JUNE DEADLINE FOR AGED OUT MINORS

Aged-out minors is a term used to describe the particular situation of separated children who have reached the age of majority and are no longer in the care of the HSE. Some separated children are granted refugee status or subsidiary protection before they turn 18. In these cases, often the young people are supported within the care system and enjoy the provision of aftercare, which may mean placement in an aftercare accommodation centre or it may just mean additional support during the transition from residential centre, hostel or foster care to independent living.

Separated children, who are still waiting for a decision on their claim, go through an ageing-out process that involves leaving the HSE care system and entering, often directly, into Direct Provision accommodation operated by the Reception and Integration Agency. These young people may be placed anywhere in Ireland. However, some young people, who age-out from HSE care but are still completing their leaving certificate (or, sometimes, other third level courses), are placed in adult accommodation in Dublin.

LEAVING CARE

As you may be aware, Direct Provision is a full-board service. All residents are provided with a bed (in most cases in a shared room, sometimes with a capacity of up to five). The centre is responsible for cooking three meals a day to be made available at three meal times during the day. This is, of course, in stark contrast to the conditions separated children have become accustomed to in foster placements and residential care centres. The separated children living in residential centres, for example, had one or more key workers, or care staff, allocated to them in addition to an agent of the HSE (either a social worker or a project worker). Aged-out minors are a vulnerable group of care-leavers who go from having a community in Dublin, in their former homes (or care facilities), to what may feel like having no one. Young people often struggle with this transition especially where specialised support does not exist, for example in Galway, or where local charity services are overwhelmed by the numbers of aged-out minors and their accompanying needs, for example in Waterford.

CASE STUDY (NAME CHANGED)

Imran is a 17 year old living in foster care. He needs consistent medical support to treat two chronic ailments. Both require pain medication and one requires surgery. He is on the waiting list at a Dublin hospital for this.

Imran is also involved in a variety of youth clubs, sports clubs and volunteer projects. He is also attending school full-time, but he has yet to begin preparation for his Leaving Certificate as he needs to improve his English language skills first. He is being supported by his current school to begin his Leaving Certificate studies in September 2013.

He is approaching his 18th birthday. He has been told by the HSE that upon turning 18, he will be moved to a Direct Provision accommodation centre outside of Dublin. He and his foster family are very concerned for his wellbeing. Imran and his family would like him to remain in the foster family until he finishes school. If this is not possible, they have indicated a placement in Dublin would at least enable them to visit each other and Imran would not be separated from his friends, school support networks and the Dublin Mosque.

Everyone in his life is very worried he may be moved in one month’s time.
Separated children who have finished their Leaving Certificate and have reached the age of 18 are typically dispersed to Cork, Galway, Sligo, Waterford or Limerick. However, this is not always the case. Some separated children are dispersed even if they have not completed their Leaving Certificate. This leaves NGOs, care staff, and former social workers scrambling to get young people into the courses they need to complete their Leaving Certificate. It is not always possible to accommodate the young person in a new school, especially in places like Galway where there are long waiting lists.

NGOs and the HSE have been providing assistance to aged-out minors who are being placed in Direct Provision hostels on an ad hoc and sometimes inconsistent basis. What has been observed is that the young people are extremely distressed and do not have the tools needed to adjust to the change in living environment. Separated children often cook ethnic food with their staff in the residential centres.

In 2010, Crosscare provided 24 hour care staff in the former large-scale hostels for separated children. They would then advocate for young people living in those Dublin-based hostels. The results were: notable improvements in the physical conditions of the hostels; the provision of care support 24 hours a day; a decrease in numbers of children going missing; and a remarkable improvement in the young people's diets.

However, in Direct Provision, they no longer have people to advocate on their behalves and look after their needs. They no longer have the support of the Irish community they had built up and they are often, for the first time truly alone. This may result in re-traumatisation and feelings of isolation. Some NGOs and care staff have expressed concern over the welfare of the aged-out minors. The demeanour and health of the young people that the NGOs have been working with seems to deteriorate during this transition period.

Furthermore, these young people no longer have homework space or quiet places to work. They are also without the financial supports that were tied to their placement in the care system and are no longer able to afford school supplies such as copy books and uniforms, especially where a change in schools occurs.

Until the end of 2010, Separated children, or children who are outside of their country of origin and separated from their parents or guardians, were housed in large hostels. The hostels were largely unsupervised and often children went missing, many still to be untraced. Presently, however, the HSE works to ensure that separated children are placed in a foster family or supported lodgings arrangement as soon as possible. This policy, titled ‘Equity of Care’, was established in response to widespread outcry over the way children were accommodated in
the hostels prior to their closure in December 2010. Under this new regime, the HSE works to provide separated children with care on a par with the wider care population made up of predominately Irish children.

It has long been argued that the application of Section 45 (the section that relates to aftercare) of the Child Care Act 1991 (as amended) in the case of separated children is still inequitable. And this is why:

Section 8.5(a) of the Refugee Act 1996 sets out the role of the HSE in respect of the ‘unaccompanied minor’ (separated child). S. 8.5(a) states that:

Where it appears to an immigration officer that a child under the age of 18 years who has arrived at the frontiers of the State is not in the custody of any person, the immigration officer shall, as soon as practicable, so inform the health board in whose functional area the place of arrival is situate and thereupon the provisions of the Child Care Act, 1991 , shall apply in relation to the child.

In simple terms, this means that the HSE has the responsibility of applying the relevant sections of the Child Care Act 1991 (as amended) to the child in question. Their obligation to provide this function comes from Section 3.1 of the Child Care Act 1991: ‘It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.’

The HSE must provide care for a separated child in some form as it is evident that an unaccompanied minor does not have a home or legal guardian to look after them in Ireland.

Once the child is referred to the HSE, the Refugee Act 1996 merely states that the Child Care Act 1991 must be invoked. It does not suggest, or require, the HSE to use any particular section of the Act in the case of separated children. This may be because the drafters of this particular piece of legislation: (A) thought the HSE would be the most appropriate and knowledgeable governmental department to decide which section of the Act to apply in the case of the individual child (based on an assessment by the social workers themselves – the Irish experts in respect of Child Care) or (B) simply did not consider the complexities of the care needs of this demographic.

It is in this same vein, if we apply the former reasoning (reasoning A), that we can suggest that the drafters of the Refugee Act 1996 saw the application of the Child Care Act 1991 as applying in its entirety. That is to say, any section of the Act through to Section 45 which relates to Aftercare could arguably be invoked. Although Section 45 does not state that all children who are in care ‘must’ be able to avail of aftercare and

CASE STUDY (NAME CHANGED)

Hussein is a young man who for a long time seemed to be doing really well but who has recently come to face many challenges.

Until the age of 18 Hussein lived in a residential centre in Dublin where he attended school and did not raise any particular concerns with centre staff. He had his ups and downs, unsurprisingly under the circumstances, but overall seemed stable and on the right track.

When Hussein turned 18 he was transferred to a Direct Provision Centre in Waterford where he had friends and school enrolment would be arranged for him. In order to assist Hussein’s transfer he was matched with an advocate provided through the Irish Refugee Council.

Initially Hussein seemed to be coping well with the transfer, which is not often the case for aged-out minors. The match with his advocate worked well; the two met frequently and started to establish a good relationship. Together they ensured that Hussein was enrolled in school and registered with the local doctor, as well as setting some short- and long-term goals for Hussein.

It was only shortly into the school year, and soon after experiencing his transfer, however, that Hussein started experiencing problems. Hussein started to lose a lot of weight. He worried about his application and he started to miss days in school. He also started to disengage with his advocate and the regional supervisor, not responding to phone calls or keeping appointments. Both contact persons received disconcerting text messages from Hussein that raised serious concerns about Hussein’s mental health, including suicide ideation. They both worked to provide him with as much support as they could but Hussein did not respond well.

Except for sporadic contact and face-to-face meetings with his advocate where Hussein did show some improvement, such as engaging in long conversations and wanting to go back to school, his actions generally showed that he was getting increasingly depressed. He became increasingly more difficult to maintain contact with. During this time Hussein also received news from home that a close family member had passed away, which only aggravated his depression and added to his anxieties regarding his application process.

The Irish Refugee Council and other agencies campaigned to have Hussein moved back to Dublin for recovery but at this stage Hussein had become so disconnected that he turned down the offer. Instead he dropped out of school and became increasingly involved with drug use. He is no longer in contact with his regional supervisor and contact person.
CASE STUDY (NAME CHANGED)

Linda is a remarkable young person who has overcome a lot of suffering in her life. She has even given a lot of time to those less fortunate in Ireland. She has assisted in various research projects and volunteered all over Dublin. Linda has, however, been subjected to forced marriage at a very early age and violence in her home country. The HSE and the Reception and Integration Agency of the Department of Justice and Equality has had access to medical files outlining past exposure to trauma and the need for on-going support and access to appropriate health services. All of her reports reference the risk of re-traumatisation. I have seen Linda go through various stages of adjustment and traumatisation as a result of her movement from the care of the HSE to hostel accommodation. I myself, have witnessed Linda lose at least one stone when she was taken from her supportive foster family and placed into a Direct Provision Centre.

Linda presented at my office in tears and extremely distressed and depressed during the transfer period. I was very concerned for her which led me to contact the HSE to try to get them to reconsider the decision to move her from care.

Linda was moved from care, but after extensive advocating from various organisations including the Irish Refugee Council. In her time in Direct Provision, she had made even more connections with the community and availed of much needed counselling in Dublin including pastoral counselling, attended church in Dublin and regularly visited the Dun Laoghaire Refugee Project and other youth and support organisations. Linda has also proven herself academically and has a private grant for her studies.

The HSE, in conjunction with RIA, however, made the decision to disperse her further, to Sligo when Viking Lodge in Dublin was closing. The Irish Refugee Council and other agencies advocated for her once again to remain in Dublin, knowing that another move would further distress and depress Linda and it would have had greatly affected her mental and physical health.

After months of advocating on behalf of Linda, the Irish Refugee Council was able to secure a place for her in Dublin. She is still very fragile and worried about her future, but she has access to counsellors, her church, good friends, her foster family and non-governmental organisations, youth services and mentors and people with whom she has long been connected. Linda and the people around her still fear another transfer to another county.

THE ROLE OF THE HEALTH SERVICE EXECUTIVE, CONTINUED

what that must look like, it does provide guidance for the HSE:

1. (a) Where a child leaves the care of a health board, the board may, in accordance with subsection (2), assist him for so long as the board is satisfied as to his need for assistance and, subject to paragraph (b), he has not attained the age of 21 years.

(b) Where a health board is assisting a person in accordance with subsection (2) (b), and that person attains the age of 21 years, the board may continue to provide such assistance until the completion of the course of education in which he is engaged.

It is rarely the case that a separated child is not in need of aftercare. This opinion is based on what is known about separated children in Europe. They are separated from their families, their country, their homes, their friends, their social networks and their schools. Moreover, a recent report found that separated children were 5 times more likely to suffer from depression, anxiety and post-traumatic stress than accompanied children.

The HSE repeatedly puts forward the argument that it is ‘government policy’ that a separated child must be placed in adult asylum accommodation, or Direct Provision, upon reaching the age of 18. This is not to say that individual social workers do not fight for few fortunate young people to remain in their foster placements beyond their 18th birthday. This is especially the case where the young person is in the middle of the academic year. However, this is not the norm, nor does it appear to be HSE ‘policy’.

However, there is only one document addressing this theme that is publically available. That is a joint policy between the HSE and the Reception and Integration Agency regarding the fate of ‘aged-out’ minors. It states that:

When an unaccompanied minor in the care of the HSE reaches 18 years of age (“aged out minor”), he or she may be referred by the HSE to the RIA for transfer to adult accommodation and service provision. In circumstances where the HSE deems such a person to be particularly vulnerable, the period in HSE care can be extended beyond 18 years of age at the HSE’s discretion.

The reference to separated children (unaccompanied minors) in the Refugee Act 1996 under Section 8.5(a), Sections 3 and 45 of the Child Care Act 1991 interpreted in good faith and even the above policy statement implies that it is ultimately up to the HSE to determine whether or not the individual unaccompanied minor should be able to avail of aftercare. However, this is not the opinion of the HSE. It is the HSE’s view that a ‘government policy’ requires that the child go to Direct Provision upon turning 18. This interpretation implies that there is a cessation clause built into the Refugee Act 1996 that would amend Section 8.5(a) to state that this provision is only
applicable until the child reaches the age of majority. This would mean that the Child Care Act 1991 only applies until the applicant reaches the age of 18. This is simply not the case. Unfortunately, this question of law (‘Is there a temporal limit to S. 8.5(a) of the Refugee Act 1996?’) has not been interpreted by a judge to-date.

Example 1: Interpreted as argued within the confines of the legislation.

1. The Refugee Act 1996 allocates responsibility for unaccompanied minor’s care to HSE with no provisos.
2. Child Care Act 1991 is invoked in its entirety.
3. Decision to provide after care in the context of Section 45 rests with the HSE considering the individual needs of the child.

Example 2: Interpreted with ‘government policy’ narrowing the protection and care legislation.

1. The Refugee Act 1996 allocates responsibility for unaccompanied minor’s care to HSE.
2. Child Care Act 1991 is invoked.
3. Section 8.5(a) of the Refugee Act 1996 ceases to apply to the unaccompanied young person when they reach 18. Therefore the Child Care Act 1991 ceases to be applicable. It is therefore the HSE’s duty to transfer the 18 year old to the Reception and Integration Agency.

The concern is thus: How do we encourage the HSE to take back the responsibility, or duty, to advocate for the child’s best interest, or welfare, and to ensure that aftercare is provided to all separated children knowing that if aftercare is not provided (in terms of the provision of secure foster family or supported lodgings accommodation), that the young person will be transferred to Direct Provision? This determination must happen without interference from the DoJE.

CASE STUDY (NAME CHANGED)

Ismail is an inspiring young person who has worked incredibly hard to overcome the challenges he has met as a separated child in Ireland.

Before turning 18, Ismail lived in residential care under the HSE in Dublin and worked hard in school to complete and succeed in his Leaving Certificate. Ismail was also very engaged in his church and the Dun Laoghaire Refugee Project. He has won awards for public speaking and is a strong advocate for integration in Ireland, having amongst other things worked with and greatly supported the Irish Refugee Council. An impressive young man, Ismail established an extensive, tight network of people who supported his continued integration in Irish society and success at school.

Nonetheless, in the middle of his fifth year of secondary school, Ismail was dispersed to Galway where he had no friends or support workers and had to wait to be re-enrolled in school. With his extensive network and success in Dublin this was an unusual and unfortunate decision as normally Ismail would have been placed in aftercare, provided to children leaving care of the State who still require support. Ismail continued to work hard to finish school and successfully completed his Leaving Certificate. His achievements won him a place in third level education in Dublin but he was met with near-insurmountable challenges in taking up this offer.

In order to fulfil his college requirements, Ismail had to stay on a friend’s couch in Dublin due to the long and expensive commute between Dublin and Galway. This led him to lose his place at the Direct Provision Centre he was staying at in Galway and being told that no accommodation was available for him in Dublin either, effectively making him homeless. At the same time, Ismail was struggling to pay his college fees.

Several efforts were made to get the Reception and Integration Agency to reconsider Ismail’s accommodation needs and eventually campaigning by the Irish Refugee Council succeeded in providing him with accommodation in Direct Provision in Dublin. Due to Ismail’s hard work and determination to complete third level education, his college offered to waive his fees. After some time, Ismail also succeeded in securing a scholarship from the One Foundation, covering all his college fees and needs.

Despite these positive developments, Ismail developed debilitating mental health difficulties and he was not able to keep up his college work. Afraid of letting down the people who had supported him he did not feel he could ask for help but instead stayed isolated in the Centre. When he improved he contacted the Irish Refugee Council for support to reapply for his scholarship and return to college.

Ismail is obviously a determined man who nonetheless has met many challenges with which he continues to struggle.
The Irish Refugee Council (IRC) is Ireland's only national non-governmental organisation which specialises in working with and for refugees in Ireland.

The main focus of our work is on those in the asylum system who are applying to be recognised as refugees. For almost 20 years, we have observed the changes that have been made in response to the arrival of refugees in Ireland. Based on extensive experience working directly with those affected, we have seen the huge financial cost of a failed system and the untold damage that has and is being done to men, women and children in the asylum process.

DONATE

Your donation will help us to work towards a fairer, more inclusive Irish society for people seeking protection. It will allow us to continue our work supporting children and young people facing the challenges outlined in this mini-newsletter.

How to donate
1. Cheque made out to Irish Refugee Council, 2nd Floor, Ballast House, Aston Quay, Dublin 2
2. Bank transfer to: AIB, 40/41 Westmoreland Street, Dublin 2, Sort Code: 93-33-84, Account No: 49657040