# Report of the Task Force

# on

# Residential Care

*December 1999*

## 1. Introduction:

**1.1** The Task Force was established with the objective of developing a strategic for residential care. This will be used by the Eastern Health Board to identify how residential care may best meet the needs of children and will inform an overall strategy for residential care in the Eastern Health Board region.

Over the last two decades the number of children being placed in residential care has reduced significantly with the development of fostering as a placement option. As a consequence, the role of residential care is perceived to have shifted to a more specialist service for children. Yet this shift has not been subjected to analysis to date; no definitive policy has been set down to give residential care a clear and defined place in the spectrum of alternative care services. The changing role of residential care has brought new and greater challenges to staff working in the direct provision of this service. The needs of children requiring residential care is greater now and residential care workers face many demands of their skill, energy and knowledge. This has not been found wanting, even in a climate where there can be much uncertainty and unpredictability. It is intended that this policy document will provide a newly focused direction for residential care clarifying, as it does, its role and purpose.

Residential care is hugely expensive in comparison to other forms of alternative care. For example, in 1999 expenditure on residential care will reach £17.6m, compared to £5.7m for family care. Such expenditure on residential care may well be necessary, but it does need to be justified. The Task Force on Residential Care, while reinforcing the need for residential care, offers a revised context for its use which must be seen in the wider context of family support and family care.

It is the stated policy of the Eastern Health Board that children should live in their own home where possible, and where this is not possible that they should live in the nearest possible approximation. Despite this emphasis on family care as a preferred option for most children, the provision of residential care within the Eastern Health Board region has increased in recent years. There are now 54 residential homes

providing a range of services for children. Within the spectrum of alternative care services there appears to be a heavy reliance on residential care, which is even being provided to children of a very young age.

Residential care, like any social service, must reflect the national policy (Shaping a Healthier Future) of promoting social gain. Therefore each placement made should be designed to enhance the social wellbeing of the child, and should represent the best option for each child at that time.

Because of these trends it is timely that the purpose and function of residential care is clearly defined, and that this definition informs the establishment of a strategic framework for residential care. Hence the establishment of a Task Force on residential care.

## 1.2. Composition of the Group

The group comprises a mixture of administrative and professional staff, each of which has relevant knowledge and experience:

Mr. Paul Harrison, Director of Child Care and Family Support Services (Chair)
Mr Ray Kavanagh, Administrator, Children & Families Programme;
Mr John Fennell, S.E.O., Child Care, Park House;
Ms Marilyn Roantree, Head Social Worker, Community Care Area 2;
Ms. Colette McAndrew, Child Care Manager, Community Care Area 1;
Ms Michelle Clear, Child Care Manager, Community Care Area 5;
Ms Rita Brosnan, Manager, Bartres Residential Centre;
Ms Ann-Marie Reilly, Manager, Glenview Residential Centre.

***Former members who contributed to the work of the Task Force include:***

Clare Egan, former Residential Manager, Goldenbridge;
Gerry Devine, former Administrator, Child Care Services;
Shay Smith, former Administrator, Child Care Services;
John Davis, former Administrator, Child Care Services;
Brid Clarke, former Director of Child Care and Family Support Services
and current Programme Manager, Children and Families.

## 1.3 Terms Of Reference

The original terms of reference included a number of operational as well as strategic objectives. The operational objectives were subsequently excluded when the Task Force commenced its work and these were dealt with elsewhere. In particular the work of Mr. Mike Laxton is highly relevant in this regard. The Children and Families Programme commissioned him to undertake a review of each individual residential children's homes in the Eastern Health Board region.

A number of general themes emerged from this work and were made available to the Task Force so that this contemporary information could be used to inform policy. In the light of this development the Task Force focused primarily on policy matters with the following terms:

- **To identify the role purpose and function of residential care in the context of the totality of child care and family support services in the Eastern Health Board region.**

## 1.4 Process

The group met in session on a large number of occasions. Its continuity was affected by a number of membership changes, including its original chairperson, Brid Clarke. To redress the adverse effect of these changes a consultant, Ms Mary Rafferty, was employed to undertake direct work with the group. She did this in association with Mr. Dave O'Brien. With this assistance the group produced a statement of purpose for residential care, together with a number of tasks, all of which have been incorporated into the final report.

# 2. Residential Care in Context

**2.1** From the outset the Task Force found it difficult, if not impossible, to consider residential care in a vacuum, separate from other forms of alternative care and family support. Therefore certain values and principles attended to in the introduction, need to be emphasised at this early juncture.

**2.2.** The report of the Consultative Planning Group (1994) has transpired to be a foundation of basic child care policy.

The concept that children should first be supported in their own home in the first instance is respected in the mission statement of successive Service Plans. The Review of Child Care and Family Support Services (Tutt Report) also drew attention to the underspending in the area of promotional activities. It follows that such a policy must be underpinned by a strategic plan of action. Two initiatives need to be taken to before residential care is considered as an option

**2.3.** Firstly, Community Care Areas need to be sufficiently resourced with family support services. It is not within the remit of the Task Force to prescribe what these services might be. However the Task Force does assert that such services should be accessed before residential care is considered. The concept of 'shared rearing', for example, is an attractive prospect.

A model of 'shared rearing' currently exists for the Travelling Community. This scheme provides for the fostering of Traveller children by members of the Travelling Community. This Task Force believes that the concept could be successfully extended to other groups of children.

**2.4** Secondly, in keeping with the Board's policy, family care should be considered as a first option where alternative care is required. In this regard the Task Force believes that the boundaries of family care could be explored further, and indeed that the boundaries between family support and family care need not be as rigidly defined as they currently are.

Again it is outside the remit of the Task Force to make recommendations in this regard, but a few examples may help to pave the way for further work in this area:

**(i)** The Community Drugs Team in Community Care Area 5 is currently piloting a form of family care, which does not necessitate the formal admission of a child to care.

(ii) The Daughters of Charity at Lisdeel House are in partnership with the Eastern Health Board piloting a fostering scheme in association with their residential care service. The concept is to recruit foster families specifically for children who are currently in care at Lisdeel, thus tailoring a care package to the individual children's needs.

(iii) Community Care Area 3 is attempting to recruit suitably qualified carers to foster a chronically ill child. The allowance will be sufficient to off set the need for alternative employment.

(iv) Other countries employ foster parents on a contract basis, with a sliding scale of fees depending on the degree of difficulty of the placement. There is a strong consensus of opinion that the current fostering allowances are simply too low to attract sufficient numbers of foster parents. It is argued that, in some cases at least, fostering should be seen as a fulltime job.

(v) Following from the above the Task Force considers that the time is right to commence a debate on the merits of 'professional' fostering. Given the degree of difficulty which some children present, combined with the difficulties associated with recruiting 'volunteer' foster parents, there is an argument for having some carers on a full time wage to provide family care to a defined category of children.

(vi) Supported Lodgings is another relatively new scheme, which works for certain groups of children. The essential difference between this and fostering is that the carers are not expected to play a part in the management of the care plan. This scheme was established to meet the needs of older children. However it now needs to be reviewed as its remit has unofficially expanded. Furthermore, analysis of the success of this scheme may well have relevance to other forms of family placement.

**(vii)** Relative foster care has recently become the biggest growing form of family placement. In 1993 only 37 relative placements were in place. This rose to 253 in 1998. It is noted that, in addition to the appropriate use of relative foster care, some applications arise as a means of a relative needing the additional finances required to care for a child who might otherwise not require to come into care. It would undoubtedly be of assistance to a large number of relatives if an income maintenance payment system were in place for relative carers who might not otherwise require the services of a health board.

**(viii)** The role of the community child care worker needs also to be acknowledged as an effective means of family support in the community, and a major contributor to the prevention of admissions of children to care. In a similar way the part played by Family Support Workers has also provided support to families at a community level.

**2.5** Residential care services cannot be considered in a vacuum without the above services being considered as first options. Residential care must not be seen as a substitute for foster care. Alternative care services need to be sufficiently robust to allow residential care to be used as an appropriate response, and not simply as the only available placement.

In this regard the Task Force is concerned that some children are placed in residential care for the want of alternative family care. There has been a recent trend in the recent past to facilitate special arrangements for the placement of children in residential care. If the same latitude could be applied to family care greater varieties of placements could be made. This may have to involve methods of financial support.

## 3. Purpose Of Residential Care

The Task Force has devised the following definition:

**The purpose of residential care is to provide a safe, nurturing environment for individual children and young people who cannot live at home or in an alternative family environment at that time.**
**This environment aims to meet, in a planned way, the physical, educational, emotional, spiritual and social needs of each child**

**3.1** For residential care to fulfil this purpose a number of key issues need to be addressed. These form the basis for the following chapters. However, before developing these issues, the following represents a snap shot of residential care as it currently exists in the region.

The following tables indicates the number of residential homes in the region, together with some basis information:

## Residential Care in the Eastern Health Board Region:

| Name | Bed Capacity | Gender | Type |
|---|---|---|---|
| Arrupe Society | | Boys Over 18' | Short Term |
| Balcurris Boy's Home | 6 | Boys | |
| Ballymun Residential | 6 | Girls | Long Term |
| Belvedere Social Services | 6 | Boys | Aftercare (Short Term) |
| Cottage Home 1 | 8 + 6 Day Care | Mixed | Long Term |
| Cottage Home 2 | 6 | Boys | Long Term |
| Cottage Home 3 | 6 | Mixed | Long Term |
| Crosscare 1 | 4 | Boys | (Short Term) |
| Crosscare 2 | 4 | Boys | After Care (Short Term) |
| Crosscare 3 | 9 + 2 Emergency | Boys | Short Term |
| Daughters of Charity 1 | 7 | Mixed | Long Term |
| Daughters of Charity 2 | 6 | Mixed | Long Term |
| Don Bosco 1 | 8 | Boys | Long Term |
| Don Bosco 2 | 3 | Boys | Aftercare (Short Term) |
| Don Bosco 3 | 6 | Boys | Aftercare (Short Term) |
| Don Bosco 4 | 8 | Boys | Long Term |
| Focus Point | 6 + 2 emergency | Mixed | Medium to Short Term |
| Homeless Girls Society | 12 +2 Emergency | Girls | Long & Short Term Beds |
| Los Angeles Society | 30 | Boys | Long Term |
| Miss Carrs Home 1 | 7 | Mixed | Long Term |
| Miss Carrs Home 2 | 5 | Mixed | Long Term |
| Miss Carrs Home 3 | 2 | | Closed at Present |
| Mrs Smyly's Home 1 | 12 | | Long Term |
| Mrs Smyly's Home 2 | 6 | Boys | Long Term |
| Salvation Army | 10 (Semi Independent) | Girls | Short Term |
| Sisters of Charity 1 | 7 | Mixed | Long Term |
| Sisters of Charity 2 | 7 | Mixed | Long Term |
| Streetline Hostel | 4 | Boys | Long Term |
| Traveller Families Care 1 | 8 | Mixed | Medium to Long Term |
| Traveller Families Care 2 | 8 | Mixed | Long Term |

## Eastern Health Board Residential Care Units

| Name | Bed Capacity | Gender | Type | Managed by CC Area |
|---|---|---|---|---|
| Aislinn | 5 | Girls | Semi Ind. Living | 2 |
| Amiens Street | 6 | Mixed | Long Term | 7 |
| An Grianan | 8 | Girls | Long Term | 7 |
| Bartres | 8 | Mixed | Long Term | 5 |
| Belclare Terrace | 6 | Mixed | Family Group Home | 7 |
| Blaithin | 8 | Mixed | Long Term | 6 |
| Clan Og | 4 | Mixed | Family Group Home | 3 |
| Creag Aran | 6 | Mixed | High Support Unit | R |
| Crossfields | 3 | Mixed | Long Term | 5 |
| Cuan Solas | 6 | Mixed | Family Group Home | 7 |
| Foxfield Road | 4 | Mixed | Family Group Home | 8 |
| Glenview | 6 | Mixed | Long Term | 6 |
| Goldenbridge | 12 | Mixed | Long Term | 5 |
| Gracepark Meadows | 6 | Mixed | Family Group Home | 7 |
| Ivy Cottage | 6 | Mixed | Family Group Home | 9 |
| Keeloge | 8 | Mixed | Short Term | R |
| Killinarden | 4 | Mixed | High Support Unit | R |
| Milbrook House | 6 | Mixed | Long Term | 3 |
| Newtown House | 8 | Mixed | High Support Unit | R |
| Owendoher House | 6 | Mixed | Long Term | 3 |
| Park View House | 5+3 | Mixed | Short Term | R |
| Pinecroft | 6 | Mixed | Family Group Home | 8 |
| Pineridge | 4 | Mixed | Family Group Home | 8 |
| St. Annes | 8 | Girls | Long Term | 1 |
| Tallaght Project | 6 | Mixed | Long Term | 4 |
| Vineyard | 6 | Mixed | Long Term | 10 |

**3.2** Traditionally residential care was provided in the form of orphanages and industrial schools. Many of these developed with the times into modern group homes and still form part of the fabric of residential care today e.g. Goldenbridge, Mrs Smyly's Homes, Lakelands.

**3.3** In addition so called 'hostels' developed for children who were regarded as homeless. e.g. The Homeless Girls Society, Don Bosco, Los Angeles.

**3.4** More recently there is an emphasis on high support units for children whose behaviour and emotional difficulties make it very difficult for them to be cared for in conventional care settings. These services have brought residential care into an era where non-offending children can be detained on an involuntary basis. This situation was brought about largely by High Court rulings when advocates for children in need of placement sought to have their rights vindicated by way of judicial review. The Task Force is concerned about a trend, which seems to have emerged as a result of these cases whereby the Court can be seen as a medium through which to acquire a high support placement.

There is no doubt that the behaviour of certain children has become more challenging in recent years. This has led in turn to increased numbers of unplanned discharges from children's homes. With such a history of discharges some children quickly become 'unplaceable' in the current system, and subsequently go on to become the subject of Judicial Review. It is not uncommon for such Judicial Reviews to take place against a background of there being a number of vacancies within the residential sector. However, individual homes feel either unwilling, or unable, to provide care for particular categories of children. Thus the care system itself can militate against the welfare of children where a placement is not forthcoming because of unsuccessful previous placements.

Policy in this area needs to reflect the sprit of Article 37 of the U.N Convention on the rights of the child, which advocates the right of the child to liberty.

**3.5** The advent of the Children Bill 1999 needs to be taken into account when planning for residential services. Among other things it will require health boards to provide for the detention of children on Special Care Orders. Within the Eastern Health Board planning and development of High Support and Special care Units is well under way. However there is a danger that unless these services are seen in the context of a continuum of care provision for children, they will be used as a means to an end when children are hard to place, rather than being reserved for children who specifically need to be placed in such settings.

**3.6** The provision of after care is emerging as an important transitional phase between care and independence. Research indicates that the absence of such service provision greatly increases the risk of significant social-medical difficulties in later life. The Task Force is of the view that policy for after care should reflect its semi-independent status. This would eliminate the practice of providing 24-hour care. Furthermore, a plan needs to be drawn up for the provision of after care based on a projection of need for such services. There is no doubt, given the restrictions in the private rented sector, young people leaving care need help in making the transition into independent living. Consideration should be given to the preparation of a joint action plan with the voluntary sector for the provision of accommodation under the social housing schemes.

**3.7** The requirements of children and young people who are actively misusing drugs are another emerging issue. It is evident that, at best, existing services are finding these children difficult to manage.

**3.8** The Board currently has examples of residential homes being established to care for sibling groups. There is some debate as to whether residential care is automatically a better option in such cases, or whether separate placements in family care would be preferable. The Task Force believes that this debate can be resolved by appropriate care planning in each individual case.

**3.9** A rapidly emerging issue is the particular needs of unaccompanied minor asylum seekers. Their diverse cultures, languages, and other requirements must be catered for appropriately.

## Management Policy

**4.1** In the past individual children's homes stood alone as independent service providers. They alone determined the type, gender and age of the children they assisted. Their only relationship with the Board was as the funding authority. Current healthcare management theory and practice, and legislation have changed this. There now needs to be a regional plan for residential care where each individual home, whether voluntary or statutory, in the range of services for children requiring residential care. For this to happen agreement needs to be reached between the Board and each residential home on its individual purpose.

**4.2** Service agreements need to be entered into with each home where its purpose is agreed. The agreement should cover such issues as for whom the service is to be provided, placement capacity, quality requirements, agreed budget and what support will be provided to facilitate the achievement of the task.

As part of this process agreement should be reached with voluntary organisations regarding the membership and role of admission/discharge committees.

With the exception of such services as may be designated regional facilities each children's home should be assigned to a particular Administrative Area. Each Area should have an agreed admission discharge policy with each children's home. .

In addition to a regional plan and individual service agreements a plan is also required for each Health Board Area.

**4.3** In considering the regionalisation of residential care cognisance must be made of the division of the Eastern Health Board into three distinct Area health boards. Therefore it would be remise of the Task force not to offer some guidance in this regard.

The totality of residential care, with the exception of regional services, should be divided between the three health boards on the basis of demonstrable need. When this is achieved it should be possible for individual health boards to trade or buy placements from each other.

**4.4** Reciprocal arrangements could usefully be explored between named children's homes whereby each could provide respite care for the other.

**4.5.** Boundaries between residential care and other forms of care and family support need to become more flexible. One example, already mentioned, is the fostering scheme out of Lisdeel children's home. Also, in some other health boards residential child care workers also undertake work in the child's family home.

**4.6** With the advent of the ERHA consideration needs to be given to distribution of children's homes across the new health boards. This is particularly so where voluntary organisations have different sites in different areas. For example, Travellers Family Care has a home in Wicklow and another in Dublin South –West.

**4.7** With the advent of service agreements Eastern Health Board staff representation on Boards of Management needs to be clarified. However, the Task Force finds that some degree of interaction between health board staff and voluntary homes is a good thing. The Partnership model offers a similar example in another area. A distinction needs to be drawn between staff acting in an advisory capacity and an executive capacity. The latter is not considered to be appropriate. A policy needs to be written on the exact purpose of staff representation on such Boards and the liability of such representatives needs to be clarified.

## Staffing

**5.1.** The recruitment and retention of staff is a major issue for the Board as a major employer of child care workers, as well as for voluntary organisations. The Task Force notes and supports a recent initiative to bring managers together to consider ways of improving recruitment and retention policy.

**5.2.** It is unsafe to presume that current child care training adequately equips new graduates to fit perfectly into the Board's requirements for residential care. . Induction courses should be introduced and repeated on a rolling basis, focusing on the particular needs of our children in care.

In addition the content of the professional training course for residential care needs to be reviewed with the colleges.

Opportunities for joint training between residential and field staff should be developed.

**5.3.** Due to the absence of sufficient numbers of adequately trained child care workers the Board, should develop on-site training in association with the qualifying authority. In addition, provision should be made for similar training in the voluntary children's homes.

**5.4.** Existing staff members who are unqualified should be able to avail of the above training as well as new members of staff.

**5.5** A training scheme should be introduced whereby long term unqualified residential staff are automatically placed on a course of in-service training.

**5.6** A management-training package needs to be introduced for residential managers, including financial management, supervision and other relevant areas.

**5.7** The current management structure needs to be reviewed. In particular difficulties arise in deputising for the manager. Consideration should be given to the establishment of the post of Deputy Manager.

**5.8** The structures that are in place should be those best serve the needs of the child. Rosters need to reflect this policy. The practice of 24-hour shifts should be examined in the light of this, as should the provision of double cover while all the children are out at school. Furthermore, the role of the residential manager needs to be a balance between administrative duties and care management.

**5.9** The on-call system, which relates to the above, is a national issue which needs to be addressed.

**5.10** The distinction between the grades of Assistant House Parent and House Parent is unclear, in the context of areas of responsibility. A generic grade of residential child care worker should be considered. Again, this relates to difficulties arising from a deficiency in the deputy manager structure, and can only be addressed at a national level.

**5.11** As with nursing grades child care workers are striving for professional status, which would be reflected by the conferring of a bachelor degree. There needs to be a harmony between the employer needs and the training provided. In this regard the imparting of life skills to a child are as important as the provision of therapy. There needs to be a sufficient mix of qualifications, experience and skills to ensure that the total needs of the child are met.

**5.12** Residential managers currently report to social work managers. This raises an issue of professional equity whereby one profession reports to another. However this is not unique and can, for example, be found in the paramedical departments of large general hospitals. Nevertheless the Task Force considers that this line management function should not be delegated to social work team leaders.

**5.11** There needs to be recognition that gender balance is an issue in the selection and maintenance of residential care teams. The needs of the service, and of the children concerned, need to be balanced against employer obligations with regard to equality legislation. Likewise, the Task Force favours the provision of mixed gender units for children. Children homes, which are exclusively single-sex should be reviewed in the light of this policy indicator.

## 6. Quality of Care

**6.1** The Task Force notes and welcomes the launch of the new national child abuse guidelines, Children First, which lays down very clear procedures for the welfare and safety of children. Similarly, the joint Eastern Health Board/Western Health Board document entitled Standards and Criteria for the Inspection of Children's Residential Centres is to be welcomed. These standards set out the perimeters for monitoring performance within the residential sector. It is anticipated that the new office of the Social Service Inspectorate will have similar effect within the health board services. However, even in the light of these developments certain fundamental policies need to be adopted and adhered to :

**6.2 Every child in care should have a social worker.**

**6.3 Residential care should be confined to children over 12 years of age.** It is considered that it is extremely difficult to cater for the developmental needs of a younger child outside of a family setting. The placement of a child under 12 years in residential care is quite likely to militate against the chances of a successful family placement later. Hence, it can be seen that it is vitally important that the provision of family care and residential care are planned for and delivered in tandem.

**6.4 Every child in care must be the subject of a care plan, which should be reviewed according to the standards set of in the Regulations for the Placement of Children in residential care.**

**6.5** Notwithstanding the requirements of the Standards and Criteria in Residential Care document, the Task Force considers it as a basic consideration that each centre must have a statement of purpose, agreed with the Health Board, clearly setting out its aims and objectives.

**6.6** These statements of purpose need to be fed into a regional plan for the Eastern Health Board which should represent a 'fit' between the needs of the children requiring care and the services on offer.

**6.7** The physical condition of some children's homes needs to be addressed. This is probably most acute within the Eastern Health Board itself.

**6.8** In particular, the provision of maintenance services to health board homes is problematic in many areas. Simple issues such as grass- cutting, minor plumbing and decoration can assume insurmountable proportions. A streamlined maintenance system urgently needs to be introduced. A policy of availing of local service providers should be adopted.

An improved system of maintenance within Eastern Health Board homes is required in order to keep in minimum standard of estate management in place. Realistically a dedicated budget is required for this purpose.

It should be seen as a normal part of a child's social development to be involved in normal household decisions and activities such as, for example, the selection of colour schemes and the painting of one's own bedroom.

**6.9** Sufficient sleeping space is another issue. By no means all children have their own bedrooms. This is a safety matter which affects staff as well children. An audit of bedroom space needs to be undertaken within the Eastern Health Board. However, the Task Force considers the policy in this area needs to reflect normal family life as much as possible, and therefore the appropriate sharing of bedrooms needs to be considered.

**6.10** In the main residential managers do not know their budget and, in any event, have very little discretion on the way in which it is spent. Managers should be the budget holder, and should receive training to be able to undertake this task. They should have the flexibility to administer the budget with some discretion, within the normal perimeters of accountability.

**6.11** There is no evidence of standardised record keeping in children's homes. Models of practice appear to have developed out of individual homes in the absence of any overall practice guideline. A standard for the content and format of records needs to be introduced.

**6.12** A more lateral approach to the use of residential care needs to be introduced. For example, residential care could be used on a part-time basis, such as three days per week where appropriate. The flexible use of residential care in ways such as this could increase bed occupancy and be more responsive to the individual needs of children.

**6.13** A further example of where a lateral approach is needed can be seen in some of the current examples of after care provision. Some of these services have reverted to the status of children's homes whereby staff provision on a 24-hour basis is required. The Task Force is of the view a policy for after care should reflect its semi-independent status. Furthermore, a plan needs to be drawn up for the provision of after care based on a projection of need for such services. There is no doubt, given the restrictions in the private rented sector, that young people need assistance in this area. In particular, young people leaving care need help in making the transition into independent living. Consideration should be given to a joint action plan with the voluntary sector for the provision of accommodation under the social housing schemes.

## 7. Conclusion

This report re-affirms the place of residential care as an essential part of the spectrum of family support and alternative care services in the Eastern Health Board region. It emphasises the need to consider residential care as an integral part of these services, and that it should be considered only in this context. The contribution of residential care workers to the advancement of residential care into a modern and professional service cannot be over-stated.

Residential care works best when it is provided in partnership with the other key stakeholders, namely the children's social workers and families.

The purpose of residential care has been clearly defined in the report and needs to be borne in mind as other services are being developed. Some of the issues highlighted in the report have national implications, and do not lend themselves to a local solution. Yet, as they are both pertinent and of fundamental importance, it was considered appropriate that they should be included in the report.

Finally, having reviewed re-defined the role and purpose of residential care, it is important to reiterate that the use of alternative care, in all its forms, should only be resorted to in the absence of a better alternative, and on the understanding that the particular placement is in the best interest of the child.