National
Children's
Resource
Centre

Barnardos
EVERY CHILDHOOD LASTS A LIFETIME

Information Pack

Child Protection

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Contents:

Principles for Best Practice in Child Protection

The principles that should inform best practice in child protection include the following:

- The welfare of children is of paramount importance.
- A proper balance must be struck between protecting children and respecting the rights and needs of parents/carers and families; but where there is conflict, the child's welfare must come first.
- Children have a right to be heard and taken seriously. Taking account of their age and level of understanding, they should be consulted and involved in relation to all matters and decisions that affect their lives.
- Early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection.
- Parents/carers have a right to respect and should be consulted and involved in matters which concern their family.
- Actions taken to protect a child, including assessment, should not in themselves be abusive or cause the child unnecessary distress. Every action and procedure should consider the overall needs of the child.
- Intervention should not deal with the child in isolation; the child must be seen in a family setting.
- The criminal dimension of any action cannot be ignored.
- Children should only be separated from parents/carers when all alternative means of protecting them have been exhausted. Re-union should always be considered.
- Effective prevention, detection and treatment of child abuse require a co-ordinated multi-disciplinary approach.
- Any intervention should be culturally sensitive and take account of the languages spoken by all parties involved, e.g. Irish speakers.
- In practice, effective child protection requires compulsory training and clarity of responsibility for personnel involved in organisations working with children.
- Early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection.

(Taken from **Guidelines for the Protection of Children in Early Childhood Services** by Barnardos NCRC**)**

The Legal Context

- The UN Convention on the Rights of the Child
- Child Care Act, 1991
- Domestic Violence Act, 1996
- Freedom of Information Act, 1997
- Protections for Persons Reporting Child Abuse Act, 1998

The UN Convention on the Rights of the Child

Ireland ratified the UN Convention on the Rights of the Child in 1992. The Convention is essentially a "bill of rights" for all children, outlining rights relating to every aspect of children's lives such as the right to survival, development, protection and participation. Principles such as:

- non-discrimination – all rights apply to all children;
- the best interests of the child – all actions concerning the child shall take account of his or her best interests;
- survival and development – every child has the inherent right to life, and the state has an obligation to ensure the child's development;
- the child's opinion – the child has the right to express his opinion and have it taken account of in any matter or procedure affecting him or her.

In addition, the Convention recognises the critical role of the family in the life of the child.

The Child Care Act, 1991

The main legislation governing the care and protection of children is the Child Care Act, 1991.

- It places a statutory duty on every health board to "promote the welfare of children in its area who are not receiving adequate care and protection."
- In addition, it strengthens the powers of the health boards to provide childcare and family support services.
- It enables the immediate intervention of health boards or An Garda Síochána where children are in danger.
- It enables the Courts to place children who have been abused or who are at risk, in the care of or under the supervision of the health boards.
- It provides arrangements for the notification and inspection of pre-school services –Child Care (Pre-school Services) Regulations, 1996, Child Care (Pre-school Services) (Amendment) Regulations, 1997 and Explanatory Guide to Requirements and Procedures for Notification and Inspection.
- It revises the provisions for registration and inspection of residential care centres.

Domestic Violence Act, 1996

This Act introduced major changes in the legal remedies for domestic violence. These are:

Safety Order – which prohibits a person from further violence, but does not require that person to leave the family home.

Barring Order – which requires the violent person to leave the family home.

This Act gives the health boards the power to intervene to protect individuals and their children from violence, and to apply for orders on behalf of a person, if they are deterred from doing so through fear or trauma.

Freedom of Information Act, 1997

This Act enables members of the public to obtain access to information in the possession of public bodies. Under the Act, a person has:

1. A right of access to personal information relating to themselves, subject to certain conditions;
2. A right to correct this information if it is inaccurate.

The exemptions and exclusions which are relevant to child protection include the following:

1. Protecting records covered by legal professional privilege;
2. Protecting records which would facilitate the commission of a crime;
3. Protecting records which would reveal a confidential source of information.

Protections for Persons Reporting Child Abuse Act, 1998

The main provisions of this Act are:

1. The provision of immunity from civil liability to any person who reports child abuse "reasonably and in good faith";
2. The provision of significant protections for employees who report child abuse.

(Taken from **Guidelines for the Protection of Children in Early Childhood Services** by Barnardos NCRC**)**

Definition and Recognition of Child Abuse

Introduction

Child abuse can be categorised into four different types: neglect, emotional abuse, physical abuse and sexual abuse. A child may be subjected to more than one form of abuse at any given time. The National Guidelines have adopted the following definitions of child abuse:

Neglect

Neglect is normally defined in terms of an *omission,* where a 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, or medical care.

Harm can be defined as the ill treatment or the impairment of the health or development of a child. Whether it is *significant* is determined by his/her health and development as compared to that which couldreasonably be expected of a similar child.

Neglect generally becomes apparent in different ways *over a period of time* rather than at one specific point. For instance, a child who suffers a series of minor injuries is not having his or her needs met for
supervision and safety. A child whose ongoing failure to gain weight or whose height is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived or intellectual stimulation. The *threshold of significant harm* is reached when the child's needs are neglected to the extent that his or her well being and/or development are severely affected.

Emotional Abuse
Emotional abuse is normally to be found in the *relationship* between a caregiver and a child rather than in a specific event or pattern of events. It occurs when a child's needs for affection, approval,
consistency and security are not met. It is rarely manifested in terms of physical symptoms. Examples of emotional abuse include:
(i) persistent criticism, sarcasm, hostility or blaming;
(ii) conditional parenting, in which the level of care shown to a child is made contingent on his or her behaviours or actions;
(iii) emotional unavailability by the child's parent/carer;
(iv) unresponsiveness, inconsistent or inappropriate expectations of a child;
(v) premature imposition of responsibility on a child;
(vi) unrealistic or inappropriate expectations of a child's capacity to understand something or to behave and control himself in a certain way;
(vii) under or over or under protection of a child;
(viii) failure to show interest in, or provide age appropriate opportunities for, a child's cognitive and emotional development;
(ix) use of unreasonable or over harsh disciplinary measures;
(x) exposure to domestic violence.
Children show signs of emotional abuse by their behaviour (for example, excessive clinginess to or avoidance of the parent/carer), their emotional state (low self-esteem, unhappiness), or their development (non-organic failure to thrive). The *threshold of significant harm* is reached when abusive interactions become *typical* of the relationship between the child and parent/carer.

Physical Abuse
Physical abuse is any form of non-accidental injury that causes significant harm to a child, including:
(i) shaking;
(ii) use of excessive force in handling;
(iii) deliberate poisoning;
(iv) suffocation;
(v) Munchausen's syndrome by proxy (where parents fabricate stories of illness about their child or cause physical signs of illness);
(vi) allowing or creating a substantial risk of significant harm to a child.

Sexual Abuse
Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. For example:

(i) exposure of the sexual organs or any sexual act intentionally performed in the presence of a child;
(ii) intentional touching or molesting of the body of a child whether by a person or object for the purpose of sexual arousal or gratification;
(iii) masturbation in the presence of a child or involvement of the child in the act of masturbation;
(iv) sexual intercourse with the child, whether oral, vaginal or anal;
(v) sexual exploitation of a child;
(vi) consensual sexual activity between an adult and a child under 17 years. In relation to child sexual abuse, it should be noted that, for the purposes of the criminal law, the age of consent to sexual intercourse is 17 years. This means, for example, that sexual intercourse between a 16 year old
girl and her 17 year old boyfriend is illegal, although it might not be regarded as constituting child sexual abuse.

(Taken from "**Children First : national guidelines for the protection and welfare of children**" by the Department of Health and Children)

Recognising Child Abuse

The ability to recognise child abuse depends as much on a person's willingness to accept the possibility of its existence as it does on knowledge and information. It is important to note that child abuse is
not always readily visible, and may not be as clearly observable as the 'text book' scenarios outlined in these guidelines suggest. The recognition of abuse normally runs along three stages,
(i) considering the possibility — if a child appears to have suffered an inexplicable and suspicious looking injury, seems distressed without obvious reason, displays unusual behavioural problems or appears fearful in the company of parents/carers.
(ii) observing signs of abuse — a cluster or pattern of signs is the most reliable indicator of abuse. Children may make direct or indirect disclosures, which should always be taken seriously. Less obvious disclosures may be gently explored with a child, without direct questioning (which may be more usefully carried out by the health board or An Garda Siochana). Play situations such as drawing or story telling may reveal significant information. Indications of harm must always be considered in relation to the child's social and family context, and it is important to always be open to alternative explanations.
(iii) recording of information — it is important to establish the grounds for concern by obtaining as much detailed information as possible. Observations should be recorded and should include dates, times, names, locations, context and any other information which could be considered relevant or which might facilitate further assessment/ investigation.

(Taken from "**Children First : national guidelines for the protection and welfare of children**" by the Department of Health and Children)

Questions which may help staff when they are concerned about a child's welfare

What are the concerns?

- Is the child behaving normally for his/her age and stage of development?
- Does the child present a change in behaviour?
- For how long has this behaviour been observed?
- How often does it occur? Where?
- Has something happened which could explain the child's behaviour?
- Is the child showing signs of distress? If so, describe (e.g. behavioural, emotional, physical signs).
- Does the behaviour happen everywhere or just in the childcare setting?
- Is the child suffering?
- Does the behaviour restrict the child socially?
- Does the behaviour interfere with the child's development?
- What effect, if any, does it have on others (e.g. other children)?
- What are the child's parents(s) views, if known?

(Taken from **Guidelines for the Protection of Children in Early Childhood Services** by Barnardos NCRC)

HOW TO RESPOND IF A CHILD DISCLOSES CHILD ABUSE

Some Guidelines:

- Be as calm and natural as possible. Remember that you have been approached because you are trusted and possibly liked. Do not panic.
- Be aware that disclosures can be very difficult for the child.
- Remember, the child may initially be testing your reactions and may only fully open up over a period of time.
- Listen to what the child has to say. Give them the time and opportunity to tell as much as they are able and wish to. Do not pressurise the child. Allow him/her to disclose at their own pace and in their own language.
- Do not show signs of disgust, anger or disbelief.
- Be careful when asking questions. Questions should be supportive and for the purpose of clarification. Avoid leading questions such as asking whether a specific person carried

out the abuse. Also, avoid asking about intimate details or suggesting that something else may have happened other than what you have been told. Such questions and suggesting could complicate the official investigation.

- Assure the child that you believe them. False disclosures are very rare in young children.

- It is important to differentiate between the person who carried out the abuse and the act of abuse itself. The child quite possibly, may love or strongly like the alleged abuser while also disliking what was done to him/her.

- It is important therefore to avoid expressing any judgement on, or anger towards, the alleged perpetrator, while talking with the child.

- It may be necessary to reassure the child that your feelings towards him/her have not been affected in a negative way as a result of what he/she has disclosed.

- Do not promise to keep secrets. At the earliest opportunity tell the child that:

  a) You acknowledge that they have come to you because they trust you.
  b) There are secrets which are not helpful and should not be kept because they make matters worse. Such secrets hide things that need to be known if people are to be helped and protected from further ongoing hurt. By refusing to make a commitment to secrecy to the child you do run the risk that they may not tell you everything or indeed anything, there and then. However, it is better to do this than to tell a lie and ruin the child's confidence in yet another adult. By being honest, it is more likely that the child will return to you at another time.

Think before you promise anything. Don't make promises which you cannot keep.

At the earliest possible opportunity:

a) Record in writing what the child has said, including, as far as possible, the exact words utilised by the child.
b) Inform your supervisor/manager immediately and agree measures to protect the child, i.e. report the matter directly to the health board.
c) Maintain appropriate confidentiality.

Ongoing Support

Following a disclosure by a child, it is important that the staff member continues in a supportive relationship with the child.

Disclosure is a huge step for many children. Staff should continue to offer support, particularly through:

- Maintaining a positive relationship with the child.
- Keeping lines of communication open by listening carefully to the child.
- Continuing to include the child in the usual activities.

Any further disclosure should be treated as a first disclosure and responded to as mentioned above.

Where necessary, immediate action will be taken to ensure the child's safety. The process involved in the assessment of reported concerns about child protection is usually as follows:

P H A S E I

1. Allegation of child abuse (neglect, emotional, physical or sexual)
2. Referral to Health Board Social Work Department
3. Social Worker consults records and makes initial enquiries (both internal and external enquiries).
4. Social Worker consults with Line Manager (Team Leader or Senior Social Worker.

P H A S E II

1. Notification to Childcare Manager, options at this point may include:
   (i) notification to An Garda Síochána
   (ii) strategy meeting with key people
   (iii) health board assessment

P H A S E III

1. Child Protection (Case) Conference. Negotiation of a child protection plan involving all key people (i.e. parents/carers, health board staff, other relevant professionals), treatment intervention if required.
2. Child protection review.

(Taken from **Guidelines for the Protection of Children in Early Childhood Services** by Barnardos NCRC**)**

Reporting Child Protection Concerns

Introduction
Child abuse is a difficult subject, and it is understandable that people may at times be reluctant to acknowledge its existence. Members of the public or professionals may be afraid of being thought insensitive, afraid of breaking confidence or afraid of being disloyal if they report suspected child abuse to the health board or An Garda Siochana. However, early intervention may reduce the risk of serious harm occurring to a child in the future. Persons uncertain about the validity of their concerns may discuss them with a health board social worker or public health nurse. This may enable them to decide whether or not to make a formal report.

The *Protection for Persons Reporting Child Abuse Act, 1998* provides immunity from civil liability to persons who report child abuse 'reasonably and in good faith' to designated officers of health boards or any member of An Garda Siochana. This means that, even if a reported suspicion of child abuse proves unfounded, a plaintiff who took an action would have to prove that the reporter had not acted
reasonably and in good faith in making the report. Giving information to others for the protection of a child does not constitute a breach of confidentiality.

Responsibility to Report
Any person, who suspects that a child is being abused, or is at risk of abuse, has a responsibility to report their concerns to the health board. This responsibility is particularly relevant to professionals such as teachers, child care workers and health professionals who have regular contact with children in the course of their work. It is also an important responsibility for staff and volunteers involved in sports clubs, parish activities, youth clubs and other organisations catering for children. The following examples would constitute reasonable grounds for concern:
(i) a specific indication from a child that (s)he was abused;
(ii) a statement from a person who witnessed abuse;
(iii) an illness, injury or behaviour consistent with abuse;
(iv) a symptom which may not in itself be totally consistent with abuse, but which is support by corroborative evidence of deliberate harm or negligence;
(v) consistent signs of neglect over a period of time.
A suspicion, which is not supported by any objective signs of abuse, would not constitute a reasonable suspicion, or reasonable grounds for concern

Standard Reporting Procedure
If child abuse is suspected or alleged, the following steps should be taken by professionals and members of the public who come into contact with children
(i) a report should be made to the health board in person, by phone or in writing. Each health board has a duty social worker who is available each day to meet with or talk on the telephone to persons wishing to report child protection concerns. (A list of contact numbers is available in Appendix 1)
(ii) it is generally most helpful if personal contact is made with the duty social worker by the person who first witnessed or suspected the alleged child abuse.
(iii) in the event of an emergency or the non-availability of health board staff, a report may be made to An Garda Siochana at any Garda Station.
NOTE: A suggested template for the Standard Reporting Procedure is contained in Appendix 2, which may be of use for staff or volunteers in organisations who work with children or are in contact with children.

The health board or An Garda Siochana, on receiving a report, will require as much as possible of the following information:
(i) names and addresses of the child, parents/carers and any other children in the family;
(ii) name and address of the person alleged to be causing harm to the child;
(iii) a full account of the current concern about the child's safety or welfare;
(iv) the source of any information which is being discussed with the health board;
(v) dates of any incidents being reported;
(vi) circumstances in which the incident or concern arose;
(vii) any explanation offered to account for the risk, injury or concern;
(viii) the child's own statement if relevant;
(ix) any other information about the family, particularly any difficulties which they may be experiencing;
(x) any factors relating to the family which could be considered supportive or protective, e.g. helpful family members, neighbours or services;
(xi) name of child's school;
(xii) name of child's general practitioner;
(xiii) reporter's own involvement with child and parents/carers;
(xiv) details of any action already taken in relation to the child's safety and welfare;
(xv) names and addresses of any agency or key person involved with the family;
(xvi) identity of person reporting, including name, address, telephone number, occupation and relationship with the family.
In cases of emergency, where a child appears to be at immediate and serious risk, and a duty social worker is unavailable, An Garda Siochana should be contacted.
Under no circumstances should a child be left in a dangerous situation pending health board intervention.

Co-operation with Parents/carers
Any **professional** who suspects child abuse should inform the family if a report is likely to be submitted to the health board or An Garda Siochana, unless doing so is likely to endanger the child. Co-operation
with the family is essential in order to ensure the safety of the child; it is more likely to be achieved if professionals can develop an open and honest relationship with parents/carers. Involvement in a child protection assessment can be difficult for parents/carers. Families may have rights to know what is said about them and to contribute to important decisions about their lives and those of their children. Sensitivity must be used, and parents/ carers should be made fully aware of what is expected of them. Professional staff must strike a balance between showing respect for families and using authority appropriately.

(Taken from "**Children First : national guidelines for the protection and welfare of children**" by the Department of Health and Children)

The Case for Mandatory Reporting of Suspected Child Abuse and Neglect

1. What is mandatory reporting?
Mandatory reporting is a system whereby certain designated persons are obliged by law to report cases of suspected or actual child abuse to the relevant authorities.

2. Why is the introduction of mandatory reporting important?
There are two main reasons.

Firstly, a mandatory reporting law would be a clear and unambiguous statement by our society that child abuse is a matter of public importance and that all necessary steps will be taken to ensure that cases of suspected abuse are reported and acted upon.

Secondly, while the arrangements for reporting and investigating cases of abuse have improved significantly, with the publication in September 1999 of detailed guidelines,[1] these guidelines still do not have formal legal authority. The Report of the Kilkenny Incest Investigation, when recommending in favour of mandatory reporting, concluded that "*Experience suggests that some professionals dealing with children may still be prepared to turn a blind eye to the unpleasant reality of child abuse and studies show that professionals and voluntary agencies often refer children on an ad-hoc, discretionary and inconsistent basis…".*[2] Systems of mandatory reporting were recommended also by the 'Kelly Fitzgerald' and 'Madonna House' enquiries.

In considering a survey on Child Sexual Abuse in Dublin, conducted in 1987, the Law Reform Commission commented "*Even the most cautious reading of these statistics suggests that there still remains a significant number of child sexual abuse cases that go unreported."*[3]

A further survey,[4] conducted by the ISPCC/Irish Marketing Surveys in 1993, found that 16% of Irish adults reported having been sexually abused in childhood. In the same year, the country's eight health boards received reports of suspected abuse in respect of just 0.34% of the country's child population.

Mandatory reporting will assist in tackling these issues of inconsistent or under reporting of abuse.

3. How will mandatory reporting help children?

Mandatory reporting will make a critical contribution in more cases of suspected abuse being referred to the appropriate authorities. While it is acknowledged that other measures, such as increased public awareness or enhanced services, are extremely important, it is clear that mandatory reporting has a central role to play in any comprehensive child protection system.

Mandatory reporting of child abuse has been in operation in all States in America since the 1970's. Since that time there has been a significant increase in the reporting of child abuse cases. In 1976, for example, reporting rates were at 10 per 1000 of the child population, but by 1987 this had risen to 34 per 1000 and in 1997 was 47 per 1000 of the child population. Nationally, in 1997 there were over three million reported cases compared to just 150,000 in 1963. [5] [6]

This experience suggests that mandatory reporting in Ireland will lead to more children being protected.

4. How will mandatory reporting benefit those working with children?

Not only will mandatory reporting benefit children, it will also assist those mandated to report, and indeed our child care system generally.

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[1] Department of Health and Children, (1999), *Children First: National Guidelines for the Protection and Welfare of Children*, Dublin: The Stationery Office

[2] McGuinness, C., (1993), *Kilkenny Incest Investigation*, Dublin: The Stationery Office

[3] Law Reform Commission, (1989), *Child Sexual Abuse*, Dublin: Law Reform Commission

[4] I.S.P.C.C.,(1996), *Another Brick From the Wall*, Dublin: ISPCC

[5]Zellman, G. and Fallen, K., *Reporting of Child Maltreatment* in J.Brier et al (Eds) 1996, *APSAC Handbook on Child Maltreatment*, New York: Sage Publications

[6] Nang, C.T.and Daro, D., (1997), *Currents Trends in Child Abuse Reporting and Fatalities: The Results of the 1997 Annual Fifty State Survey*, Chicago: N.C.P.C.A.

- Mandatory reporting will provide a clearer legal framework within which mandated professionals will be obliged to operate. The element of discretion will be removed and reporters who may be reluctant, or afraid, to report cases will be able to do so with the support of the law. In considering this matter the Law Reform Commission noted that "*to many professionals the most attractive feature of a mandatory report law is its 'empowering' nature. It relieves them from some of the onus of discretion.*"[7] Consequently, there should be a reduction in the concerns reporters may have about legal action being taken against them.

- The introduction of mandatory reporting, with the Protections for Persons Reporting Child Abuse Act, 1998, can be seen as an important legislative complement to the establishment of clear systems for reporting and investigating cases of suspected abuse. Along with the 1999 National Guidelines for the Protection and Welfare of Children it will ensure that reporters will be clear about who to report to and in what format. Equally, those charged with investigating reports will operate in a more clearly defined structure. With a more consistent approach in operation throughout the country, public confidence in the 'child protection system' will be improved.

  As with the National Guidelines, the introduction of mandatory reporting will require adequate training for mandated reporters both in understanding and identifying child abuse and in operating the reporting system. While this will require considerable investment, it will result in large numbers of people who work with children becoming more aware of child abuse and being clear about how they can properly report their concerns.

5. Are there arguments against the introduction of mandatory reporting?

Yes, arguments against mandatory reporting have been put forward by professionals and agencies working with children. While Barnardos does not agree with these arguments, it is important that they are recognised and responded to.

The principal arguments are:

(i) *There would be an increase in the number of unsubstantiated cases reported, and this would lead to scarce resources being put into investigation as opposed to other services.*

In response, Barnardos would point out that dealing with unsubstantiated cases is an inevitable part of the child protection system and the investigative process. In 1997 over half of the cases of suspected abuse referred to health boards were unconfirmed. While somewhat similar trends can be expected after the introduction of mandatory reporting, what we can also anticipate is adequately trained reporters who will be clearer about which cases they should or should not report.

However, the essential response to this argument is that while there may be an increase in the number of unsubstantiated cases reported, there will also be an increase in the number of confirmed cases of child abuse reported and detected, with more children protected as a result.

(ii) *The child care system will be "swamped" and resources will not be available to meet demand. Whatever resources are available will be diverted into investigation with less available for treatment or preventive services.*

[7] Law Reform Commission, (1989), *Child Sexual Abuse,* Dublin: Law Reform Commission

While these concerns are real, from the point of view of children's needs and rights, Barnardos does not consider the "resources" argument to be sustainable.

Putting it bluntly, it is not acceptable to say to children 'we cannot investigate or deal with suspected cases of abuse because we do not have the staff/time/resources to do so'. Mandatory reporting will certainly require increased investment in our child care services, but that is the price we should be prepared to pay to properly protect children.

Indeed, it can equally be argued that the introduction of mandatory reporting will lead to an overall enhancement of our child care services. One commentator has noted that *"in countries with mandatory or quasi mandatory reporting … professionals and politicians alike cannot avoid the issues. They have to respond to the problem itself and they have to respond to the size and quantity of the issue. They have to provide money, they have to provide services, they have to train people, they have to clarify and allocate tasks and responsibilities, and for better or worse they have to deal with the need for therapy and protection of vastly increased numbers of abused children".*[8] It is quite likely, therefore, if teachers, doctors, social workers and nurses are all designated as reporters, that they will seek guarantees that their reports will be dealt with efficiently and that necessary services will be available.

The argument that resources will be diverted from therapeutic or support services into investigation is not acceptable or valid. We should not have to make choices between different types of necessary services. Barnardos is committed to a comprehensive range of services for children ranging from support to therapeutic to protection interventions. All are important and all need to be resourced.

(iii) *The professional/client relationship will be damaged. Parents, for example, may be reluctant to bring a child suspected of abuse to a doctor if the doctor is obliged to report the matter. Adults/young people who have been sexually abused may not engage in therapy if they know the therapist is obliged to report the matter on and that they may be involved in an official investigation.*

These concerns are legitimate and they raise sensitive issues concerning professional practice. In response, Barnardos would make the following points:

- At a national level the introduction of mandatory reporting will need to be accompanied by appropriate information and education strategies. These should be designed to educate the public and professionals about the requirements of the new system and the requirements it places on certain professionals.

- It will be important for relevant professionals to explain to clients about the limits to the principle of confidentiality. Indeed, such limitations are not new and have been set out clearly by, for example, doctors and psychologists who currently acknowledge the need to pass on information to protect other people.

- With regard to therapeutic situations it is clear that these must be handled in a sensitive manner. While professionals engaged in therapeutic work will be obliged to report certain information, good practice suggests that this responsibility will be used as a means of working with clients both in understanding why this is necessary and in facilitating them to be active participants in the process.

[8] Furniss, D., (1996), *Does Mandatory Reporting Help to Protect Children?,* in Journal of Child Centred Practice, Vol 3 No 2

Therefore, while the above arguments have some validity, when they are analysed they do not constitute proper grounds against the introduction of mandatory reporting.

(*Taken from* ***Barnardos Policy Briefing No. 4***)

Websites, Contact Details and Resources for further information:

Barnardos National Children's Resource Centres:
Christchurch Square, Dublin 8.
Tel: 01 4549699
Fax: 01 4530300
Email: ncrc@barnardos.ie

Bowling Green, White St., Cork
Tel: 021 4310591
Fax: 021 4310691
Email: **ncrc@cork.barnardos.ie**

10 Sarsfield St, Limerick
Tel: 061 208680
Fax: 061 440214
Email: info@midwest.barnardos.ie

River Court, Golden Island, Athlone
Tel: 090 6479584
Fax: 090 6479585
Email: ncrc@athlone.barnardos.ie

41 – 43 Prospect Hill, Galway
Tel: 091 565058
Fax: 091 565060
Email: ncrc@galway.barnardos.ie

http://www.barnardos.ie/
Copies of "Barnardos Policy Briefing No. 4: The Case for Mandatory Reporting" and copies of "Guidelines for the Protection of Children in Early Childhood Services" can be referenced at your nearest NCRC. "Policy Briefing No. 4" is also available free of charge and can be obtained by sending an A4 SAE with 60c to cover postage to your nearest NCRC.

Child Abuse Prevention Programme (CAPP*)*
The Lodge
Cherry Orchard Hospital
Ballyfermot
Dublin 10
Tel: 01 6206347
Fax: 01 6206347
Website: *www.staysafe.ie*

Aims to prevent child abuse and bullying by providing training for teachers and parents of primary school children and by developing safety skills education programmes for children at primary level.

Children at Risk in Ireland Foundation (CARI)
110 Lower Drumcondra Road, Dublin 9
Tel: 01 8308529
Fax: 01 8306309
http://www.cari.ie/
Provides post-assessment specialised child-centred psychotherapy to children and adolescents who have experienced sexual abuse and to their non-abusing members of the family. Services include individual counselling, play therapy, sand therapy, art therapy and group therapy. CARI also provides support, information and parenting advice to the non-abusing parents. Also includes outreach programme.

Commission to Inquire into Child Abuse
Second Floor, St. Stephen's Green House, Earlsfort Terrace, Dublin 2
Tel: 01 662 4444
Callsave: 1850 20 11 20 (Rep. of Ireland)
Lo-Call: 0845 3098 139 (N.I. and U.K.)
http://www.childabusecommission.ie/
The Commission has been given three tasks under the Commission to Inquire into Child Abuse Act, 2000: To listen to the experiences of people who were abused as children in institutions, to investigate abuse of children in institutions and find out why it happened and who was responsible for it;and to report directly to the public within two years about: what happened in the past, what should be done to help survivors of abuse now, what should be done to protect children not in the care of their parents now and in the future.

Department of Health and Children
Hawkins House, Hawkins Street, Dublin 2
Tel: 01 6354000
Fax: 01 6354001
http://www.doh.ie/
Department of Health and Children website contains a link to publications where a copy of "Children First: national guidelines for the protection and welfare of children" can be downloaded.

Sexual Abuse Assessment Units
Guidelines on the identification and referral of the cases of sexual abuse are issued by the Department of Health and Children. For further information, contact your local health board community care office.

Support Network for Professionals in Child Protection
C/o 70 Lower Leeson St., Dublin 2.
Tel: 01 6614911
Fax: 01 6610873
Laragh Counselling Service offers therapy to adults, male and female, who have been sexually abused in childhood. Clients can be seen individually or in a group setting. Training, supervision and consultancy can be provided by Laragh to other services who are likely to encounter this clientele and can be offered free of charge to other public services, subject to availability of resources.