireland* (Ombudsman for Children, 2007), at p. 107. The Ombudsman for Children notes that 32% of all complaints to her office between April 2005 and December 2006 related to the HSE. See also the *Report of the Ombudsman for Children to the Oireachtas Joint Committee on Health and Children on complaints Received about Child Protection* http://www.oco.ie/assets/files/publications/special_reports_oireachtas/Updated%20reports/ReportoncomplaintsaboutchildprotectionJan2006p.pdf, 30 January 2006, at p. 6.

¹⁶⁶ Social Services Inspectorate, *Inspection of Five Rivers Island and the HSE, Final Report, October 2006* (SSI, 2006), at p. 13.

¹⁶⁷ Ombudsman for Children Act, 2002, Section 11.

¹⁶⁸ See Ombudsman for Children, *Annual Report of the Ombudsman for Children* (2005), and Office of the Ombudsman for Children, *Report of the Ombudsman for Children to the UN Committee on the Rights of the Child on the occasion of the examination of Ireland's Second Report to the Committee* (Office of the Ombudsman for Children, April 2006).

¹⁶⁹ Mental Health Commission, *Annual Report 2009* (MHC, 2009), at p. 73.

such a service is also necessary for children admitted for mental health treatment, as they are a particularly vulnerable group.

It is very positive that in the *Report of the Inspector of Mental Health Services 2009 – St. Joseph’s Adolescent In-patient Unit*, the inspector notes that “complaints policy and procedures were in place. The procedure for making complaints was discussed in detail with the resident and parents or guardians on admission.”¹⁷⁰ The inspector notes that no complaints had been made. In St. Anne’s Unit, it is noted that “[t]he HSE complaints system was in operation. Leaflets were on display in the unit and there were weekly community meetings where residents could voice their concerns and suggestions.”¹⁷¹ In relation to Warrenstown Child and Adolescent In-Patient Unit, the inspector notes that a general information pack about the centre was found to contain a section on complaints although it was not adequately age-appropriate, as was also the case with other information leaflets in the centre.¹⁷² It is commendable that the units are making an effort to provide information on complaints mechanisms, and that those mechanisms appear to be open to children (at least in theory); but without an effective advocacy service to assist children to make complaints, it is unlikely that children will use any more formal complaints mechanisms than those which permit them to make suggestions internally in a unit.

Inspections of child and adolescent mental health units are a vital means through which the vindication of the civil rights of children, amongst other things, can be monitored. The most recent inspection reports in relation to such units include references to facets of the right of children to be heard. This is a positive development; however, no mention is made of children having given their opinions when institutions were inspected. It is arguable that in line with current recognition of the value of children’s views on matters concerning them, children should be consulted in relation to such inspection reports. The reports on historic institutional abuse of children have taught us that children must be listened to.

¹⁷⁰ Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – St. Joseph’s Adolescent In-patient Unit, St. Vincent’s Hospital, Fairview* (Dublin, 2009), at p. 30.

¹⁷¹ Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – St. Anne’s Child and Family Centre* (Dublin, 2009), at p. 30.

¹⁷² Inspectorate of Mental Health Services, *Report of the Inspector of Mental Health Services 2009 – Warrenstown Child and Adolescent In-Patient Unit* (Dublin, 2009), at p. 19.

2.10 European Convention on Human Rights

The ECt.HR has addressed the matter of the detention of children for mental health treatment on several occasions. It has held that all patients detained for mental health treatment must have a right of access to appeal to a judicial body which is independent of the executive and which holds the powers of a court, including the discretion to order discharge.¹⁷³ The judicial body need not be a traditional court, but it must be independent and provide the individual with a right to be heard and a right to be legally represented.¹⁷⁴

The case most relevant to detention of children with mental health difficulties is that of *Storck v Germany*, which related to a German woman who had spent 20 years in psychiatric institutions and hospitals.¹⁷⁵ The applicant was originally admitted at the age of 15 years at the request of her father and against her wishes. Three years later she was admitted to another clinic at her father's request, following various family conflicts. After receiving medical treatment for schizophrenia she developed a post-poliomyelitis syndrome and had, at the time of the case, severe disabilities, such as a lack of ability to speak. In 1994, an expert report stated that she had never suffered from schizophrenia, despite the fact that she had received treatment for such a disorder, but instead that the behaviour which she had displayed was as a result of conflicts with her family. The ECt.HR held that States are obliged under Articles 5 and 8 of the ECHR to ensure the existence of effective supervision and review of decisions to detain individuals for mental health reasons or to treat them without their consent. Furthermore, the Court held that States are also under an obligation to provide effective supervision and review of any deprivation of liberty or interference with the physical integrity of a young person.

Another case which is relevant to the position of children is that of *HL v The United Kingdom*,¹⁷⁶ in which the ECt.HR held that psychiatric patients who could be referred to as "incapacitated compliant patients" (i.e. a patient does not demonstrate resistance but is not considered to have the capacity to consent) should receive protections

¹⁷³ *X v United Kingdom* (1981) 4 EHRR 188.

¹⁷⁴ *Ibid.*

¹⁷⁵ (2005) 43 EHRR 96.

¹⁷⁶ 45508/99 (2004) ECHR 471.

similar to those for involuntary patients, in order to guard against unlawful detention. The applicant had autism and lacked the capacity to consent to medical treatment. He became agitated and engaged in self-harming behaviour in a day centre, and ultimately a consultant psychiatrist determined that he required inpatient treatment. The medical officer responsible for the applicant had considered detaining him compulsorily under the Mental Health Act 1983; however, the professional concluded that this would not be necessary, as the applicant had not resisted admission. As a result of the lack of procedural regulation, the ECt.HR observed that the healthcare professionals at the hospital had assumed full control of the liberty and treatment of the applicant, a vulnerable incapacitated individual, solely on the basis of their own clinical assessments. The Court did not question whether those professionals acted in good faith in accordance with what they considered to be the applicant's best interests. However, the Court laid down that the very purpose of procedural safeguards is to protect individuals against any potential professional lapse, and therefore found that this absence of procedural safeguards amounted to a failure to protect against arbitrary deprivations of liberty and, consequently, to comply with the purpose of Article 5(1) of the ECHR. Following this judgment, the United Kingdom amended its legislation to allow for additional safeguards for such patients: for example it introduced the Mental Capacity Act 2007, discussed earlier in this chapter.

It appears then that, even if some case could be found to defend this highly undesirable situation in which children under the age of 18 years are considered unable to consent to medical treatment, we would still be confronted with a situation in which the Mental Health Act 2001 and Irish practice generally in relation to children and mental health treatment is not compliant with the ECHR. Where a child is considered not to have the capacity to consent, and could therefore, be referred to as "a vulnerable incapacitated individual" it seems that the Convention necessitates automatic review of a decision to detain for the purposes of mental health treatment. As considered above, distinctions between the rights of adults and children in the mental health context must be necessary and proportionate and should have a "reasonable relationship of proportionality between the means employed and the aim sought to be realised".¹⁷⁷ Where children lack capacity, it is unjustifiable to deny them legal rights which are granted to adults in the same situation. Where children have the

¹⁷⁷ "Belgian Linguistic" case, Series A, No. 6, judgment of 23 July 1968, at para. 10.

maturity to consent, or where they resist or refuse to consent, the same point can be argued and legislation in Ireland should recognise this.

2.11 Recommendations

The Mental Health Act 2001 should be amended to include a separate section which clarifies the rights of children in relation to that Act.

Such an amendment to the Mental Health Act 2001 should:

- Stipulate that individuals aged between 16 and 17 years are considered to have the capacity to consent and to refuse consent to admission and treatment. Thus adults and such individuals would have the same rights;
- Require that a mental health professional determine the capacity of children under the age of 16 years to consent on a case by case basis;
- Stipulate that children under the age of 16 years who do not have the capacity to consent to detention and treatment in an approved unit should not be referred to as “voluntary patients” simply because a parent or guardian has provided consent. This group of patients should be referred to as “informal” patients;
- Require that, where a child under 16 years of age is held not to be competent to consent, the decision to detain should automatically be reviewed by a Mental Health Tribunal;
- Stipulate that, where a child under 16 years of age is held to be competent to consent but resists admission and treatment (i.e. refuses to provide consent), the decision to detain should automatically be reviewed by a Mental Health Tribunal.

In addition, a detailed code of practice on admission to and treatment of children within mental health institutions should be published.

Consent should be sought for each aspect of the child’s care and treatment as it arises.

The Mental Capacity Bill should be amended to include persons aged 16 years and older.

An advocacy service should be established which would serve children admitted for mental health treatment. It should assist them, amongst other things, to make complaints where they wish to do so.

A checklist should be created and given to all children admitted to hospital for mental health treatment to ensure that children have been fully informed of their civil rights (e.g. right to information, etc.).

Children should be consulted in the course of inspections of individual units.

SECTION 3: Children and the Criminal Law

3.1 Best Interests of the Child: The Welfare of Young Offenders in Ireland

3.1.1 Introduction

International law emphasises the importance of protecting the welfare of young people who engage in offending behaviour. Article 40(1) of the UNCRC provides that children in conflict with the law have the right to be treated:

“in a manner consistent with the promotion of the child’s sense of dignity and worth, which reinforces the child’s respect for the human rights and fundamental freedoms of others and which takes into account the child’s age and the desirability of promoting the child’s reintegration and the child’s assuming a constructive role in society.”

This assertion requires age-appropriate treatment of children who commit criminal offences. Article 40 of the UNCRC identifies the right to due process and children’s right to have charges explained to them in language they comprehend. The need for an age-appropriate justice system in which the welfare of the child is the focal point is emphasised in the UNCRC. It states that the progression of a youth justice system in which the child’s interests are of paramount importance and the inherent dignity of the child is preserved, must be prioritised.

The United Nations Standard Minimum Rules for the Administration of Juvenile Justice 1985 (the “Beijing Rules”) recommend that every youth justice system should emphasise the well-being of the young person. Article 52 of The United Nations Guidelines for the Prevention of Juvenile Delinquency 1990 (the “Riyadh Guidelines”) requires governments to enact laws that promote the well-being of all young people. Despite the fact that the Beijing Rules have no direct legal effect upon either international or national legislative bodies, they indicate the minimum recommended standards on youth justice matters.

Article 3 of the UNCRC states that “in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative bodies or legislative bodies, the best interests of the child shall be the

paramount consideration.” Article 37(b) of the UNCRC states that no child shall be deprived of his or her liberty unlawfully or arbitrarily. It requires further that the arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

3.1.2 Detention of a Child

It is a well-established principle that the detention of a child should be only a measure of last resort. This principle has been expressly identified by:

- Article 8 of the UNCRC;
- Rule 13.1 (in the context of detention pending trial) and Rule 19 of the Beijing Rules;
- Rules 1 and 2 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty 1990.

These provisions also specify that detention of a child should be for the minimum period appropriate.

3.1.3 The Irish Position

In the Irish legislative framework, the Children Act 2001 (the 2001 Act) adopts the position of international instruments by stating, “a period of detention should be imposed only as a measure of last resort”.¹⁷⁸ In addition, Section 143(1) of the 2001 Act states that a court “shall not make an order imposing a period of detention on a child unless it is satisfied that detention is the only suitable way of dealing with the child”.

A National Study of the Children Court¹⁷⁹ noted that 37% of the young people who were observed being detained (on remand) were committed for breaking their bail conditions and/or failing to appear in court. The research indicated that, although the vast majority of young people are remanded on bail rather than in custody in the Republic of Ireland, there is no support or supervision available to them, and as a consequence, many fail to comply with their bail conditions and are detained on

¹⁷⁸ Children Act 2001, Section 96(2).

¹⁷⁹ J. Carroll, E. Meehan, and S. McPhilips, *The Children Court: A National Study* (Association for Criminal Justice Research and Development, 2007).

remand.¹⁸⁰ In 2008, another study,¹⁸¹ examining the question of young persons aged 16–21 in remand custody, replicated the finding of the earlier national study that the young people under review were frequently remanded in custody as a result of non-compliance with bail. The findings of the later study were based on court and prison research¹⁸² over a two week period. During the court observation, nine individuals were remanded in custody. The reason in eight of these nine cases was non-compliance with bail requirements. Approximately half of the prisoners interviewed were originally released on bail but were remanded in custody due to re-offending, failure to attend court or the breach of bail conditions during the bail period. Less than one-third of the prison study were remanded because of the serious nature of their charge or because they were deemed to be at risk of re-offending. In common with most young offenders, the majority of remand prisoners' alleged crimes were not essentially violent in nature but were related to public order offences and theft.

According to the National Study,¹⁸³ the typical young offender before the courts is a young male, aged 16 or 17, not living with both parents and from a home with many difficulties. Typically, there will be some level of substance abuse in his home by a member of his family. He leaves school before doing his Junior Certificate, has no qualifications and has no engagement with mainstream education. Where literacy levels are assessed, low levels of reading and writing skills relative to the young person's age will be found. The typical young offender comes before the Children Court facing six charges, and will appear before the Children Court again an average of eight times for each of his six offences before his cases conclude some six months after his first appearance. In the meantime, the young offender will be on bail with conditions imposed by the judge which typically include a curfew, restrictions on movement and a requirement to sign on at a Garda Station every day. The usual consequence for the breach of a bail condition is that the accused young person is remanded in custody until the case reaches its determination.

¹⁸⁰ Ibid.

¹⁸¹ Sinead Freeman, 'The Experience of Young People Remanded in Custody: A Case for Bail Support and Supervision Schemes', *Irish Probation Journal*, vol. 5 (2008), 91–102.

¹⁸² The prison research took place at St Patrick's Institution, Cloverhill Remand Prison and the Dóchas Centre between February 2005 and March 2006. This was prior to the change in the system made on 1 March 2007 which prohibits the use of an adult prison for those under the age of 18.

¹⁸³ See also note 179.

In practical terms, a young person's experience undoubtedly impacts upon his or her ability to comply with bail conditions. In essence, the absence of a structured foundation to their lives means that many of these young people are unaccustomed to performing set tasks or attending at times specified in bail conditions. Their unstable, unstructured lives and poor literacy skills are at the root of their difficulty with compliance. Indeed the failure to explain, or the inadequate explanation, of bail conditions further exacerbates this difficulty. While there is a statutory duty, under Section 88 of the 2001 Act, to explain the reasons for detention on remand to young people, a similar obligation is not imposed for those remanded on bail. As stated above, Article 40 of the UNCRC identifies the right to due process and children's right to have charges explained to them in language they comprehend. The right to due process undoubtedly requires a full explanation of the conditions of bail and the implications of failure to adhere to those conditions.

Analysis of the data given in both studies reveals that the vast majority of the young people on remand have little structure or stability in their lives. Freeman's 2008 study reveals that half of those on remand were not engaged in any purposeful, structured activity such as education, employment or training prior to remand. Almost three-quarters admitted using drugs in the six-month period before remand, with nearly one-third of the drug-users taking daily doses of cocaine, ecstasy and/or heroin outside prison. Less than one-half of the prisoners reported receiving assistance for mental health difficulties – primarily depression, aggression and conduct disorder. Despite their young age, many prisoners reported that a number of destabilising events such as family conflict, parental separation, the imprisonment of family members (one-half) and the death of close family and friends had impacted negatively on their support networks.

The operation of our remand system for young persons is callous and self-defeating. The bail system imposes conditions on young persons which many of them will be unable to fulfil, making inevitable the remand that bail is supposed to avoid. Custodial remand appears to affect particularly vulnerable young people who have frequently little or no previous custodial experience. The use of remand custody for such vulnerable young people is an inappropriate and disproportionate measure, particularly in light of the principle of Section 96 of the 2001 Act promoting custody

as a last resort and the provisions limiting the use of custody under the UNCRC.

3.1.4 Additional Implications of Detention on Remand

3.1.4.1 Sentencing

Importantly, the implications of non-compliance with bail are not limited to detention on remand. Where a child released on bail fails to comply with a condition to which the release is subject and is subsequently found guilty of an offence, the court's sentencing may take into account the child's failure to comply with bail conditions and the circumstances in which that occurred.¹⁸⁴ As Walsh states, this may well result in a more severe sentence than would otherwise have been imposed.¹⁸⁵

3.1.4.2 Homelessness

Almost one-fifth of those detained on remand in the 2008 study¹⁸⁶ stated that they had lost their accommodation during their detention. A number of those detainees interviewed were remanded because they had no fixed abode. The Office of the Minister for Children and Youth Affairs in its study *Young People on Remand*¹⁸⁷ highlights the particular vulnerability of young people with unstable housing arrangements to detention on remand by virtue of their life circumstances and the limited availability of alternative care placements. It was recommended that consideration be given to developing and expanding alternatives to detention on remand: specifically services such as bail hostels and remand foster care.

Remand custody fails to address the issues that result in young people failing to comply with bail. Instead, the disruptive effects of custodial remand may result in future breaches of bail. Studies all point to the fact that young people who breach bail would be better served by options other than custodial remand and highlight the important role that bail supervision and support (BSS) schemes could play in the Irish context.

¹⁸⁴ Children Act 2001, Section 90(2).

¹⁸⁵ Dermot Walsh, *Juvenile Justice* (Thomson Round Hall, 2005), p. 89.

¹⁸⁶ Sinead Freeman, 'The Experience of Young People Remanded in Custody: A Case for Bail Support and Supervision Schemes', *Irish Probation Journal*, vol. 5 (2008), 91–102.

¹⁸⁷ Mairéad Seymour and Michelle Butler, *Young People on Remand* (Office of the Minister for Children and Youth Affairs, September 2008), p. 69.

3.1.5 Bail Support Schemes: The Approach in Other Jurisdictions

For legislation in this area to be genuinely effective, policies must be implemented that reduce the risk of detention for young people on remand by supporting compliance with bail conditions and providing means to ensure those in detention are held for the least amount of time possible. Bail support schemes have been widely used in other jurisdictions such as Britain, Canada, Germany, Australia and Belgium, in an effort to improve compliance with the conditions of bail and to reduce the number of young people detained on remand and the duration of detention. Research undertaken suggests BSS programmes have the potential to reduce the number of young people re-offending while on bail and the number detained on remand.

3.1.5.1 United Kingdom

In the United Kingdom, BSS schemes provide targeted, practical support to young people who would not otherwise be given bail. The support is provided by the local Youth Offending Team and may include help with temporary accommodation, health or drugs treatment and support to attend school, training or work. By mitigating some of the risk in granting bail, such schemes give the courts confidence and enable more young people to await trial on bail. There are approximately 155 youth offending teams across England and Wales responsible for working with young offenders. Their duties include working with the courts to provide bail support and to prepare pre-sentence reports, administering non-custodial sentences and the resettling of young offenders in custody. Evaluations of the provision of such programmes show that children and young people are safeguarded and the likelihood of their further offending reduced.

The BSS schemes available in England, Scotland and Northern Ireland generally take the following form. Individuals are selected to participate on a BSS scheme following an initial assessment of their needs, their bail history and current circumstances. This assessment is conducted either at court or in remand custody. Following the assessment, a customised support and supervision programme tailored to each individual is presented and agreed before the court. The programme is subject to continual review during the bail period and regular interactions, including individual case management, supervision of court attendance and compliance with bail conditions, compulsory reporting to a specified individual at a particular location,

group work and regular home visits with parents.

Modified BSS schemes generally contain compulsory and voluntary elements which may include a range of measures to assist individuals while on bail, including substance use interventions, health counselling and referral, training courses, employment advice, liaison with employers and education providers, assistance in finding stable accommodation, referrals to specialist accommodation services, family mediation and participation in beneficial leisure activities. The monitoring of curfews may be made by telephone calls, visits or in some cases voice verification or electronic tagging. BSS schemes staff support court attendance by ensuring the receipt of correct information from solicitors, police and the courts, in addition to promoting responsible attitudes to the court process among individuals and their family members.

Research evidence¹⁸⁸ demonstrates that BSS schemes have a success rate of approximately 80% in preventing re-offending and enabling young people to abide by bail conditions and attend court.

3.1.5.2 An evaluation of BSS: Northern Ireland

In Northern Ireland, the Northern Ireland Office identified the implementation of a BSS scheme as a strategic objective in response to the numbers of young people admitted to custody either on remand from the courts or under PACE legislation. The BSS scheme came into effect in 2003. It was thought that an effective BSS scheme would fulfil obligations under the UNCRC and the expectations of the court and the public that those granted bail should be properly supervised.

Bail supervision and support is defined in Northern Ireland as:

“the provision of services (intervention and support) designed to help young people awaiting trial or sentence to successfully complete their periods of bail within the community by providing support and services matched to the circumstances of the young person, the alleged offence and grounds for refusal of bail.”

The BSS scheme in Northern Ireland is a community-based project designed to help

¹⁸⁸ Bail Support Policy and Dissemination Unit 2000, Youth Justice Board 2002, SACRO 2004.

ensure that young people awaiting trial or sentence successfully complete their period of bail by returning to court on the date due without committing further offences or interfering with the course of justice. The core components of the BSS scheme contain elements of both supervision and support which are based upon issues identified in the initial bail assessment process. The programmes seek to address and effectively manage the risks that the young person may pose to his or her community.

The aims and objectives of the scheme are:

- To provide individual BSS programmes for those at risk of having bail denied or for those whom the court fears may fail to appear and offend if allowed bail;
- To minimise inappropriate remands to custody;
- To ensure that remands to custody only occur when all other options have been explored;
- To ensure that any custodial remand is for as short a period as possible;
- To give the court accurate and verified information to assist in the decision making process;
- To provide support and assistance to young people to prevent breaches of bail conditions; and
- To help ensure that young people attend court as required.

As a pilot, the Northern Ireland BSS scheme focused upon young people remanded in custody. The conclusions of the Northern Ireland Office's Evaluation Report¹⁸⁹ on the scheme state that it makes a positive contribution to the youth justice system in Northern Ireland. Following analysis of data from the Office and the BSS scheme, interviews of the young people and parents, case studies, foster-carer interviews and stakeholder consultations, the Evaluation Report's findings in respect of the BSS may be summarised as follows:

- The ethos of the BSS scheme complements the current legislative requirement that custody is to be used as a last resort for only the most serious and persistent offenders;
- The BSS scheme's approach attempts to engage and support young people. It is a positive, rather than a punitive measure;

¹⁸⁹ Northern Ireland Office, Statistics and Research Branch, *Evaluation of the Bail Supervision and Support Scheme NIO Research and Statistical Series: Report No. 13* (Belfast: Statistics and Research Branch), 2006. www.nio.gov.uk.

- The ideology of the scheme is supported by stakeholders representing a wide range of agencies including the judiciary, the Public Prosecution Services, solicitors and social workers;
- The BSS scheme provides equality of opportunity in that its services are provided to anyone remanded in custody who is deemed to be at risk of having their bail application refused;
- The different elements of the scheme can combine to deal with the courts' concerns, examples of which are issues of accommodation, breach of bail, offending, diversionary activities, supervision and education;
- The BSS team was successful in assessing the level of support required for each individual;
- The bail assessment process ensures that the bail proposal which follows is tailored towards the needs of the court and the young person. It also ensures that proposed bail conditions are based on measured assessments of what is appropriate;
- The courts value the written proposals submitted by the BSS team and often call for their input during the court hearing;
- The terms and conditions of the bail proposal and the agreed BSS scheme means that young people are held accountable for their actions and that a breach of any of the scheme's conditions are a breach of bail;
- The majority of young people wish to obtain bail in order that they may have the freedom to see their friends and family, rather than as a result of their dislike of the Juvenile Justice Centre. This may motivate young people to agree to bail conditions that they may not be able to maintain;
- Discussions with young people found that breach of bail is not necessarily a pre-meditated action. Additional support and activities, for example at weekends, may divert young people away from risk behaviours;
- The available data suggests that the BSS scheme does have a positive impact upon reducing offending whilst on bail and reducing breaches of bail. At the very least it offers support to young people in order to maximise the likelihood that they will adhere to the conditions of the scheme;
- Satisfaction amongst beneficiaries of the scheme in the support that young people receive in obtaining and maintaining bail is high. Individuals on the

Inside Out and the Remand Fostering programmes value the relationships established with the project workers under the BSS scheme. The evidence suggests that this intensive level of support does enable some young people to reintegrate into the community during and after participation in the BSS scheme;

- Comparisons show that the BSS scheme is financially more cost-effective than custodial remand.

3.1.6 Ireland: The Proposed Approach

The research undertaken in the study of the Office of the Minister for Children and Youth Affairs clearly shows the likelihood that young persons benefiting from bail support and alternatives to remand programmes will have a reduced risk of future detention. The study identified a number of issues that have the potential to improve compliance among all young people remanded on bail.

The recommendations were structured around three issues:¹⁹⁰

1. Communicating information to young people and their families:

Effective communication in the courtroom serves to enhance young people's comprehension of the consequences of their actions on themselves, their family, the victim(s) and the wider community, as well as allowing them an opportunity to be heard and to participate in proceedings against them. It is recommended that training in awareness and communication skills be provided to the judiciary and other members of the legal profession in order to facilitate more effective communication with young people about the consequences of complying with the conditions of bail. The time that can legitimately be devoted to explaining bail requirements to young people is limited in the context of a busy courtroom. Taking into account the poor educational history and learning problems experienced by many of the young people concerned, it is recommended that consideration be given to the appointment of a designated bail officer to provide and explain information to young people and their families immediately after the court hearing. Where such a service is impracticable, especially, it is recommended that accessible information be provided in the form of user-friendly leaflets or through the use of communicative technologies such as CDs or DVDs for those with literacy difficulties.

2. Addressing time delays:

Delays in processing cases in the Children Court potentially increase the risk of re-offending and detention for young people. The introduction of a bail information scheme is recommended as a mechanism for coordinating the information about young people required for the court case,

¹⁹⁰ Mairéad Seymour and Michelle Butler, *Young People on Remand* (Office of the Minister for Children and Youth Affairs), 2008, p. 69.

thereby reducing the time taken to process cases.

3. Bail support/alternatives to detention on remand:

Bail support programmes offer an important diversionary route for young people at risk of breaching their conditions of bail and those at risk of detention on remand. The development of a pilot bail support programme by Young Person's Probation is welcomed and it is recommended that priority is given to expanding access to similar programmes in an expedient manner on a nationwide basis.

The Irish Youth Justice Strategy 2008–2010 states its aim as being the development of policies and programmes for young people in conflict with the law in a way that will address the needs of young people and society. The Strategy makes specific reference to bail support, stating that the Irish Youth Justice Service will “work in partnership with the Young Person's Probation (YPP) and other relevant organizations to review current bail information and support arrangements to ensure remands are used as a last resort, in line with the principles of the Children Act 2001 (as amended)”.¹⁹¹ However, in July 2010, it was reported¹⁹² that the planned bail support programme for high risk young offenders had not been commenced because of “costs and planning” issues, a fact confirmed by the Department of Justice and Law Reform.

Under the strategy, a pilot scheme was to be established in Dublin and Limerick by the end of 2008, with national implementation of the programme to occur during 2009. In December 2008, the government stated that work on developing bail support for young people would be progressed as a main priority for the strategy in 2009. The proposed programme was a result of a report, *Young People on Remand*, which found that the most common result (80%) of remand hearings observed at the Dublin Children's Court was a decision to remand a young person on bail. Over one-third (39%) of the 120 professionals consulted for the study noted that young people rarely, or never, understood what it meant to be on bail and only a small minority (4%) thought that young people always understood. The report highlighted that professionals considered the inadequate availability of support services to young people on bail as a substantial reason for the nature and extent of non-compliance

¹⁹¹ Irish Youth Justice Service, *The National Youth Justice Strategy 2008–10* (Irish Youth Justice Service, 2008).

¹⁹² *The Irish Examiner*, Friday, 16 July 2010.

with bail conditions. It concluded that most professionals supported the view that a bail support scheme, whereby barriers to compliance would be identified and addressed during the bail period, would be an effective means of increasing compliance with the conditions of bail. The implementation of the bail support project was due to be reviewed by the Department of Justice at the end of 2010.

The findings of all the studies referred to above suggest that non-compliance with bail contributes considerably to the number of young people on remand. BSS schemes have been acknowledged to have the potential to play a beneficial role in the Republic of Ireland in dealing with the difficulties reported by young people during the bail period. The planned piloting of BSS schemes by the Probation Service was a welcome development in the Irish context. By gaining immediate government and community agency support, BSS schemes may provide better outcomes for young people in the youth justice system than remand custody and thus for society as a whole.

3.1.7 The Conflict – Impeding the Implementation of Recommendations

The Irish government's proposal to include a new protection for children in Article 42 of the Constitution represents a commitment to value and protect childhood. The proposal enshrines the right of the courts to secure the best interests of the child in need of support and care in any court proceedings relating to adoption, guardianship, access or custody disputes. Regrettably, the specific exclusion of court proceedings involving young offenders suggests that the Children's Court is not required to consider the best interests of children who offend.

The exclusion of young people who engage in offending behaviour from this constitutional protection highlights the artificial distinction between neglected and delinquent children. This exclusion is compounded by the National Youth Justice Strategy recommendations that the best interests of young offenders must be weighed against various competing concerns: in particular society's responsibility to the victims of criminal behaviour and community safety.¹⁹³ Such a stance not only defies Ireland's commitments under international law but also disregards the well-established connection between child maltreatment and subsequent youth offending,

¹⁹³ Irish Youth Justice Service, *The National Youth Justice Strategy 2008–10* (Irish Youth Justice Service, 2008).

which confirms that many children who come into care after an offence have experienced deprivations similar to those of non-offenders.¹⁹⁴ Such evidence proves that there is little to distinguish the young person who offends from the young person who is in need of adoption and guardianship or involved in access and custody disputes. However, the proposed Irish approach relegates welfare considerations to a secondary consideration in cases involving young offenders.

A similar approach is adopted in the United Kingdom.¹⁹⁵ It is true that when sentencing the courts are required to have regard to the welfare of the young person who has engaged in offending behaviour;¹⁹⁶ however, this regard for welfare is undermined by the greater weight afforded to the requirement to prevent offending in accordance with section 9 of the Criminal Justice and Immigration Act 2008 Act. This approach is far removed from the United Nations Committee on the Rights of the Child recommendation that the best interests principle be integrated into all youth justice law and policy.¹⁹⁷

Any proposed amendment to the Constitution should involve a review of the Scottish system, which does not distinguish between troubled young people and young people in trouble. Scotland's Children's Hearings system was initiated by the Social Work (Scotland) Act 1968 and is incorporated in the Children (Scotland) Act 1995. There was a concern in the late 1950s and early 1960s that change was needed in the way society dealt with children and young people in trouble or at risk. A committee was therefore set up in 1960 under Lord Kilbrandon to investigate possible solutions. The committee found that children and young people appearing before courts, whether they had committed offences or were in need of care and protection, had common needs. The committee considered that the then existing juvenile courts were not suitable for dealing with these problems because they had to combine the characteristics of a criminal court with an agency making decisions on welfare. Separation of these functions was therefore recommended. The establishment of facts

¹⁹⁴ Andrew Bebbington, and John Miles, 'The Background of Children who enter Local Authority Care', *Br J Soc Work*, vol. 19 (1) (1989), 349–368.

¹⁹⁵ Raymond Arthur, 'Protecting the Best Interests of the Child: A Comparative Analysis of the Youth Justice Systems in Ireland, England and Scotland', *International Journal of Children's Rights* 18(2) (2010), 217–231.

¹⁹⁶ Section 44 of the Children and Young Persons Act 1933.

¹⁹⁷ United Nations Committee on the Rights of the Child, 2008, 26–27.

(where they were disputed) was to remain with the courts, but decisions on what action was needed in the welfare interests of the child was to be the responsibility of a new and unique kind of hearing.

Children's Hearings took over most of the responsibility from the courts for dealing with children and young people under the age of 16, and in some cases under the age of 18, who commit offences or who are in need of care and protection. The hearing panel considers and makes decisions on the welfare of the child or young person before it, taking into account all the circumstances, including any offending behaviour. It has to decide on the measures of supervision that are in the best interests of the child or young person. It receives a report on the child and his or her social background from a social worker in the local authority, and where appropriate from the child's school. Medical, psychological and psychiatric reports may also be requested. Parents and usually the child, if he or she is over the age of 12, are provided with copies of the reports at the same time as the panel members. The hearing discusses the circumstances of the child fully with the parents, the child or young person and any representatives (e.g. the social worker and the teacher) if present. As the hearing is concerned with the wider picture and the long-term well-being of the child, the measures which it decides on are based on the welfare of the child.

In consideration of the fact that the government has suspended the implementation of the proposed BSS system on cost grounds, the complete overhaul of our youth justice system to follow the example of Scotland's is arguably too costly a measure at present. However, the priority afforded to the welfare consideration in the Scottish system can at least be recognised by the implementation of BSS schemes in this jurisdiction.

3.1.8 Conclusion

Despite the studies which reveal that young people who engage in offending behaviour are often those who themselves have endured abuse and disadvantage, the proposed Irish amendment to Article 42 of the Constitution excludes these most vulnerable young persons. The young person who is in need of adoption and guardianship or involved in access and custody disputes is protected; but the young offender's needs are disregarded. All young persons deserve protection in all court

matters; however, it may be argued that by virtue of the potential infringements to due process, young offenders should be afforded greater protection. The distinction between young persons before the courts for access disputes and young offenders is a false one predicated on the government's emphasis on the prevention of offending. Both "categories" of young person share the same characteristics and needs: therefore both groups should be afforded equal constitutional protection of their best interests. Young offenders are victims. Therefore the implementation of a scheme such as the BSS would provide a level of support that these victims urgently require for the protection of their welfare.

Moreover, when considering the importance of welfare, the long-term benefits of avoiding penal custody must be highlighted. Evidence has shown that "welfare and imprisonment are inversely related, States that spend more on welfare will have lower imprisonment and vice versa."¹⁹⁸ Further research supports this fact by demonstrating that BSS schemes are more cost-effective than custodial remands.¹⁹⁹ Therefore investment in programs such as a bail support programme will prove cost-effective in the long-term whilst protecting the welfare concerns of all young people, including young offenders, in accordance with the UNCRC.

3.1.9 Recommendation

The inclusion of young offenders in any consideration regarding the welfare of vulnerable young persons by way of constitutional amendment would represent a unified welfare approach in Ireland that would ensure that the youth justice system is not simply a subsystem of the general criminal justice system. Such inclusion would serve a dual purpose: not only would it prevent the unnecessary incarceration of young people, but it would also help to create a youth justice system that addresses the causes of youth offending.

¹⁹⁸ David Downes and Kirstine Hansen, *Welfare and Punishment; The Relationship between Welfare Spending and Imprisonment*, (Crime and Society Foundation), 2006. See www.crimeandjustice.org.uk

¹⁹⁹ Northern Ireland Office, Statistics and Research Branch, *Evaluation of the Bail Supervision and Support Scheme NIO Research and Statistical Series: Report No. 13* (Belfast: Statistics and Research Branch), 2006. SACRO 2004.

3.2 Inter-agency Cooperation

3.2.1 Introduction

The issue of inter-agency cooperation is of key importance for the national campaign to combat child abuse. This importance is underlined by the State's obligation under Article 3 of the UNCRC to ensure that in all actions concerning children, whether undertaken by public or private institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. Article 3(3) of the UNCRC provides that:

“States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.”

This provision of the UNCRC articulates a basic principle of sound administration in the design and provision of child care and child protection services. Standards governing the provision of those services must be established, services must adhere with those standards and the State must provide sufficient supervision and monitoring. Inter-agency cooperation may be defined as the communication of suspected abuse to all relevant bodies and the formulation of a comprehensive and rapid response that ensures that children are not placed at any further risk by suspected abusers. The Child Care Act 1991 provides the legal framework for child care and protection in Ireland. Section 3(1) of the Act imposes a duty on the HSE to promote the welfare of children who are not receiving adequate care and protection. This duty is central to the Irish child care system and the legislation imposes a positive duty to protect children at risk. This duty can be accomplished by the dual approach of identifying children not receiving adequate care and the effective coordination of information from relevant sources, such as the Garda Síochána and schools. The obligation to share and collect information is endorsed by the *Children First Guidelines* (1999, 2010).

The absence of inter-agency cooperation on child protection issues was highlighted in the Murphy Commission report as a matter of serious concern. The report stated that the lack of coordination within the Catholic Church, as well as the lack of coordination by the various agencies involved, effectively prevented the appropriate handling of complaints of abuse at both investigative and aftercare stages. The

requirement for clear and unambiguous guidelines outlining the various steps to be adhered to was emphasised as an essential issue that had to be addressed. The Ferns Report further highlighted the matter of inter-agency cooperation by its recognition of a significant difficulty in the process of sharing information between the Church, the Gardaí and the HSE.

During 2010, the Irish administrative system underpinning the protection of children has been the subject of further review from various sources. Commentary in respect of the system has been provided by the Ombudsman's report, by way of a document from St. Clare's and St. Louise's Child Sexual Abuse Assessment and Therapy Service and two High Court judgments. In addition, policy change in the administrative system has been reflected in the integration of the *Children First Guidelines* into a new policy document of the Garda Síochána, *The Investigation of Sexual Crimes against Children and Child Welfare* (2010). While there has been no shortage of analysis of child protection requirements, these latest commentaries reflect analysis of the actual practical measures required from the administrative system to tackle child abuse. This analysis of inter-agency cooperation involves an overview of such practical measures, new policies enacted within the administrative system and legal principles that must be adhered to in the context of the exchange of information within agencies and by way of disclosure orders by the court.

3.2.2 Inter-agency Cooperation – Effective Implementation of the *Children First Guidelines*

3.2.2.1 The Ombudsman for Children – April 2010 Report

The Ombudsman for Children issued a report in April 2010 as a result of an investigation into the implementation of *Children First, National Guidelines for the Protection and Welfare of Children*. The investigation reviewed the period from 2003 up to (but not including) 2008 and was conducted under legislation that enables the Ombudsman to initiate an investigation.²⁰⁰ Whilst a number of positive conclusions were reached, a significant number were negative, particularly in respect of findings of unsound administrative practice. In particular, the Ombudsman identified variations in practice, a lack of internal scrutiny and a failure of inter-agency

²⁰⁰ Ombudsman for Children Act 2002, Section 10(1)(a)(ii).

cooperation as issues that must be addressed immediately.

Section 7 of the Ombudsman for Children Act 2002 provides that the Ombudsman for Children shall encourage public bodies to develop policies, practices and procedures designed to promote the rights and welfare of children. Accordingly, the Ombudsman's recommendations for positive change are an important commentary on the issue of child protection. This review will focus on the report's findings in respect of particular aspects of inter-agency workings that must be resolved.

3.2.2.2 Assessment and management of child abuse – the Strategy Meeting

The *Children First Guidelines* contain procedures for the assessment and management of child abuse. The *Guidelines* envisage participation in different inter-agency meetings by those involved in child protection to ensure that assessment and management is effectively conducted. A particularly important meeting required by the *Guidelines* is the Strategy Meeting. The *Guidelines* state that a Strategy Meeting should be considered following preliminary enquiries and submission of notification. The meeting is intended to involve all professionals in a case – particularly An Garda Síochána. The purpose of a Strategy Meeting is to share available information, consider legal options, identify sources of further information and allocate responsibilities for further enquiry, and to agree with An Garda Síochána how the remainder of the inquiry will be conducted.

The Strategy Meeting focuses on a particular case to decide how that case is to be taken forward. A Strategy Meeting is particularly important where a case may have criminal aspects for it will ensure that the HSE works in tandem with An Garda Síochána and the possibility of any prejudice in a criminal investigation will be prevented.

3.2.2.3 Findings of the report – Strategy Meetings

Gardaí consulted for the purposes of the Ombudsman's report stated that Strategy Meetings are often not being held, or are held following a significant time delay. In some cases this has resulted in the child and alleged perpetrator being interviewed without notification to An Garda Síochána. In such circumstances, the potential to prejudice criminal investigations cannot be understated.

3.2.2.4 Joint Garda/HSE working procedures

Another set of important procedures for Joint Garda/HSE collaboration is set out in the *Children First Guidelines*. This is the requirement for the use of joint action sheets, certain forms for notification, and the identification of staff within each organisation for liaison purposes. However, approximately half of the areas reviewed for the purposes of the Ombudsman's report complied with these requirements on paper only. Of the remaining areas there were others that did not comply because of the absence of local information in spite of being provided with HSE/Garda Protocols, others did not utilise joint action sheets and had no structured liaison with Gardaí, despite the existence of substantial informal cooperation in some instances.

3.2.2.5 Requirement for clarity and accountability

The Ombudsman's report emphasised the fact that an effective cooperative working relationship requires not merely liaison between state agencies and the Garda Síochána, but also clarity as to the duties of those involved. This also helps to guarantee accountability. It was deemed that the failure to operate joint liaison arrangements, formal notifications and joint action sheets in many parts of the State greatly obstructed the implementation of the *Children First Guidelines* in the period reviewed and undoubtedly reduced the possibility of the successful prosecution of offenders.

3.2.2.6 Findings of the report

The Ombudsman's report concluded that the failure in the period from 2003 up to (but not including) 2008 to put in place appropriate mechanisms to drive forward inter-agency implementation of the *Children First Guidelines* involved unsound administration as defined in Section 8 of the Ombudsman for Children Act 2002. The report concluded that responsibility for the unsound administration of inter-agency matters lay with the Department of Health and Children to the extent that it related to problems such as Garda/HSE cooperation, variable implementation by Health Boards in the period prior to the creation of the HSE and the failure to ensure inter-agency cooperation more generally, for example through Local Child Protection Committees and Regional Child Protection Committees.

3.2.2.7 Further support for the findings of the Ombudsman’s Report: Briefing Document

The 2010 document from St. Clare’s and St. Louise’s Unit²⁰¹ mirrored many of the concerns and findings of the Ombudsman’s report. It outlined the reality of the failure to universally accept and uniformly apply the *Children First Guidelines*. The document highlights the varying interpretations of the *Guidelines* by different professionals and organisations as to their respective roles and responsibilities.

3.2.3 Improvements: The New Garda Policy Document *The Investigation of Sexual Crimes against Children and Child Welfare* and Revised *Children First Guidelines*

The introduction of the new Garda policy document, *The Investigation of Sexual Crimes against Children and Child Welfare*, and the *Revised Children First Guidelines* (published in 2010 but not yet operational) may improve certain aspects of the cooperative relationship between agencies with particular responsibility for child protection. For example, the procedure in respect of Strategy Meetings may be strengthened by these documents. Whereas previously only the *Guidelines* stated, “It is essential that the designated Garda attend any child protection conferences or strategy meetings to which s/he is invited,” the fact that this statement is now included in a Garda policy document will hopefully result in greater adherence to this important stage in HSE/Garda cooperation. More importantly, now both the Garda policy document and the *Revised Guidelines* enable supervision of this requirement. The *Revised Guidelines* state that “An invitation to attend and an agenda for any child protection conferences should be sent in the first instance to the Garda Superintendent in order to facilitate the attendance of the designated Garda, if appropriate.”²⁰² Similarly, the Garda policy document supports such an arrangement by providing “an invitation to attend child protection conferences will be sent to the District Officer in order to facilitate the attendance of the designated Garda”.²⁰³

²⁰¹ Briefing Document for Minister Barry Andrews, 27 September, 2010 – compiled by St. Louise’s Unit, Our Lady’s Children’s Hospital Crumlin and St. Clare’s Unit, The Children’s University Hospital, Temple Street.

²⁰² *Revised Children First Guidelines*, Chapter 7, Section 7.11.4.

²⁰³ An Garda Síochána, *The Investigation of Sexual Crimes against Children and Child Welfare* (An Garda Síochána, 2010), 31.12.5.

3.2.4 Joint Training and Interviewing: Further Opportunity for Improvement

The 2010 document from St. Clare's Unit and St. Louise's Unit identifies as a serious concern the fact "that it is the exception rather than the rule that there is joint interviewing involving Gardaí and Social Workers". This matter needs to be addressed as currently the reality is that there may be a parallel Garda investigation alongside a child protection investigation. Repeated interviewing by separate agencies can cause the type of trauma and upset for a child that could be avoided by joint interviewing. Effective coordination and training could eradicate this needless duplication of effort with its attendant risk of further trauma to children.

From a legal perspective, limiting the number of times a child is interviewed will reduce the potential for the type of contamination of a child's recollection of events that could lead to the failure to secure a conviction. The document also highlights the professionals' serious concern that requests by the defence in a criminal prosecution for copies of the DVD's of units' interviews and reports could uncover differing accounts of the same events by children during separate Garda and unit interviews, an outcome which would be a significant impediment to a conviction. In a positive development, An Garda Síochána informed the Ombudsman's Office in March 2010 that plans had been made with the HSE to design and deliver joint training nationwide on the *Children First Guidelines*.

However, whilst the Ombudsman's Office welcomed this development, the Ombudsman's report cautioned that "the fact of joint training does not ensure joint working." The creation of proper liaison structures is the cornerstone of joint working. In the absence of such structures, the benefits of joint training and interviewing will be seriously undermined. The Ombudsman's report highlights the serious concern that such structures have not been formally established in significant parts of the State and strongly recommends that joint liaison structures be established in all areas where they are absent.

3.2.5 Garda/HSE Cooperation: Unresolved Ambiguities

Whilst the importance of accountability is highlighted in the *Revised Guidelines*, regrettably they do not fully rectify the issue of ambiguities. For example, the *Revised Guidelines* correct uncertainty surrounding the assignment of personnel, stating that

the liaison team assigns “additional personnel where necessary”; whereas the previous *Guidelines* appeared to stipulate that both the liaison team *and* a Superintendent were to assign personnel. However, an example of continued ambiguity is provided by the ill-defined functions of the liaison management team. For example, it is unclear whether the liaison management team is to oversee joint cooperation generally or in each individual case as the *Revised Guidelines* merely reiterate that their function is to review progress in “the case”. Moreover, the omission of such functions in the Garda policy document undermines the potentially valuable function of internal review by the liaison management team. The Garda policy document simply refers to the functions of the liaison team in general terms: they are to be “responsible for ensuring that interagency liaison occurs and that each Standard Notification Form is appropriately processed” but no undertaking of any supervisory or review duties is stipulated.

3.2.6 A Solution to Inter-agency Cooperation Failings: Statutory Obligation

The *Revised Guidelines* and the Garda policy document are welcome developments that will hopefully bring about real improvement in inter-agency communication. However, it may be argued that any improvements regarding accountability and clarity or strategy meetings as a result of these documents will always fall far short of their full effect in the absence of a statutory obligation placed on child care professions to cooperate. The real compliance with child protection measures envisaged by the Child Care Act 1991 will only be realised when legislation enforces a statutory obligation to comply with the *Guidelines*. The Ryan Implementation Plan 2009 in response to the publication of the Ryan Report contained a commitment to place the *Children First Guidelines* on a statutory basis; however, legislation to fulfil that commitment is still outstanding.

3.2.7 Inter-agency Cooperation: The Requirement to Safeguard the Rights of Alleged Perpetrators

Whilst inter-agency cooperation is essential to combat child abuse, the procedures utilised must safeguard the rights of alleged perpetrators in accordance with constitutional justice and Article 6 of the ECHR. Two recent High Court judgments have provided important direction on the role of the HSE in investigating complaints

of child abuse. The decisions in *M.I. v HSE*²⁰⁴ and in *P. v A Secondary School*²⁰⁵ illustrate the courts' attitude to inter-agency cooperation in child protection.

Both decisions refer to the interpretation given to Section 3 of the Child Care Act 1991 in the 1998 judgment of *M.Q. v Gleeson*.²⁰⁶ In that case, the applicant was enrolled on a childcare course that included a placement in a children's play centre for the duration of the course. The Health Board was aware of previous abuse allegations against him but no criminal proceedings had been initiated against him and no protective proceedings had been taken against him regarding his children. However, when the Health Board was informed of his enrolment on the course they contacted the course providers. He was then excluded from the course placement. The High Court upheld the disclosure and the exclusion as being in accordance with the Health Board's duties under the Child Care Act 1991.

An important statement was made by Barr J. that the obligation to protect children extended to "children not yet identifiable who may be at risk in the future by reason of a specific potential hazard to them which a board reasonably suspects may come about in the future". This statement effectively extends the duty of protection to any child who may suffer harm as a result of any potential for danger that the HSE has knowledge of. Contacting relevant bodies to notify them of concerns regarding potentially dangerous individuals discharges this duty. Such notification must be made solely for the purpose of protecting children. It is not intended to represent a judgment of guilt; rather it simply guarantees that a fair assessment of the complaint may be made by obtaining further information and notifying other relevant bodies of potential risks. In order to make a fair assessment of each complaint, the accused person should be provided with information about the complaint and afforded an opportunity to respond in writing. The *M.Q.* judgment represents a compromise between the HSE's duty to protect children through a process of information management and the procedural protections afforded to accused persons by the rules of natural and constitutional justice.

²⁰⁴ [2010] IEHC 159.

²⁰⁵ [2010] IEHC 189.

²⁰⁶ [1998] 4 IR 85.

The two recent judgments provide some instruction on how that compromise may be carried out in practice. In the *M.I.* case, the applicant had been accused of sexually abusing a 13-year-old girl. He sought to prevent any HSE investigation taking place until criminal proceedings against him were resolved, and to prevent the dissemination of any information about the case. Hedigan J. stated his opinion on the case as follows:

“This type of investigation is a most serious obligation that falls on the respondent. The safety of vulnerable children is at stake. Such an investigation should always occur at the earliest possible time after the risk to a vulnerable child is apprehended and before the risk crystallises into actual harm.”

He further stated the significance of inter-agency cooperation and communication between professionals with a child protection aspect to their roles, in view of its pivotal role in the efficacy of any investigation. The disclosure of any information must be minimal and necessary, and strictly targeted to specific child protection concerns. He argued that the observance of these principles would create a fair balance between the rights and obligations of the State, the accused person and the vulnerable child. This case is currently on appeal.

The *P.* judgment details a serious instance of inadequate inter-agency cooperation in the State. In November 2001, the Health Board in the case received information about alleged sexual abuse committed by a teacher against a pupil in a secondary school. The Health Board failed to notify the Gardaí until January 2002 and it was not until July 2003 that the accusations were relayed to the accused. Several meetings were requested by the Health Board to discuss the allegations, but the teacher refused to attend, having been denied any advance information about the allegations. The teacher was told in December 2003 that if he continued his refusal to attend, his employers would be informed. Between January and November 2005, the Health Board failed to assign a social worker to the case. In December 2005, the Health Board accepted evidence from the victim’s counsellor in America that the complaint of sexual abuse was verified, not on the basis of any investigation but merely from the consistency of his account and his emotional reactions. Thereafter, an inter-agency meeting was held in February 2006. This was the first occasion that the school had access to all the relevant material. At this stage, a social work report was

commissioned which expressed the view that the teacher posed a serious risk to children and he was placed on administrative leave by his school. He was not invited to the meeting at which this decision was made and was prevented from making any representations. It was not until the school held a meeting to renew his suspension that he was allowed to make representations. In January 2007, the suspension was revoked but the teacher chose not to resume his employment while the allegations remained. O'Neill J. refused to prohibit any future investigation, given the public interest in discharging the protective obligations imposed by Section 3 of the Child Care Act 1991.

The astonishing facts of the case highlighted a fault-ridden investigative and collaborative procedure. The Court criticised the Health Board. The State's protective duties as outlined in *M.Q.* and recently restated in *M.I.* were endorsed by the Court. The approach taken by the Health Board wholly failed to serve either the adequate protection of children or to afford even minimal due process rights to the teacher. Firstly, the significant time delays before the Gardaí were contacted, before the school was provided with the information and before an inter-agency meeting was held placed a large number of students in the teacher's care at serious risk. Secondly, the time delays involved between the various stages and the delegation of the investigative process to an American counsellor represented an unjustifiable impediment to the teacher's ability to defend his reputation.

One of the major issues highlighted in the Murphy Commission's report is the lack of inter-agency cooperation on child protection issues. The Gardaí, the HSE and, according to circumstance, the organisation of which the perpetrator is a member, ought to adhere to clear guidelines outlining the various steps which should be taken. The Murphy Report highlights the lack of coordination within the Catholic Church as well as the general lack of coordination stemming in part from governmental inaction on child protection. The matter of inter-agency cooperation was also highlighted by the Ferns Report. The report noted that there had been a significant problem with the sharing of information between the Church, the Gardaí and the Health Board. The problem arose in part because the priests concerned had not been convicted of a criminal offence and hence legal concerns arose around sharing information about these priests among agencies. A new policy was introduced whereby the relevant

information could be shared to better protect children by way of an Inter-agency Review Committee. The Ferns Report stated that:

“The procedure [has] considerable merits. It is a procedure which should and could be adopted in any case in which continuing problems or a series of problems arises in relation to child sexual abuse.”

The report also urges that the authorities should raise at meetings of the:

“Committee, suspicions, rumour or innuendo which are known to them in relation to misconduct of any member of the clergy. ... so often ... in the past, ... after a disclosure of abuse, people in the community claimed to have known for a long time of rumours of wrongdoing or abuse by particular priests. If there are rumours it should be possible between the three authorities to establish whether there is any basis for them.”

However, the recommendation of the Ferns Report was not followed. The Murphy Report states that:

“The Commission has been advised by An Garda Síochána that they nominated and forwarded to the HSE a list of superintendents to sit on the proposed committees but that the HSE has informed participants that it was not proceeding with the committees due to difficulties that arose surrounding the legality of the discussion and use of information that amounts to rumour, suspicion, innuendo or allegations of abuse.”

Reference is made to the Protocol between the Crown Prosecution Services and local authorities in England on the exchange of information in the investigation and prosecution of child abuse cases as a possible model for reform of the law in this jurisdiction.²⁰⁷

3.2.8 Recommendations

Arguably, statutory agencies such as the HSE are not adhering to their duties and regrettably the law is not assisting them to do so. The failure to regulate the exchange of soft information severely compromises the protection of children in the State. The Child Care Act 1991 provides the HSE with very limited powers in non-familial sexual abuse cases. The decision in *M.Q. v Gleeson* dealt with the responsibilities that the HSE has to alleged abusers when it seeks to make information about them known

²⁰⁷ Crown Prosecution Service, Association of Chief Police Officers, Local Government Association of England, and Association of Directors of Social Services, *A Protocol between the Crown Prosecution Service Police and Local Authorities in the Exchange of Information in the Investigation and Prosecution of Child Abuse Cases* (CPS, 2003), <http://www.cps.gov.uk/publications/agencies/protocolletter.html>

to third parties. The only power that the HSE possesses to disclose information to third parties arises from the wide-ranging duty to protect children which is found in Section 3 of the Child Care Act 1991. In the absence of more specific guidance, the ability of the HSE to justify information sharing is largely based on a questionably broad interpretation of its powers. The Murphy Commission requested that the law be clarified in respect of both the duty to disclose information to relevant third parties and any duties to the alleged abuser.

3.2.9 Court Ordered Disclosure of Confidential Records

The 2010 document from St. Clare's and St. Louise's Unit highlights the fact that the defence in sexual abuse prosecution cases frequently seeks units' assessment documents. The assessment documents are provided to the Gardaí with parental consent for inclusion in the Garda file that is issued to the D.P.P's office for the determination as to whether or not a case will proceed to a criminal trial. The Irish Counselling Service has reported a marked increase in applications for access to the complainant's medical and/or therapeutic records in sexual assault cases. Disclosure orders and witness summonses are becoming increasingly common in respect of counselling services, and in the absence of clear practice and/or legislative guidelines on this issue, concerns as to the relevance of such requests, and fears of a decline in those seeking counselling and therapy, or indeed reporting sexual abuse as a result, should be examined.

3.2.9.1 The Irish position

The disclosure of the complainant's medical and psychiatric reports are critical issues central to the procedural fairness of child sexual abuse cases, particularly in respect of child sexual abuse cases of distant origin. However, these important issues have yet to be subjected to sustained analysis and consideration by the Irish Superior Courts. In the absence of such analysis, the principal foundations of the Irish criminal justice system, specifically Articles 40.3.1° and 40.3.2° of the Constitution provide guidance.

Article 40.3.1° requires the State to guarantee respect for the personal rights of the citizen in its laws; Article 40.3.2° requires the State to protect and vindicate by its laws the life, person and good name of every citizen. The Irish criminal justice system fully recognises the constitutional right of the accused to justice. In addition to this

cornerstone principle, the ECHR provides further guidance: Article 6 covers the right of an accused to a fair trial and Article 8 guarantees the right to private and family life, home and correspondence. Article 8 is a qualified right in that it may be interfered with in the interests of the permissible aims of the State. Article 8(2) states:

“There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

3.2.9.2 Northern Ireland

The courts of Northern Ireland have considered the issue of disclosure orders for third-party documents on numerous occasions over the last decade. McCollum J.’s direction on this issue in *The Queen v Hewitt Anderson*²⁰⁸ is instructive:

“In determining what if any material should be disclosed to the defence the court must balance the parties’ respective rights under the European Convention on Human Rights, the defendant’s right to a fair trial under Article 6 and the complainant’s right to respect for their private and family life under Article 8”

McCollum J. further stated that matters should not be disclosed that merely provide material for cross examination or would throw doubt on the general credibility of the complainant, but matters should be disclosed to the defence if there was evidence:

- Of false accusations of any significance having been made against any person by any of the complainants;
- That any other person is alleged to have indulged in sexual activity with any complainant;
- That any significant criminal conviction has been recorded against the complainant on matters directly related to the allegations made which demonstrates the attitude of the complainant to the defendant;
- From medical notes or reports which might reveal a medical condition affecting the reliability of the complainant.

Further clarification regarding the disclosure process is provided by Hart J. in *R v. Hume and Another*:²⁰⁹

²⁰⁸ [2002] NICC 12.

²⁰⁹ [2005] NICC 30, at para. 19.

“In cases involving sexual abuse where issues of public interest immunity and/or confidentiality will inevitably have to be considered ... the proper procedure in such cases is for the solicitor on behalf of a party seeking such an order to write in the first instance to the third party indicating as precisely as possible the category of documents sought ... the letter should then state that as it is anticipated that questions of public immunity and/or confidentiality may arise, application will be made to the crown court for an order directing the production of the documents to the court, and not to the solicitor for the defendant and the court will decide whether any documents require to be disclosed. The Notice Party should also be informed that they are entitled to appear and make such representations to the court whether disclosure should be permitted.”

3.2.9.3 England and Wales

The last 20 years have seen the evolution of the law in England and Wales as regards disclosure orders. The process for disclosure and objection to disclosure has been established by way of legislation and judicial rulings. However, legal argument continues as to whether counselling records are “material evidence” that should be disclosed. The ongoing debate concerns public interest immunity, specifically the balancing of the public interest in justice against the public interest in facilitating access for victims of abuse to counselling for the purpose of restoring their well-being and ability to function in society. The Staffordshire ruling²¹⁰ made changes to criminal procedure rules that resulted in a requirement to advise the person whose notes may be sought that an application exists for disclosure of their records. Such a person must be so notified and afforded the opportunity to make representations to the court before the commencement of the trial. In the event that the person wishes to make representations, the court will arrange a hearing date.

3.2.9.4 Canada

Legislation regulates the use of third-party records in criminal proceedings in Canada. Sections 278.1–278.91 of the Canadian Criminal Code provide a comprehensive system for the use of confidential records in sexual offences cases. The legislation applies to any record containing personal information for which there is a reasonable expectation of privacy including psychiatric, medical, educational, therapeutic, employment, adoption and social services records.

The disclosure process involves a written application to the trial judge. The

²¹⁰ *R. (on the application of T.B.) v Stafford Combined Court* [2006] EWHC 1645 (Admin).

application must detail the reasons for which the accused considers that the record is relevant to the trial. The application must be served on the prosecution, the third party in possession of the record, the complainant and any other persons to whom the record relates. In order to exclude speculative applications, the statute sets out a list of assertions that are insufficient to establish that the record is relevant.

The legislation involves a two-stage process:

Stage 1 – Whether the document should be produced to the judge?

This is decided by an *in camera* hearing. The owner of the document, the complainant and any other person to whom the record relates may make representations. At this stage, the judge will consider the following factors:

1. The probative value of the record.
2. Whether production of the record is based on a discriminatory belief or bias.
3. The potential prejudice to the personal dignity and right to privacy of any person to whom the record relates.
4. Society's interest in encouraging the reporting of sexual offences.
5. The effect of the determination on the integrity of the trial process.

Stage 2 – If the judge decides to view the document, whether the judge should order disclosure?

The judge will consider the matter in the absence of the parties and in arriving at a decision he or she must consider the same factors as at the first stage. The judge must make decisions on the following issues:

1. Whether the defence should see the document.
2. Where disclosure is ordered, whether conditions to protect the privacy of the complainant may be imposed.
3. Whether to make an order that the document be edited or only viewed by officers of the court or that no copies be made or that the accused or counsel for the accused must not disclose the content of the record.

3.2.9.5 Australia

All Australian States apart from Queensland have legislation protecting sexual assault counselling records. Evidence disclosing the content of sexual assault counselling is inadmissible without the permission of the court and the following standards must be met before disclosure can be ordered. The standards for disclosure are:

1. The evidence must have substantial probative value.
2. There must be no other evidence which could prove the disputed facts.
3. The public interest in disclosure must outweigh the potential harm to the complainant.

The legislative definition of harm is:²¹¹ “Actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm such as shame, humiliation and fear.”

3.2.9.6 Scotland

The Coulsfield Review in Scotland²¹² concluded that the common law rules in Scotland regarding disclosure were uncertain and legislation was recommended. The Criminal Justice (Scotland) Act 2010, Part 6 of which deals with disclosure, largely adopts the Review’s recommendations. The legislation explains and extends the duty of the Crown. The Crown’s Staff Disclosure Manual explains that the Crown services must disclose to the defence, “all information received and known to the Crown in the course of the investigation and any criminal proceedings.”²¹³

Section 116 of the Act details the broad range of material that may have to be disclosed to the defence. It is “material of any kind given to or obtained by the prosecutor in connection with the case against the accused.” In addition, the Crown has a duty under Section 121(2)(b) to disclose any information that would materially weaken or undermine the case of the prosecution; or would materially strengthen the case of the accused; or constitutes information that is likely to form part of the case of the prosecution.

²¹¹ Criminal Procedure Amendment (Sexual Assault Communications Privilege) Act 1999, Section 57.

²¹² The Rt Hon Lord Coulsfield, *Review of the Law and Practice of Disclosure in Criminal Proceedings in Scotland* (The Scottish Government, 2007).

²¹³ Crown Office and Procurator Fiscal Service, *COPFS Disclosure Manual: A Guide to the Disclosure of Evidence in Criminal Proceedings and Fatal Accident Inquiries* (8 edn) (COPFS, 2010), para. 13(ii).

The Coulsfield Review identified one of the categories of evidence that should be disclosed to the defence as: “Information which may cast doubt on the credibility or reliability of the Crown witnesses.”²¹⁴ The type of information that may have to be disclosed under the proposed new regime could include any mental health records, or psychological or psychiatric reports in regard to the complainant. It could also include evidence in records held by social work or educational departments, the Children’s Hearings system or similar public bodies.

There are limited grounds for resisting or restricting disclosure. The defence can object if disclosure is withheld, but the complainant has no such right to express an objection. Where information is of a type that needs to be disclosed, there are provisions in the Act to limit the extent of the disclosure. The Crown can redact details that would otherwise be confidential and are not germane to the alleged offence. The Crown can apply to the court under Section 122(4) for an order of non-disclosure of sensitive material if the information in question meets the test for disclosure but its disclosure would be likely to result in any of the following:

1. Causing serious injury, or death, to any person.
2. Obstructing or preventing the detection, prevention, investigation or prosecution of crime.
3. Causing serious prejudice to the public interest.

For complainants in sexual offences cases, the only viable ground upon which to withhold records will usually be that disclosure would “cause serious prejudice to the public interest”. To make a successful application for non-disclosure the Crown has to show that the public interest in the complainant retaining confidentiality of his or her records outweighs the right of the accused to obtain disclosure in order to conduct his or her defence properly and receive a fair trial.

3.2.10 Recommendation

The Irish courts have not considered in any great detail the problems associated with the disclosure of third-party records, such as counselling and medical records relating to the complainant, by the prosecution. In other countries, such as England and Canada, where there is no appellate review of decisions to allow trials to proceed,

²¹⁴ The Rt Hon Lord Coulsfield, *Review of the Law and Practice of Disclosure in Criminal Proceedings in Scotland* (The Scottish Government), at p. 69, Recommendation 7. Also see note 212.

persons with a history of sexual abuse convictions have sought to challenge the lack of proper disclosure of records in order to impugn the fairness of the trial. It is likely that, in light of the reduced numbers of persons seeking prohibition since the decision in *S.H. v. D.P.P.*,²¹⁵ appeals based on the lack of disclosure of such records will become more common.

Ireland urgently requires legislation governing the issue of disclosure. In any discussion regarding potential legislation in this matter, findings of the analysis above regarding other jurisdictions, and in particular the need to balance the complainant's privacy with the accused's right to a fair trial, should be considered.

The Coulsfield Review in Scotland acknowledged the threat to privacy rights as a result of disclosure: “[i]t is therefore fair to say that victims and witnesses have much to lose from an enhanced system of disclosure of information to the accused and his representatives.”²¹⁶ The Review also noted that “the accused's right to a fair trial must ultimately take precedence over any other person's right to privacy.”²¹⁷ As complainants in Scotland are not entitled to their own legal representation, they have to rely upon the Crown to identify and to defend their privacy interests. A difficulty for complainants recognised in the new Scottish legislation is that complainant's privacy interests are not recognised as a separate entity in the Act but are considered only as one component of the “public interest”.

The ECt.HR has ruled that the Article 8 interests of complainants “are in principle protected by other, substantive provisions of the Convention”, which implies that Contracting States should organise their criminal proceedings in such a way that those interests are not unjustifiably impacted upon. The Court has also ruled that in appropriate cases the interests of the defence should be balanced against those of any witnesses or victims called upon to testify.²¹⁸

Any new statutory framework proposed in respect of disclosure should seek to

²¹⁵ [2006] 3 IR 575.

²¹⁶ The Rt Hon Lord Coulsfield, *Review of the Law and Practice of Disclosure in Criminal Proceedings in Scotland* (The Scottish Government, 2007).

²¹⁷ *Ibid.*

²¹⁸ *Doorson v The Netherlands* (1996) 22 EHRR 330, at para. 70.

achieve a balancing act between reconciling the interests of the complainant, the public, and the accused in deciding whether non-disclosure is justified. An alignment of the complainant's privacy interests with the public interest should be sought. One could then argue that the effect of disclosure of personal records would be such a powerful disincentive to report sexual offences and to seek counselling/therapy that it does seriously prejudice the public interest.

The issue of who would in fact represent a complainant's privacy interests should also be considered. The D.P.P. may well find that the duties of serving the public interest and representing the complainant's right to privacy are in irreconcilable conflict. The D.P.P. cannot both serve the public interest and adequately shield the complainant from disclosure applications. Arguably, in the absence of any express statutory rights for advocacy of a child complainant's interests, and with no guidance given as to the degree of consideration or protection he or she will be afforded, the right of a child complainant to privacy is seriously undermined.

One option that would recognise the vulnerable position of complainants in these circumstances is to acknowledge that their privacy rights are discrete and distinct from the public interest and therefore justify the appointment of an independent legal adviser who would be a Children's Advocate. The appointment of a Children's Advocate is permitted in Canada where it has long been recognised that the disclosure of records in such situations raises serious issues of privacy and equality. Rape complainants are entitled to instruct their own counsel to look after their interests in applications by the defence for recovery of medical and therapeutic records and other confidential papers such as diaries. Canada accepts that "the values protected by privacy rights will be most directly at stake ... where the maintenance of confidentiality is crucial to a therapeutic, or other trust-like, relationship."²¹⁹

As do Canadian citizens, Irish citizens have the benefit of a constitutionally protected right to privacy. Therefore, if the Article 8 rights of complainants are to be fully recognised, it may be argued that they must be provided with independent legal representation to protect their interests.

²¹⁹ *R v Mills* [1999] 3 S.C.R. 668, at para. 89.

3.2.11 Recommendations Regarding Legislation and/or a National Protocol Regarding the Disclosure of Information in Cases of Abuse

The establishment of a National Protocol for the Exchange of Information in relation to the Investigation and Prosecution of Cases of Abuse is an important development in child protection. To date, the absence of such a protocol between the HSE, the D.P.P. and An Garda Síochána has impeded the exchange of information in the investigation and prosecution of cases involving abuse.

Whilst it may be argued that legislation would provide a greater possibility of success, the effectiveness of protocols within the United Kingdom is noteworthy. There the recently updated *Working Together to Safeguard Children* document provides a comprehensive guide that is consistently complied with across the United Kingdom. The aim of any new legislation and/or the protocol should be to provide agreed practice for the parties as to the sharing and exchange of information in the investigation of cases of alleged abuse and for the purposes of criminal prosecutions.

When drafting new legislation and/or a new protocol, the HSE, An Garda Síochána and the D.P.P. should be mindful of the current inter-agency frameworks already in existence. New measures must utilise existing frameworks as a foundation to establish a transparent process with clear, unambiguous guidelines for the sharing of information. An independent review committee must also be made available to ensure that the system is working appropriately and to support transparency.

An Effective Solution

New legislation and/or a new protocol should supplement the existing policy and legislative tools that already provide guidance on inter-agency work. Measures should also be put in place to correct the existing administrative failings in respect of *Children First* as highlighted above. Thus the measures required for an effective solution can be summarised as follows:

1. New legislation and/or a new national protocol regarding inter-agency cooperation and the exchange of information should:
 - Be unambiguous;
 - Set out clear criteria to assist in dealing with exchanging soft information;

- Be transparent;
 - Be such as to ensure accountability;
 - Be designed to be in the best interests of the child.
2. Legislation to place the *Children First Guidelines* on a statutory basis, thereby ensuring a collective duty to report concerns of neglect or abuse of a child.
 3. The continuance of joint training to aid collaborative inter-agency workings.
 4. Legislation regarding court ordered disclosure that supplements any new legislation and/or protocol regarding inter-agency cooperation.

3.3 The Criminal Justice (Public Order) Act 2011

3.3.1 Introduction

The Criminal Justice (Public Order) Act 2011 introduces new laws restricting begging. The legislation was drafted in response to the High Court judgment of *Dillon v D.P.P.*²²⁰ in which the legislation governing this issue, Section 3 of the Vagrancy (Ireland) Act 1847, was found to be unconstitutional. The High Court held that the prohibition against begging represented a breach of the right to freedom of expression and freedom to communicate as protected by Article 40.6.1° of the Constitution. In addition, the Court held that the offence of begging as provided by the 1847 legislation was so vague and ambiguous that it also represented a breach of Articles 34.1, 40.1, 40.3 and 40.4.1° of the Constitution because of its lack of certainty. However, the Court stated that there was nothing in its decision to prevent the Oireachtas from enacting new laws to control begging. The Court considered that the right to freedom of expression can be limited for the common good and in the public interest in certain circumstances. On that basis, the 2011 Act does not prohibit all forms of begging, it instead seeks to prohibit begging only where such activity is accompanied by unacceptable behaviour such as harassment, intimidation, assault, threat or obstruction.

²²⁰ (2007) I.E.H.C. 480.

Section 2 of the Act creates a summary offence that imposes a class E fine, a custodial sentence of up to one month or both.

Section 3 affords new powers to An Garda Síochána to give directions to persons who are begging in particular locations or circumstances. Members of An Garda Síochána are now able to direct a person who is begging to desist from acting in that manner and to leave the vicinity of that place in a peaceful manner.

Subsection (2) provides that a Garda may exercise the new power where the person is begging at or near the entrance to a dwelling, an automated teller machine or a vending machine. Subsection (3) provides that directions may be given where the person is begging at or near the entrance to a business premises at any time when that premises is open to the public for business and the Garda has reasonable grounds for believing that the behaviour or number of persons begging is deterring the public from entering that premises. A person who is begging near a business premises but in a manner that is not interfering with customers may not be subject to a direction. The conditions in subsection (2) or subsection (3) must be met before a direction can be issued. In other words, the begging must be causing obstruction or intimidating potential customers, or it must be causing, or likely to cause, people to stay away.

Section 4 establishes the powers of arrest under this legislation. The section provides that the Gardaí may arrest without warrant any person who is reasonably suspected of having committed an offence under Sections 2 or 3. A Garda may require a person arrested under this section to give his or her name and address. Any person who fails to comply with this request or who gives false or misleading information is guilty of an offence and is liable to a class E fine upon summary conviction. Subsection (5) provides that a person's address may be a place that he regularly visits. The Minister for Justice and Law Reform stated in the Dáil, "this has been added to facilitate persons who are without a permanent address and it ensures they can comply with the request for details of his address from the arresting Garda". The Minister when presenting the legislation to the Dáil, further stated:

"It enables us to update the law on begging in a manner that is not only consistent with the Constitution, but in a way that ensures maximum effectiveness in enforcement, with reduced

emphasis on prosecutions and penalties. It targets those whose begging presents an unacceptable interference with the normal conduct of life in society.”

3.3.2 How the Legislation will Affect Children

When presenting the legislation to the Dáil, the Minister for Justice and Law Reform stated: “I want to make clear that the present Bill does not in any way alter section 247 of the Children Act 2001. That section makes it an offence to procure or to control a child for the purposes of begging.” It may be argued that such a statement provides little assurance that children will not be disproportionately affected by the legislation. The 2011 Act contains no minimum age for the commission of the offence. It was recently reported²²¹ that the number of children begging in Dublin is on the increase with 966 sightings in 2009 as opposed to 887 in 2008, a 9% increase on the previous year. According to the Leanbh service of the Irish Society for the Prevention of Cruelty to Children, whose volunteers spent 1,120 hours engaging with children on the streets last year, the majority of those begging belong to Roma and Traveller communities and there is also a small number of homeless children begging.

3.3.3 Recommendations

The 2011 Act pursues enforcement and excludes rehabilitative intervention and support. Any legislation restricting begging should at the very least be supported by a protective measure for children begging, their welfare being of paramount importance and the instance of a child begging constituting the very essence of welfare in jeopardy. The *Revised Children First Guidelines* categorise four types of child abuse: neglect, emotional abuse, physical abuse and sexual abuse.

The *Guidelines* define neglect in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care. The *Guidelines* further state; “Neglect is as potentially fatal as physical abuse. It can cause delayed physical, psychological and emotional development, chronic ill-health and significant long-term damage. It may also precede, or co-exist with, other forms of abuse and must be acted upon.”

²²¹ Annual figures released on 9 November, 2010 by Leanbh; reported by *The Irish Times*, 9 December 2010.

The Gardaí are required to report concerns of abuse to the HSE. It may be argued that the criminal law enforcement provided by the Criminal Justice (Public Order) Act 2011 must be integrated with a clear policy obligation to report the fact of a child begging to the HSE.

The Garda policy document states “all signs (of abuse) must be considered in the wider social and family context”. It may be argued that the fact of a child begging represents a clear sign of neglect that must be reported to the HSE and acted upon in order to protect the child.

The statement by the Minister for Justice and Law Reform that there is no economic justification for begging is untenable in the current economic climate. The HSE introduced a funding freeze on services dealing with homelessness in July 2008. This resulted in people, including children, being turned away from emergency accommodation. The demand for such services cannot be met; therefore the number of children begging is likely to increase further.

Forcing a child to beg is an infringement of his or her rights, in particular his or her right to education, and is a degrading activity. Moreover, children and young people who are forced to beg are very vulnerable to exploitation and abuse. This vulnerability is exacerbated by the lack of a 24 hour nationwide social work service and the closure of two city centre hostels which catered for homeless boys and girls aged 12–18. The cost of imprisonment should be directed towards the rehabilitative intervention and support that the Gardaí should be required to initiate by way of reporting instances of children begging to the HSE.

3.4 Criminal Law (Sexual Offences) Act 2006 – High Court Challenge Rejected

On the 26 March 2010, the High Court rejected a challenge to the Criminal Law (Sexual Offences) Act 2006 that was based on a claim of gender discrimination. The challenge was based upon the claim that the young male accused should not be prosecuted for having sex with a 14-year-old girl when he was 15 years of age, under the 2006 law that allows boys to be prosecuted for such offences but excludes girls

from prosecution. The case arose out of the so-called “Romeo and Juliet” provision in laws introduced in 2006 as a response to the Supreme Court judgment in the *C.C.* case overturning as unconstitutional the provisions of the Criminal Law (Amendment) Act 1935 on underage sex on the grounds of the absence of a defence of “reasonable mistake” as to the victim’s age.²²² The boy had challenged Section 3 of the 2006 Act that created an offence of defilement of a child under 17 years of age and provided for a sentence of up to five years’ imprisonment. He had linked that challenge to Section 5 of the Act that states a girl under 17 cannot be guilty of such an offence.

In her ruling Dunne J. held that while the relevant law did amount to gender discrimination, such discrimination was not invidious or capricious. As the risk of pregnancy as a result of underage sex was borne by girls only society was entitled to deter such activity and to place the burden of criminal sanction on those “who bear the least adverse consequences” of it.

Dunne J.’s reasoning may be summarised as follows: the measure provided for different treatment of boys and girls and as such it had to be viewed as being discriminatory on grounds of gender; but the fact that there was case law legitimising discrimination founded on difference in capacity or social function of men and women allowed for discrimination that is not invidious, arbitrary or capricious. Dunne J. stated that Section 5 did provide for specific immunity from prosecution in a very limited set of circumstances and a similar approach had been taken by law-makers in other jurisdictions. The objective of the 2006 Act was to protect children from sexual abuse and it dealt with a complex and wide range of sexual activities, circumstances and levels of culpability. It provided that immunity from prosecution applied to the one area of sexual activity that can result in pregnancy and the consequence of such activity carried no risk for boys or men. The risk was only borne by girls.

Dunne J. referred to a study during the case that showed the younger the age of sexual intercourse, the greater the probability of a negative outcome such as the increased risk of unintended pregnancy, sexually transmitted diseases, lower educational and job attainment as well as a greater risk of poverty.

²²² *C.C. v. Ireland* [2006] 4 I.R. 1.

It was stated that the “adverse consequences that flow from under-age sex fell to a greater extent on girls rather than on boys”. Far from being an example of “good old fashioned discrimination”, as claimed by counsel for the boy, or a form of “rough equalisation”, the 2006 Act provides a limited immunity to girls in the one area of sexual activity that can result in pregnancy.

Dunne J. held that “Society is entitled to deter such activity and to place the burden of criminal sanction on those who bear the least adverse consequences of such activity.” The 2006 Act goes “no further than necessary” to achieve this object and if it were the case that the adverse effects of underage sex were borne equally by boys and girls, there would be no rational basis for the difference in treatment of both sexes.

As that was not the case, Dunne. J. concluded that the discrimination identified in Section 5 of the 2006 Act was “legitimated” because it is founded on difference of capacity, physical or moral, or difference of social function of men and women, in a manner which is not invidious, arbitrary or capricious. The judge also agreed with the State that the equality provisions of the ECHR do not bring the matter “any further” than the provision in Article 40(1) of the Irish Constitution that all persons are equal before the law. The case is currently on appeal.

SECTION 4: Trafficking of Children and Prostitution – A Review

4.1 Previous Reports

In the 2007 and 2008 editions of this Report the issues of child trafficking, grooming and child pornography respectively were considered.²²³ A number of recommendations were made therein. A number of years have since passed and it would appear that implementation of the steps necessary to protect children from these acts remains outstanding. There have been recent calls from NGOs for these issues to be assessed once again.²²⁴ This Report supports those calls for reform.

4.2 Domestic Reform

Clearly, children by their very nature are vulnerable to exploitation. Empirical research shows that child prostitution in Ireland is an issue of serious concern. Unfortunately, by its very nature the prevalence of child prostitution is difficult to properly identify and assess. Indeed the UN Committee on the Rights of the Child in the concluding observations to its 2006 report commented, with concern, on the lack of information available in Ireland on this issue. The first step that needs to be taken to address this concern is to calculate properly the scale of the problem and identify where it is most prevalent; having done so a tailored response could be developed to deal with the problem. Rhetoric can only go so far. There is no doubt that all stakeholders in this area from the Government, to NGOs and even the Special Rapporteur on Child Protection honestly give voice to their credible concerns on this issue. However, action is required. Admittedly, in these economically stringent times, the availability of the finances required to tackle this problem may be a cause for concern. Whilst that should not be the case, nonetheless an air of realism is required and those who act in the area of child protection need to adapt to the general change

²²³ Geoffrey Shannon *Report of the Special Rapporteur on Child Protection* (Geoffrey Shannon, November, 2007), Section 4; Geoffrey Shannon, *Second Report of the Special Rapporteur on Child Protection* (Geoffrey Shannon, October, 2008), Section 3.

²²⁴ See for example, ECPAT International and Children's Rights Alliance, *[Ireland] Country Progress Card* (ECPAT International and Children's Rights Alliance, 2010).

in economic circumstances that has swept the country. This does not mean that there ought to be a curtailment in child protection services. Instead, it is suggested that forward planning and assessment of the problems concerning children should be concluded before action is taken. A greater understanding of the problem should lead to a more direct route to tackling it. Identification of the root cause will then enable those in the field to focus their efforts, which in turn should result in economically sustainable child protection services in Ireland.

The ground work required for this has been done to a large degree by various NGOs throughout the years, and they ought to be commended for this. Such organisations have identified problem areas and indeed the causes of same. It is now incumbent on the government to utilise public funds to tackle these problems.

As noted above, of particular concern at present, despite previous reports, is the issue of child trafficking and prostitution. Barnardos has identified a number of causes for this: firstly the demand for paid sexual services in this country. Simple economics dictates that if demand for a product/service falls then so too does the supply. Thus, if Ireland reduces the demand for paid sexual services, the numbers involved in prostitution, including children, will also fall. To achieve this, payment for sexual services must be penalised. This would have the knock-on effect of reducing child trafficking as it has been shown that one of the main purposes for child trafficking is sexual exploitation.

The Immigrant Council of Ireland has established an alliance, *Turn Off the Red Light: End Prostitution in Ireland*, which highlights the position in Sweden and Norway in which the purchase of sexual services is penalised. On 1 January, 1999, Sweden became the first country to introduce legislation penalising the purchase, but not the sale, of sexual services.²²⁵ It is a comprehensive provision in that it applies to any form of compensation provided in return for sexual services, including payment by way of alcohol or drugs. In addition, it applies if payment is made conditional on the service first being provided and even if a person other than someone availing of the service provides the compensation. A person found guilty of an offence may be fined

²²⁵ Chapter 6, Section 11 of the Penal Code.

or imprisoned for up to six months. The operation of this law was reviewed after 10 years and it was found to have led to a reduction in the number of men paying for sexual services in Sweden, coupled with a reduction in the number of women and children being trafficked for the purposes of sexual exploitation.

Barnardos also identifies the categories of children involved in child prostitution as follows:

1. Those who have left the care system.
2. Those who have experienced homelessness.
3. Those who suffer from alcohol and/or drug addictions.
4. Separated and trafficked children.

Those children who have left the care system are a cause of particular concern. These are children brought into care by the State because the State was obliged to care for them in circumstances where the biological parent(s) would not or could not. A biological parent's moral duty to care for his or her child does not end upon the child reaching the age of majority; indeed nor does the legal duty.²²⁶ Why then should the duty on the State to care for such children end upon the child reaching the age of majority? Adequate aftercare facilities are required so as to ensure that a child makes the transition from being in care to being a contributing member of society. This is not the case at present, and it is an issue that should be addressed immediately. In addition, for those children who have left care, irrespective of their age, a nationwide out-of-hours social work service ought to be provided.

Other matters also remain outstanding. In the 2007 edition of this Report, it was recommended that an offence of grooming be introduced into Irish law. To date, this has not occurred. For reasons set out in the 2007 Report, such an offence ought to be introduced. Also, in 2000, Ireland signed the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, but it has yet to ratify same.

²²⁶ See by way of example Succession Act 1965, Section 117.

4.3 Developments at European Union Level

The first development to note is that following the passing of the Lisbon Treaty, the European Union Charter on Fundamental Rights has been incorporated into Irish law. Article 5(3) expressly prohibits the trafficking of human beings. Under Article 24 of the Charter the rights of children are expressly recognised. There is now a legal imperative to act in this area so as to prevent the trafficking of children into and out of Ireland.

As trafficking of human beings is an international phenomenon, the European Union has recognised that the best means of dealing with this problem is at European Union rather than State level. Thus, while preserving the principle of subsidiarity, the European Union has proposed a Directive “on preventing and combating trafficking in human beings, and protecting victims”.²²⁷ The proposed Directive has passed the first reading stage of the European Parliament. The European Union recognises that one of the root causes, if not *the* root cause, of trafficking in human beings is social vulnerability. Thus the proposed Directive is not only aimed at preventing trafficking but also at providing support and assistance to the victims of trafficking so as to try to prevent those persons from falling victim once more.

The proposed Directive seeks to “establish minimum rules concerning the definition of criminal offences and sanctions in the area of trafficking in human beings”.²²⁸ Article 2 imposes a mandatory obligation on member states to ensure the following intentional acts are punishable:

“The recruitment, transportation, transfer, harbouring or receipt of persons, including exchange or transfer of control over that person, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.”

²²⁷ European Commission, *Proposal for a Directive of the European Parliament and of the Council on preventing and combating trafficking in human beings, and protecting victims, repealing Framework Decision 2002/629/JHA* (COM (2010) 95 final – 2010/0065 (COD)).

²²⁸ Article 1.

The proposed Directive also seeks to impose a mandatory obligation on member states to assist and provide support to victims of human trafficking.²²⁹ Specific obligations are proposed in relation to child victims of trafficking;²³⁰ in particular those concerning the rights and representation of a child victim in criminal investigations and proceedings.

It is not known when, or indeed if, this proposed Directive will enter into force. As it is a Directive, it would not become automatically enforceable in Irish law. A transposition period of possibly two years would operate to enable member states to introduce domestic legislation that would meet the requirements of the Directive. Indeed, in accordance with Protocol 21 annexed to the Treaty on the Functioning of the European Union, Ireland may choose not to adopt the Directive. Whilst Ireland is legally entitled to opt out of this Directive, it is recommended that we do not exercise this option. Evidently child trafficking is a global problem and is one from which Ireland is not immune. Global problems require global solutions. Therefore, to properly tackle the problem of child trafficking in Ireland it is incumbent upon the State to adopt the Directive if and when it becomes operative and transpose the same to the fullest extent into Irish law.

4.4 Recommendations

The trafficking of children for any purpose is unacceptable in any modern society. It would appear that one of the main purposes of the trafficking of children is that of sexual exploitation. It is necessary to eradicate the demand for this and this requires the introduction of stringent laws designed to go to the root of the problem. It is recommended that consideration be given to the position in Sweden and Norway, and indeed the United Kingdom, in which the purchase of sexual services has been penalised, with a view to introducing a similar system in this country.

It is also recommended that adequate aftercare support systems be put in place to assist and support children who leave State care to make the transition to becoming independent members of society. In addition, out-of-hours social services support ought to be made available nationwide.

²²⁹ Article 10.

²³⁰ Articles 12, 13 and 14.

Legislation needs to be enacted to criminalise the grooming of children. In addition, whilst Ireland has signed the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, it should ratify same forthwith.

At present, the European Union is proposing a Directive on preventing and combating trafficking in human beings, and protecting victims. Whilst Ireland is legally entitled to opt out of this proposed Directive, it is recommended that it does not.

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