Scottish Journal of Residential Child Care: An international journal of group and family care experience

Volume 21.1

What future for voluntary children's residential providers in Ireland?

Martin Power and David Power

Abstract

In Ireland, voluntary provision of children's residential services has a history that predates the foundation of the Irish State. Voluntary providers have thus endured regardless of wars, economic crises, social upheavals, scandals, pandemics, and many other changes. However, the current climate is arguably challenging voluntary providers to their core. Only just being kept afloat by State funding, they are operating against the backdrop of a hollowing out of the third sector, within a mixed economy of provision that is increasingly being dominated by private providers. Moreover, they are, and have been, chronically and comparatively underfunded for many years, and staff are understandably demoralised by the scant progress on pay restoration in line with their counterparts. To compound matters further, the impending regulation of social care workers and proposed inspection regime changes are likely to only increase demands on both providers and staff. This paper is a collaboration between a director of a voluntary children's residential provider and an academic in social care. It uses the director's experiences as a lens to explore and explain the drivers and challenges voluntary residential providers face, and to ask if there is a future for voluntary residential children's providers in Ireland.

Keywords

Voluntary providers, residential childcare, state support, Ireland

Corresponding author:

Dr Martin Power, Director Social Care Programmes, Discipline of Health Promotion, NUI Galway, National University of Ireland, Galway, martin.p.power@nuigalway.ie

Introduction

In the Republic of Ireland there is a long history of health and social care service provision by non-state actors. Indeed, at the time of the foundation of the Irish State in the early 1900s, Catholic religious orders were the main providers of health and social care services, including children's residential services, and this remained so throughout most of the twentieth century (Adshead & Millar, 2003; Harvey, 2007; Mulkeen, 2016; O'Sullivan, 2008). As the numbers entering religious orders declined steadily, particularly from the 1980s onwards, the care workforce became increasingly secularised, and in 2005 the professional title Social Care Worker was given statutory recognition within the Health and Social Care Professionals Act (2005) (Barrington, 2003; Moran, 2013). However, while the opening of a register for social care workers will mark a significant development on the path to the professionalisation of social care work, the register is not expected to open before late 2023 (CORU, 2020; Flynn, 2019; Williams & Lalor, 2001).

In parallel with such developments the infrastructure of children's residential services has also changed dramatically, especially in recent decades. In the late 1990s voluntary providers and religious orders delivered the majority of provision, with limited direct provision by the state (Crimmens, 1998). In the early 2000s, however, the last of the religious providers ceased involvement and provision was by the state or voluntary/charitable bodies which received state funding, mostly under the auspices of the Health Service Executive (HSE) (Darmody et al., 2013; O'Sullivan, 2008). In 2014, the Child and Family Agency (Tusla) was established and responsibility for children's residential centres was transferred to Tusla from the HSE (a brief description of the key agencies is provided at the end of this introduction).

While voluntary providers have thus been a cornerstone of the sector throughout the nineteenth and twentieth centuries, today's landscape is increasingly shaped by private providers (Branigan & Madden, 2020; Mulkeen, 2016). Since 2015, for instance, the number of private services has increased substantially from 92 to 120, while the number of voluntary providers has remained static at 25 (Branigan & Madden, 2020). Indeed, the number of voluntary providers has

changed little since the mid-1990s, when 24 residential childcare services were managed by voluntary bodies (Crimmens, 1998). Tusla operated services have similarly remained relatively consistent in number since 2015, decreasing slightly from 41 to 39 services. However, this followed a period of marked public sector reduction, driven by the global crash of 2008, with the retraction of public provision opening up fertile territory for private provision to expand into (Fenton, 2021).

In addition to a general increase in demand for residential services over recent years and an increase in the time children are spending in care, other factors have also contributed to an expansion in services. These include the continued shift away from larger to smaller, more homely placements, more sensitivity in the care system to the needs of vulnerable and marginalised children, increasingly complex cases, and a corresponding focus on enhanced services (Branigan & Madden, 2020). The latter in particular is reflected in the costs of residential placements, which increased from €162million in 2016 to €193million in 2019, with private services incurring 87% of those cost increases, Tusla services 2%, voluntary services 4%, and administrative cost increases accounting for 7% (Branigan & Madden, 2020). Though the increase in the cost of voluntary services was extremely modest, particularly given the impact of the European Working Time Directive in 2018, the occupancy rate simultaneously fell and voluntary providers had the lowest occupancy rates in 2019, at 61% (Tusla 84%, Private 77%).

This latter point is crucial, as it highlights, if indirectly, some of the particular challenges for voluntary providers. Unlike private providers, who are paid on a per-placement basis with financing linked to numbers, voluntary providers 'receive grant-aided funding in line with Service Level Agreements' based upon the capacity of the provider and regardless of occupancy rate (Branigan & Madden, 2020, p. 21). Thus, decreasing occupancy rather than cost increases is perhaps a better indicator of pressures on voluntary services that are confined by rigid funding agreements.

There are a number of drivers of the pressures on voluntary providers, most notably, chronic underfunding, which is compounded by the absence of pay restoration for staff. More importantly perhaps, pressure can only build further,

given the impending introduction of registration for social care workers and potential changes to the inspection regime. This paper is a collaboration between David, a voluntary residential centre director, and Martin, an academic in social care, and it argues that voluntary residential providers are facing an increasingly untenable and unsustainable situation. In fact it is David's opinion that, 'these services are at breaking point, and the future looks bleak for the voluntary providers'.

This paper is divided into two sections. Section one examines the challenges around funding of voluntary providers and the related issue of pay restoration. It draws upon comparisons with similar challenges to the third sector in Scotland, which have resulted in third sector providers handing back contracts and exiting the social care market. Section two explores the broader context of a hollowing out of the third sector in Ireland and the implications of impending changes in social care that are likely to further increase pressures on voluntary providers.

Brief description of key agencies in Ireland

Health Service Executive (HSE). The HSE is the agency responsible for the delivery of public health and social care services in Ireland and it reports to the Minister of Health. In political science parlance, the Department of Health steers and the HSE rows. The HSE is Ireland's largest single employer, with over 100,000 staff, of all types and grades from consultants to cleaning staff. The HSE is partitioned organisationally into a number of divisions, such as 'acute hospitals', 'mental health' and 'primary care', and it is geographically organised by regions (9), local health offices (32) and local health centres. The HSE is also the main funder for many social care services that are delivered by third sector providers (www.hse.ie).

Tusla – The Child and Family Agency. Tusla is the state agency responsible for improving children's lives and wellbeing. Tusla services include child protection and welfare, family support, early years services, and domestic violence. Tusla has over 4,000 staff and an annual budget of over three quarters of a billion euro (www.tusla.ie).

CORU. CORU is Ireland's regulatory agency for health and social care professionals, such as social workers, medical scientists, occupational therapists,

and speech and language therapists, with each profession having a registration board within CORU. CORU's role is to protect the public through setting and monitoring educational standards and continued professional development requirements, as well as maintaining a register for each profession and instigating fitness to practice hearings when necessary. CORU has an extensive staff and currently regulates over 20,000 professionals, with more professional registers scheduled for opening over the coming years (www.coru.ie).

The Health Information and Quality Authority (HIQA). The HIQA is the regulatory agency for health and social services and providers, including acute and community healthcare providers, children's services, disability, and older people's residential providers. The HIQA develops standards, registers providers, and carries out inspection and monitoring visits, holding the power to close providers where deemed necessary. Within children's residential services, however, an 'anomaly' exists – the HIQA inspects Tusla services, but Tusla inspects private and voluntary providers.

Voluntary providers and the failing life-support system

If declines in occupancy rates are the canary in the mineshaft for the dangers facing voluntary providers, the causes are firmly located in underfunding. Cost for mainstream placement per week figures between 2017 and 2019 point both to chronic underfunding previously and increasing underfunding comparatively (see Table 1).

Provider type	2017 cost	2019 cost	Difference
Tusla	6,465	6,338	- 127
Private	5,712	6,713	+ 1,001
Voluntary	4,459	4,730	+ 271

Table 1 (figures from Branigan & Madden, 2020, p. 52)

Much of the cost increase for private providers can be attributed to the impact of the introduction of the European Working Time Directive in late 2018, which meant more staff were needed (Branigan & Madden, 2020). This was reflected in an increase in the rate for private mainstream placements per week, from €5,000 to €6,000, and from €6,000 to €6,800 for enhanced placements. In

addition, in mainstream placements 'the duration of care was highest in private services', though Branigan and Madden highlight that this conclusion is based on a snapshot of current placements only (Branigan & Madden, 2020, p. 17). It is clear from Table 1 that no corresponding rate increase was offered to voluntary providers, and reducing occupancy was thus perhaps a predictable outcome, since there would be few other avenues available, and as David highlights 'services are widely acknowledged to be under-funded'.

It is a situation that mimics events in Scotland, where Cunningham et al. (2019) found that many third sector social care providers cited chronic underfunding and the failure of funders to provide adequately for the introduction of the Scottish Living Wage as primary reasons for their subsequent handing back of contracts. More worryingly perhaps, '[o]f those organisations that handed back contracts, the majority indicated that the contracts concerned had been held for over ten years' (Cunningham et al., 2019, p. 5). As such, just as in Ireland, where some voluntary providers can trace their history as far back as the mid-nineteenth century, it is often the case that it is long-established organisations that are under pressure and leaving the market.

In Scotland, such challenges, and the handing back of contracts, inevitably impacted significantly on staff retention and recruitment (Cunningham et al., 2019), with similar trends increasingly obvious in Ireland. The extent of these issues is best exemplified by the relationship between funding and staff pay and conditions. Prior to the establishment of Tusla, voluntary residential providers were funded as either Section 38 or Section 39 organisations. While the legislative basis for these arrangements and their implementation is outdated, complex and ambiguous at best, an obvious distinction was frequently applied in practice (McInerney & Finn, 2015). Employees of Section 38 organisations were effectively entitled to public sector pay scales and benefits, while those in Sector 39 organisations were to be largely aligned with, but not entitled to, such arrangements (McInerney & Finn, 2015). What this meant during the austerity period for example was that:

> despite not being considered as public servants and despite not being entitled to the same terms and conditions as public servants (including pension entitlements) staff in organisations in receipt of Section 39

> funding were expected to adhere to the cuts required in public sector and Section 38 funded bodies (McInerney & Finn, 2015, p. 15).

Perhaps unsurprisingly, therefore, McInerney and Finn's (2015) conclusion was that the difference between Section 38 and Section 39 organisations was largely a 'function of finance rather than reflecting a difference in actual services delivered', and was driven by the continued preference for the state's arms-length approach to service provision that was manifest in 'a desire to hold on to "flexibility" by not entering into a more long-term or fixed arrangement' (McInerney & Finn, 2015, p. 14).

With the establishment of Tusla, children's voluntary residential providers were re-categorised and became Section 56 providers. As the economy rebounded in the wake of the austerity period, pay restoration was introduced for Section 38 employees, but a prolonged union campaign was required to secure similar pay restoration for those working under Section 39. However, as voluntary children's residential providers had been re-categorised as Section 56 organisations in 2014, they fell outside agreements on pay restoration for section 39 employees, and unions have now lodged a claim to have them included (FORSA, 2021). Unions have also recently submitted a parallel claim for community and voluntary service workers in other social care services, who have similarly endured pay stagnation and an expansion of precarious employment conditions (Hurley, 2021). If such developments highlight a hollowing out of the third sector and an increasing shift toward neo-liberal policy agendas, for employees of voluntary children's residential providers they can only add insult to injury. Reasonable expectations of pay restoration, in line with colleagues in the public sector and similarly funded organisations, have now gone unfulfilled not once, but twice, and the situation remains unresolved at this time. Certainly, David is of the view that:

> Over the years the voluntary providers have been asked to do their bit for the country. They were part of the pay cuts with colleagues in the public service. The promise of restoration of pay was there as the country came out of the dark days.

It is perhaps also worthy of note that a recent report by Social Care Ireland (Power & Burke, 2021) regarding challenges to recruitment and retention in social care work, found that pay and conditions were by far the greatest challenge. Indeed, within children's residential services specifically over half (53.7%) of respondents (n=121) highlighted an element of pay and conditions as the single greatest challenge to recruitment and retention (Power & Burke, 2021). Hours and a lack of respect and recognition were the next two greatest challenges noted by children's residential social care workers. The focus on hours can be attributed to the fact that close to half (45.5%) of respondents were regularly rostered for 24-hour shifts (Power & Burke, 2021). Given the negative impacts on morale of the lack of progress around pay restoration, and the message it appears to convey in terms of respect and recognition, there may be little surprise that David's experience is that staff:

> Always provide the best care to young people. They go the extra mile. They pull out all the stops. But, social care teams have started to question their value to the state and the way they are expected to do the same job.

Moreover, pay and conditions, and respect and recognition, have long been cited as particular barriers for social care workers in residential childcare services (Williams & Lalor, 2001). If in the past these issues were often shaped by the hiring of qualified staff, this is no longer the case, and a degree qualification in social care is now the norm, with many staff holding post-graduate level qualifications (Power & Burke, 2021; Power & D'Arcy, 2018).

In light of the impending introduction of registration and the progression of the professionalisation of social care work, social care workers are likely to have reasonable expectations of improvements to conditions and enhanced status. Not least because registration with CORU will mean social care workers will be regulated in the same way as their social work, occupational therapy, or speech and language colleagues. Moreover, concern around pay and conditions in particular, is only likely to increase with registration, as there will be regular costs such as registration fees and a need for professional indemnity insurance (Byrne, 2016; Howard, 2012). In addition, there will no doubt be expectations that employers will support social care workers in meeting their mandatory

continued professional development requirements, either financially or by providing protected time. Thus, the demands on voluntary providers can only increase, potentially challenging voluntary providers' ethos and success in building their organisational family and relationships over the long-term. While David feels that 'the turnover of staff in voluntary providers is so low the organisations must be doing something right', but there can be little doubt that registration and a continued expansion of private provision are likely to make talent acquisition more challenging and costly in the longer-term. This can only disadvantage voluntary providers further.

A low turnover of staff is undoubtedly influenced positively by the familial ethos of voluntary providers and their flat organisational hierarchies, especially in smaller centres where centre directors/managers and social care workers work side-by-side daily. Nonetheless, this also means that in small- or medium-sized centres in particular, directors/managers can be pinch points in increasingly overloaded systems. Indeed, Harvey (2007) noted that since their introduction in the 1990s, service level agreements have meant that 'the list of obligations of the voluntary and community organisation has lengthened, while the list of obligations on the state side has changed little' (Harvey, 2007, p. 15). This is reflected in David's experience, and it is his opinion that, 'the expectations on the service and the personnel grew and grew. Regulation and risk management became a feature for such organisations, but without the support and back-room teams'.

This experience of an ever-growing weight of expectations and demands was a recurring theme throughout the Handing Back report, which noted that increased administrative and managerial workloads were rarely factored into contracts or payments (Cunningham et al., 2019). Unstable, insecure, or underfunded contracts, recruitment and retention challenges, the need to respond rapidly to changing circumstances and workloads through adjusting rosters or shifting staff areas or responsibilities all involved considerable volumes of administrative and managerial oversight and work (Cunningham et al., 2019). In an Irish context, what this means in day-to-day practice, especially for smaller voluntary providers, is that a limited number of individuals can be largely responsible for a great many things. As David highlights, this can include 'governance, quality of

care, human resources, industrial relations, financial control and budgets. The list goes on, including sometimes also putting the bins out, as there is no one else to do it'.

What this means in terms of the future of voluntary providers is even more worrying, as in David's opinion it is clear that, 'the pressure and amount of responsibility that goes with the task is not being resourced to meet regulation and compliance. It is viewed as the organisation's failure of duty to meet standards, but without being resourced to do so'. In Scotland, Cunningham et al. (2019) noted a similar trend of both mounting pressures and chronic and continued underfunding, which forced many providers into running up large deficits before handing back contracts. Regardless of how unenvious a choice running up a deficit is, it is likely a choice few voluntary providers in Ireland would have available. Indeed, stark warnings have been raised in relation to mounting deficits in many disability services in Ireland, as they are similarly voluntary organisations that are solely or largely reliant on state funding (Wall, 2021).

Voluntary residential children's providers, the hollowing out of the third sector, and what the future may hold

In large part, such issues are inevitable in increasingly market-orientated competitive systems. As anyone who has played Monopoly knows, growth and expansion are written into the very fabric of the competitive model. However, for voluntary/charitable organisations the emphasis is on providing a service rather than expanding a business or making a profit. The impact of the marketisation of welfare systems and the hollowing out of the third sector in Ireland is vividly illustrated by recent changes surrounding Local Employment Services. Local employment services have, since their formal establishment in the mid-1990s, received state funding, which is channelled through local providers embedded in communities, to support people from disadvantaged areas into employment (O'Halloran, 2021). However, the Department of Social Protection has recently advised that EU directives on public procurement now require a competitive tendering process to be enacted for such services. This has caused consternation amongst local employment providers and unions, who argue that local employment providers are ill-equipped for competitive tendering models because

of both their ethos and funding mechanisms. As one employment service worker observed in a press interview:

> We don't want to make a profit from people. People shouldn't be commodities that we can actually make money from and because of this type of model that they're introducing, that would be exactly what we would provide, but we're not private contractors (Connelly, 2021).

Current services can of course compete in the tendering process. However, this not only goes against their ethos of service provision, but also leaves them at a financial disadvantage, since funding is largely provided on an annual basis and services therefore do not have a stockpile of reserves (Connelly, 2021). Services and staff are therefore unlikely to be comforted by the Minister for Social Protection's suggestion that '[d]epartment officials had given a lot of explanation and none of the potential providers should need to employ a consultant to prepare their tender because they have all been so well-informed' (O'Halloran, 2021). As Glynos et al. (2014) highlighted in relation to such debates around healthcare provision in the U.K., notions that tendering or commissioning processes can be blind to the type of provider, whether state, for-profit or not-for-profit, simply 'deflects attention away from the considerable resources at the disposal of for-profit global health conglomerates' (Glynos, et al., 2014, p. 64).

In a similar fashion to local employment services, residential children's services receive annual funding through service level agreements. As such, they too are unlikely to have a reserve of financial resources available to engage consultants or tender writing experts, nor are they likely to have the expertise in-house. While some larger services may have support staff and backroom teams to assist, clearly directors of smaller services cannot add to their already extensive list of responsibilities (Branigan & Madden, 2020). To put this challenge in context - the two highest paid private children's residential provider companies received €15.8 million (approximately £12.6 million) and €11.1 million (£8.9 million) respectively for 2020 (Power, 2022). There may be little surprise then that against such a backdrop David feels that 'a major concern from voluntary providers is the unknown'.

If the unknown is a concern for centre directors/managers, examining developments in the U.K. suggests clearly that Glynos et al. (2014) were correct

in their warning. Ofsted's (2021) recent report on the ownership of children's residential providers in the U.K. highlights that over 80% of children's residential homes are now privately owned, with only 5% owned by voluntary providers. Private ownership was also increasingly being concentrated, with only one in eight private providers owning a single home, while the two largest providers owned a total of 302 homes between them, with both having expanded again in the year between March 2020 and March 2021 (Ofsted, 2021). As such, the economies of scale that large companies can enjoy not only make voluntary providers vulnerable, but also other private providers, especially smaller ones.

If such developments highlight the increasing neo-liberal penchant in social policy in Ireland and beyond, which emerged with particular force during the austerity period (Allen, 2012; Dukelow & Kennet, 2018; Meade, 2018), it also highlights a problem that has been a consistent feature of the health and social care policy framework for decades. The lack of input into decision-making and the annual nature of service level agreements, and their predecessor Section 65, funding grants, have long limited voluntary and community organisations' capacity to plan for the long-term and have created 'high entry barriers' for new entrants from voluntary/community organisations (Harvey, 2007, p. 15). This hand to mouth approach to funding provision is perhaps most obvious in the figures noted earlier around the near static number of voluntary providers of children's residential services for over three decades. Indeed, during the more recent period of 2016 to 2019, Tusla closed 9 centres and opened 11, two voluntary providers closed and one opened, while 25 private providers closed and 42 opened. Voluntary provision is therefore remarkably stable, no doubt in part due to its ethos of providing a needed service regardless of concerns over profit or public sector restructuring initiatives and/or neo-liberal agendas.

In contrast, in light of instability overall in the sector and the rapid growth of private provision, the media have begun to question the increasing reliance on private providers. Here, Tusla's response is unlikely to settle nerves in the voluntary residential sector. In a September 2021 interview with *The Irish Examiner*, Tusla's Chief Executive, Mr Bernard Gloster, agreed that there was a concern around the reliance on private providers and advised that a plan to reduce this reliance was forthcoming. This concern was, however, mainly

centred around private providers exiting the market at short notice (Baker, 2021). Yet, voluntary providers, who have the longest history of service provision and have demonstrated remarkable stability and the lowest levels of closures/turnover across decades, are not being funded to the same extent as the private providers that Tusla has now expressed concern about an over-reliance upon. Perhaps most worryingly for voluntary providers and their staff was the suggested underlying rationale for concern:

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

A further anxiety around the sustainability of voluntary providers is an impending change of inspection regimes. While Tusla centres are currently inspected by the Health Information and Quality Authority, private and voluntary providers are inspected by Tusla. Mr Gloster observed in the same interview that Tusla funding and inspecting private centres was 'a significant anomaly', which there was also a commitment to resolve (Gloster, as cited by Baker, 2021). The viability of voluntary centres would likely come into question if they were to be inspected by the Health Information Quality Authority, not least because of the extremely limited leeway they have to respond to any failure to meet requirements, especially given chronic underfunding over many years. In David's opinion the situation can be summed up as one where 'many voluntary providers and boards are asked to stand over compliance and finances knowing that we are under resourced and while only the state agencies can solve the problem, there appears to be no appetite from them.'

Conclusion

In seeking to examine the situation confronting voluntary providers and to explore the question of whether they now perhaps face the greatest threat to their long existence as a cornerstone of children's residential provision, we have drawn attention to the marketisation of services, the expansion of private providers, and to similar developments in other jurisdictions. This should not be taken as a criticism of private provision. Rather our aim has been to highlight

how increasing marketisation is not a neutral playing field, nor is it provider blind, but instead it is a playing field that privileges private provision over alternative approaches. This is especially the case where voluntary providers are confined by funding mechanisms that clearly limit their capacity to compete if necessary. Moreover, it seems fair to suggest that there is almost a sense that good will is somehow sufficient to keep voluntary providers afloat, and no doubt much of that good will has been squandered by the pay restoration debacle and ever-increasing demands without matching increases in funding.

Voluntary providers who look outward to developments in other countries, or who look inward at developments nationally, particularly the clearly unequal funding afforded to their services and the warnings of a potential collapse of services in the disability sector, can only feel disheartened, if not completely demoralised. Similarly, social care staff in voluntary providers could be forgiven for looking over their shoulders and wondering whether it is time to abandon ship before it is too late. The irony that market mechanisms are often valued for notions of providing choice seems hard to reconcile with reducing the diversity of provider types in children's residential care. Certainly, where a mixed economy of provision that includes state, private and third sector providers is reduced to state/private, then it is a binary rather than a mixed economy. At the same time, marketisation is also likely to diminish diversity in other ways, as economy of scale demands squeeze out smaller providers. Either way, clearly something has or will be lost. Most importantly perhaps, as David highlights, 'having served the state so well over the years, it would appear that the state is failing the voluntary providers, and also the young people who use the service'.

References

Adshead, M., & Millar, M. (2003). *Ireland as Catholic corporatist state: A historical institutionalist analysis of healthcare in Ireland*. Limerick: Department of Politics and Public Administration, University of Limerick.

Allen, C. (2012). The model pupil who faked the test: Social policy in the Irish crisis. *Critical Social Policy*, *32*(3), 422-439.

Baker, N. (2021). Tusla, chief says level of private residential companies for children is a worry. *Irish Examiner*, September 27th. Retrieved from https://www.irishexaminer.com/news/arid-40706966.html

Barrington, R. (2003). *Health, medicine and politics in Ireland 1900-1970*. Dublin: Institute of Public Administration.

Branigan, R., & Madden, C. (2020). *Spending review 2020: Tusla residential care costs*. Dublin: Department of Children and Youth Affairs.

Byrne, C. (2016). Ready or not? Statutory registration, regulation and continuing professional development for social care workers in Ireland. *Administration*, *62*(2), 9-29.

Conneely, A. (2021). Job fears over tendering process for Local Employment Services. *RTE News*, 29th September. Retrieved from https://www.rte.ie/news/ireland/2021/0929/1249560-employment-oireachtas-committeee/

CORU (2020). *Update on the registration of social care workers* (May, 2020). Retrieved from https://coru.ie/about-us/registration-boards/social-care-workers-registration-board/updates-on-the-social-care-workers-registration-board/update-on-the-registration-of-social-care-workers/

Crimmens, D. (1998). Training for residential child care workers in Europe: Comparing approaches in the Netherlands, Ireland and the United Kingdom. *Social Work Education*, *17*(3), 309-320.

Cunningham, I., Baluch, A., James, P., Jendro, E., & Young, D. (2019). *Handing back contracts: Exploring the rising trend in third sector provider withdrawal from the social care market*. Strathclyde: Coalition of Care and Support Providers Scotland.

Darmody, M., McMahon, L., & Banks, J. (2013). *Education of children in care in Ireland: An exploratory study*. Dublin: The Economic and Social Research Institute and Robbie Gilligan, Children's Research Centre.

Dukelow, F., & Kennett, P. (2018). Discipline, debt and coercive commodification: Post-crisis neo-liberalism and the welfare state in Ireland, the UK and the USA. *Critical Social Policy*, *38*(3), 482-504.

Fenton, M. (2021). Spending review 2020: Tusla residential care costs. *CURAM*, Spring, *56*, 8-13. Retrieved from https://online.fliphtml5.com/wmqes/rpxf/#p=1

Flynn, S. (2021). Social constructionism and social care: Theoretically informed review of the literature on evidence informed practice within the professionalisation of social care professionals who work with children in Ireland. *Child Care in Practice*, *27*(1), 87-104.

FORSA (2021). *Claim lodged for section 56 workers*. FORSA members news bulletin. Retrieved from https://forsatradeunion.newsweaver.com/designtest/b74eeuh35mv

Glynos, J., Speed, E., & West, K. (2014). Logics of marginalisation in health and social care reform: Integration, choice and provider blind provision. *Critical Social Policy*, *35*(1), 45-68.

Harvey, B. (2007). *Evolution of health services and health policy in Ireland*. Dublin: Combat Poverty Agency.

Howard, N. (2012). The Ryan Report (2009). A practitioner's perspective on implications for residential childcare. *Irish Journal of Applied Social Studies*, *12*(1), 37-48.

Hurley, S. (2021). Unions lodge 3% pay claim for community, voluntary sector workers. *RTE News*, 9th November. Retrieved from https://www.rte.ie/news/ireland/2021/1108/1258688-unions-pay-claim/

Joint Committee on Social Care Professionals. (2002). *Final report of the Joint Committee on Social Care Professionals. Government of Ireland*. Retrieved from https://www.lenus.ie/bitstream/handle/10147/46110/10672.pdf?sequence=1&isAllowed=y

McInerney, C., & Finn, C. (2015) *Caring – at what cost? Rebuilding and refinancing the community and voluntary sector*. University of Limerick: Department of Politics and Public Administration.

Meade, R. (2018). The re-signification of state-funded community development in Ireland: A problem of austerity and neo-liberal government. *Critical Social Policy*, *38*(2), 222-243.

Moran, J. (2013). *Unfinished business: Social policy for social care students in Ireland*. Dublin: Orphen Press.

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

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

O' Halloran, M. (2021). Minister insists she is not privatising local employment services in request of tenders. *The Irish Times*, July 1st.

O'Sullivan, E. (2008). *Residential child welfare in Ireland, 1965-2008: An outline of policy, legislation and practice: A paper prepared for the Commission to Inquire into Child Abuse*. Dublin: Trinity College.

Power, J. (2022). Tusla to draw up plan to reduce dependence on private residential care. *The Irish Times*, January 10th.

Power, M., & Burke, C. (2021). *Recruitment and retention in social care work: A Social Care Ireland survey*. Dublin: Social Care Ireland. Retrieved from https://socialcareireland.ie/wp-content/uploads/2021/12/Recruitment-and-retention-report-SCI.pdf

Power, M., & D'Arcy, P. (2018). *Statutory registration amongst social care workers survey*. Social Care Ireland. Retrieved from https://socialcareireland.ie/wp-content/uploads/2018/05/Reg-awareness-report-MP-TD-Final-May-2018.pdf

Wall, M. (2021). Analysis: Collapse of voluntary disability providers is major worry for HSE. *The Irish Times*, April 5th.

Williams, D., & Lalor, K. (2001). Obstacles to the professionalisation of residential child care work. *Irish Journal of Applied Social Studies*, *2*(3), 73-90.

About the authors

Dr Martin Power is Director of Social Care Programmes at NUI Galway, a member of the Workers Advisory Group within Social Care Ireland, and an avid armchair rugby fan. Martin has published on risk and regulation, care planning and social care work, particularly professionalisation of the social care workforce.

David Power is Director at Smyly Trust and has qualifications in social care and management, was a President of the Irish Association of Social Care Workers and founding member of Social Care Ireland, as well as representing the profession on the Health and Social Care Professionals Council (CORU) for 8 years.