FAMILY PROBLEMS – SUBSTITUTE CARE:

CHILDREN IN CARE AND THEIR FAMILIES

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Kathleen O'Higgins

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GENERAL SUMMARY

Introduction

The rationale for undertaking a study of this nature is based on the increasing awareness of children's rights and their need for the continuity and security of a stable family. With respect to this area of children's rights, as a result of the Report of the Inquiry into the Kilkenny Incest Case, the Minister for Health Mr. Brendan Howlin, has announced that consultations are to begin between the Government and the Attorney General in relation to one of the recommendations of the Committee of Inquiry. Consideration will be given to amending Articles 41 and 42 of the Constitution so as to include a statement of the constitutional rights of children. The importance of the family to the child, apart from the Constitutional emphasis on the importance of the family, is clearly stated in the United Nations Convention on the Rights of the Child ratified by Ireland in September, 1992. Section 3 of the *Child Care Act, 1991* specifically states that, *inter alia* "a health board shall have regard to the principle that it is generally in the best interests of a child to be brought up in his own family". For some children the opportunity to experience a stable family life never exists. Some families never operate as a unit. Others break down temporarily or permanently and some parents are unable or unwilling to care for their children. In these circumstances, where an extended family cannot provide for the children, the State may be obliged to provide temporary or permanent substitute families for such children.

This study concentrated on characteristics of children in substitute care and their families in one Health Board region of Ireland during 1989. It was argued that the child cannot be treated in isolation as problems leading to substitute care for children are not intrinsic to the child but are very much part of family problems. It is also argued that, of course, in certain limited circumstances, care may be a positive experience for a child. However, in general, research indicates that taking a child into care is seriously disruptive and possibly damaging.

Data and Methods

A structured questionnaire was prepared and the relevant social worker in the Health Board completed one for each child in care at any time during 1989. The community care social workers are the key workers with

children in need of care or protection. Thus, as the main source of information on children placed in care, they played the crucial role in the collection of the data.

In this study two levels of analysis were used to examine the factors which led to the placement of a child in care. These levels were (i) the external context, e.g., employment status and formal support services and (ii) the internal context, for instance, poor mental or physical health of parents, problems with alcohol or poor kin relationships.

Main Findings

The number of children in care in Ireland has risen from 1,665 in 1970 to 2,756 in 1989 – an increase of 40 per cent over those years. The study shows figures for Ireland from 1980 which indicates a small but steady increase of admissions over discharges.

Following on data for Ireland the study concentrated on the data from the Health Board in question. The demographic characteristics of the children were examined first and it was found that although children were admitted to care at a young age, their ages in 1989 were considerably older, indicating that the children had spent long periods in care. The age groups are, of course, arbitrary but do indicate that, for instance, one-fifth of all children in care during 1989 had been admitted aged less than 6 months old. While children were more likely to have been admitted from the younger age groups, their "present" ages in 1989 were far more likely to have been in the older age groups. Overall, there appeared to be a preponderance of older children in care. Sixty-eight per cent of all the children in care during 1989 were aged 7 years and older.

Age at admission and present age are compared with the age breakdown in the Census of Population 1986 for the Mid-West region. The information here points out that children under 4 years of age have a higher incidence of admission to care than their proportion in the population would warrant, while children's "present" age in care is more likely to be in the older age groups, for instance, an over-representation in the 10-14 year age group compared with the Census figures.

A majority of the children in care in 1989 had been admitted through Court Orders and there appeared to be a build-up in care of children who had been admitted on foot of a Court Order. Numbers of admissions by Court Order in any given year are not increasing, but the proportion of children in care, originally admitted on foot of a Court Order, is increasing. The study speculates that perhaps when a child is admitted to care through a Court Order it is more difficult to solve the family problems

to enable the child to be returned to his or her family. There may also be a lack of initiative to discharge because of the seriousness of the case.

The children of single and lone parents generally appeared to be more vulnerable to placement in care, as they were very much over-represented in the population of children in care. This vulnerability of non-marital children to placement in care and the seeming continued increase in the number of non-marital births may present a problem for policy makers. However, because lone parent families are becoming more common, this factor may be a poor discriminator and the question which suggests itself from the data is – which members of these large groups, potentially at risk, actually come into care?

Access and contact between the children in care and their families, both immediate and extended, are regarded as being essential. What could be regarded as a high proportion of children in care in this study have extremely poor or no contact with their parents or relatives. The evidence shows the main reason to be neglectful parents in the cases of poor or no contact. However, some of the children themselves did not want any further contact with their parents. Where contact and access were otherwise unproblematic, there is a grave need for the development of innovative access visit facilities. Few suitable locations are available for parents to take their child on an access visit. Given that the parents generally lacked financial resources, some assistance with say, a day at the seaside, visits to places of interest or use of hotel/leisure facilities, would make the contact more relaxed and help the parents communicate with their child more effectively.

Coming to the parents of the children in care, they were mostly poorly educated, of low social status, likely to be unemployed and lacking any great degree of kin or neighbourhood support. The main problems manifested by the parents which affected their children, leading to their placement in care, were emotional or psychological ones, alcohol abuse and some degree of mental illness.

The study comments that it is not surprising that the families come from a marginalised working-class group, with high unemployment levels and poor education. The high lack of kin support was felt to be caused by the inability of the families to reciprocate any help given, reciprocity being a necessary component of social interaction.

As regards reasons why children were actually taken into care, neglect, in the sense that the child was not necessarily abused but was unkempt and/or hungry, was the most outstanding reason. Neglect takes place over a long period, is a continuous lack of care about the welfare of one's children. Thus neglecting one's children may be more culpable in a

number of instances than say, physical abuse, but receives less publicity. Neglect of children may come from deeper parental needs than abuse of children.

The "Kilkenny case" demonstrates the likelihood that abuse is not always recognised for what it is by either the statutory services or the general public. The "real" level of abuse is likely to be much greater than that revealed by the number of children taken into care because of abuse.

Children also came into care in large numbers because of a crisis of some sort in their family – a mother was ill and there was no relative or friend to look after the children.

Considering the type of care experienced by the children, older children were less likely to be placed in foster care and the majority of children in residential care were older marital children who had spent a long time in care. The children in this study had been in care for various lengths of time. The span was from less than 6 months to more than 12 years.

The Mid-Western Health Board, Social Work Department, Child Care Service, published a policy document *Child Care Policy and Practice Statement* in 1991. This was, of course, many years after the admission of the children to care in this study. The statement limits the grounds on which a child is admitted to care and stresses family support to counteract the need for care. With the implementation of the policy set out in this statement, a number of the reasons for admission of the children who were in care or admitted to care during 1989 would not now apply. It is to be hoped that with continued support the practice and policy statement can be fully implemented. In addition to the awaited implementation of the *Child Care Act, 1991*, it would make certain that the principles which informed the *Task Force Report* of 1980 – that laws and policy combine to ensure that children can receive the care and protection they need in their own families – will finally be put into practice.

Chapter 1

INTRODUCTION

The central task of this study is to describe the main features of families which a Health Board considered were not providing adequate care or protection for their children thereby leading to the placement of those children in substitute care. This study provides data not previously assembled on substitute care for children in Ireland. Such data include family and kinship characteristics and reasons for placement of children in care. The "child in care" is not a well-defined and unitary concept. This is evidenced to some extent by an earlier ESRI study *State Care – Some Children's Alternative*, based on the limited Irish data then available as well as a number of research reports elsewhere.[1]

For some children the opportunity never exists to experience a stable family life. Some families never operate as a unit; some break down temporarily or permanently; some parents are unwilling or unable to care for their children. In families reconstituted after separation between the natural parents, a child or children of one or other parent may be rejected by the new partner. The State then has to provide temporary or permanent families for such children where they can be given the opportunity to develop to their full potential.

When children are taken into care, it may be on one or other of two bases – the voluntary placement of a child in the care of a Health Board, or the compulsory removal of a child from his/her parents on the order of a Court. Children are taken into care voluntarily under the provisions of the Health Act (1953) Section 55. In the case of a Court Order the legal provision is contained in the Children Act (1908) Sections 20, 24 and 58. A child or young person may be placed in care in the following situations:

(i) where he/she has committed a crime;
(ii) where he/she is persistently absent from school; and
(iii) where he/she requires care or protection.

[1] O'Higgins, K. and M. Boyle (1988) and see, for instance, Packman *et al.*, (1986); and Millham *et al.*, (1986).

The situations at (i) and (ii) are primarily matters for the Minister for Education and the special schools which operate under the aegis of the Department of Education. The present study is concerned with children in category (iii) above, who are currently in the care of the State, because they have no family or their family is not considered fit to or will not look after them, either permanently or temporarily. Therefore, the definition used in this study for a "child in care" refers to a child in the care of a Health Board, whether placed in a setting outside his or her nuclear family under supervision of a Health Board, or being supervised by a Health Board but remaining at home. The definition "child" refers here to a child or young person in care, which may include young persons up to 21 years of age. Children in need of such care or protection for the purposes of this study are those who lack proper care or guardianship, and against whom official "offences", such as neglect, ill-treatment, assault or abandonment are judged to have been committed.

Previous work undertaken at the ESRI (O'Higgins and Boyle, 1988) was based on a data set provided by the Department of Health. It was beyond the scope of that study to deal with issues which are extremely important: for instance, (i) the underlying factors determining what stresses on families lead to children being placed, discharged or retained in care in Ireland; (ii) the socio-demographic and familial/kinship characteristics of children taken into care; (iii) the care careers of the children placed in care; and (iv) the effect of the existence or lack of social services, e.g., day-care facilities, in a community care area. The current more thorough investigation provides information to complete the picture of the role substitute care plays in the State's response to some families with problems.

Rationale

The rationale for undertaking a study of this nature is based on the increasing awareness of children's rights and their need for the continuity and security of a stable family. The *Task Force Report on Child Care Services* (Ireland, 1980) made a statement concerning the importance of a stable family setting for children. Added to that, Farmer (1979, p.197) points out that before Bowlby's (1951) research it was not fully realised that the institutionalisation of children deprived of home life, even in a hygienic and well-run establishment, might have serious repercussions on personality development and possibly on the acquisition of social maturity and skills. Both of these effects could give rise to problem behaviour, a matter of concern for the whole society. Later Ayres (1985) contended that substitute care, either residential or foster, is hazardous to the well-being of any child. He stated:

> We have all observed the resolution of family dysfunction by care to be replaced by a new set of difficulties which are frequently much worse than the original family problems. (Such difficulties include separation anxiety, foster parent disruption, identity problems, depression, withdrawal and confusion.) (p.18).

This statement supports other findings.[2] In certain limited circumstances, care may be a positive experience for a child as outlined in, for instance, Berridge (1985) and Fisher, *et al.* (1986). However, in general, research indicates that taking a child into care is seriously disruptive and possibly damaging. Of course, not taking a child into care may also be equally or more damaging particularly for children suffering from violence or sexual abuse.

Little was previously known of the type of children or their families studied here – children in the care of a Health Board who have been deprived of a normal home life. They are seldom problematic in the sense that they are not themselves involved in crime but are usually victims of their families' problems. This is a group that excites less political interest than, say, children who are involved in crime. So the aim of the present study was to identify the particular characteristics of the families of children in care in one Health Board Region; i.e., Mid-Western, characteristics which may have made these families more vulnerable. No control group was used but comparisons with the relevant national and regional populations were made where appropriate and available.

The Importance of the Family to the Child

The importance of the family to the child is clearly emphasised in the United Nations' Convention on the Rights of the Child which, its preamble declares, is

> Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance, so that it can fully assume its responsibilities within the community (United Nations, 1989.)

The Convention also recognises that for the full and harmonious development of his or her personality, a child should grow up in a family

[2] See, for instance, Rowe and Lambert (1973), Packman *et al.* (1986).

environment, in an atmosphere of happiness, love and understanding. Article 9 pledges State Parties to ensure that a child shall not be separated from his/her parents against their will unless it be judged, with appropriate law and procedures, that such separation is necessary in the best interests of the child. This Convention was ratified by Ireland in September, 1992.

The Universal Declaration of Human Rights and the European Social Charter, signed by all 12 European Community countries, endorsed the essential place and role of the family in society and the actions which must be taken to protect it. For a certain number of States, endorsement is included in their Constitutions. Family policies are explicit in some States and implicit in others, but all have a general public and political acceptance of the need for support for families.

In Ireland, recognition of the Family as the natural, primary and fundamental unit of society is enshrined in the Irish Constitution (Article 41). The Family is defined as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law. In Section 2° of Article 41, the State guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.

Section 3 of the Child Care Act 1991 specifically states that, *inter alia*, "a health board shall have regard to the principle that it is generally in the best interests of a child to be brought up in his own family". This principle has to be upheld in any consideration of the admission of a child into care.

Definition of "Family"

The concept of "Family" encompasses most types of households, although there is considerable cross-national variation in both types of households and families. This pluralistic character of family and household is one which is now widely accepted, and enshrined in a general principle of non-interference in the "private" lives of individuals. Governments of the 12 Member States of the European Community respect this principle, while continuing to exercise the role of arbitrator in the event of conflicting rights. This occurs despite the fact that the majority of EC States have articles in their country's Constitution which guarantee a special institutional protection for families founded on marriage. Reference was explicitly made to family rights in the Constitutions of 8 States: the then Federal Republic of Germany, Spain, France, Greece, Ireland, Italy, Luxembourg, and Portugal (see: European Observatory on National Family Policies, 1990).

Apart from defining the family as a moral institution, no further definition of what constituted a family was written into the Irish Constitution. However, the term "family" was ruled on by the Supreme Court in a case in 1964 as relating only to a family based on marriage – that is a valid marriage under the law of the State. The Task Force on Child Care Services in Ireland, reporting in 1980, concluded that if, as the Constitution states, children have equal "natural and imprescriptible" rights, then it would be inconsistent if the Constitution recognised some of the essential institutions ("families") providing parenting, but did not recognise others, such as an unmarried mother and her child. The need for a broader definition of "family" was stressed. Some members of the Task Force were inclined to the view that "the Supreme Court today might ... give a judgment more appropriate to present day knowledge of these matters" (Ireland, 1980, p.213). These members were optimistic about the possibility of the Supreme Court reversing earlier decisions and accepting a broader definition of "family". Up to the present this has not occurred, but some changes would appear to have been made in certain associated areas. For instance, the Social Welfare Act, 1991 provides that unmarried couples will in future be treated in the same manner as married couples with regard to assessment of means, income and payment of child-dependent allowances for the purposes of certain family-related social welfare schemes. This, in effect, gives cohabiting couples the same status as married couples, thus illustrating a change at Government level and an acknowledgement that marriage alone does not confer the status of "family" on a couple and their children.

In Article 42.1 on Education, the State acknowledges that the primary and natural educator of the child is the family, and the State guarantees to respect the inalienable right and duty of parents to provide, according to their means, for the religious and moral, intellectual, physical and social education of their children. In Section 5 of Article 42 it is stated that in exceptional cases, where the parents, for physical or moral reasons, fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child.

There can be no need to stress further that the basic principle underlying all care of children in EC countries is that the family is the proper, appropriate and best environment for the socialisation of children. The family is regarded as the primary source of love and individual care for children and provides the setting in which children's needs can be met. Ultimately, the welfare of children depends on the stability of the family to

which they belong. It is reasonable to assume that children who have a warm, continuous and intimate relationship with their parents or parent throughout childhood will develop a sense of identity, self-worth, an ability to trust others and himself/herself, a capacity to handle stress and frustration and to make and maintain relationships.

Recent years have seen significant changes in Irish society. Some of these would seem to have particular implications for the future of alternative or substitute care. For instance, there has been a decline in the birth rate over the past two decades – from an annual average of 21.7 per 1,000 population in the 1970s to 14.7 per 1,000 in 1989 (Clancy, 1991, p.17) by far the lowest rate ever recorded in Ireland. For the first time since records commenced the fertility rate went below the replacement rate (2.11 in 1989). Likewise, there has been a decline in the marriage rate from 7.0 per 1,000 population in 1970 to 5.1 per 1,000 in 1989 (Clancy, 1991, p.10); a renewed growth of net emigration from a figure of 1,000 in 1981 to one of 46,000 for the year ended 1988/1989 and 31,000 in 1989/90 (NESC, 1991). The unemployment rate was calculated in EUROSTAT (1991) as 15.7 per cent for 1989. Only Spain's 17.1 per cent was higher in the EC in 1989. The Irish rate was almost twice the EC average of 9.3 per cent.

Other changes which are most relevant to this study are the steady growth in the annual rate of births outside marriage which in 1989 had reached 13.6 per cent of all births compared with 2.7per cent in 1970 (Department of Health, 1990) and a threefold increase was recorded in the proportion of married women in the labour force. This proportion rose from 7.5 per cent in 1971 to 23.4 per cent in 1987 (Blackwell, 1988, p.14).

The number of children in care in Ireland as a whole has risen from 1,665 in 1970 to 2,756 in 1989 – an increase of 40 per cent (Department of Health Census of Children in Care figures). As regards type of care, the proportions in residential care and foster care remained virtually static between 1970 and 1985 (57 per cent in foster care in 1970 and 56.6 per cent in foster care in 1985) (Gilligan, 1990, p.7). However, figures from the Department of Health returns for 1989 show a steep rise in the percentage in foster care – up to 72 per cent of all placements, and a rise also in the actual number of children fostered. Gilligan (1990, p.7) notes that there are fewer children fostered now than there were in the 1920s, 1930s and 1940s, probably because of more rigorous screening of prospective foster parents nowadays. Yet the present total of children fostered at any one time, at just over 1,800, represents a considerable increase on the low point of 932 in 1972. The 1980s saw many positive developments in fostering.

There was a revival in the use of foster care leading to its dominance as a form of placement for children in care. New regulations were introduced, public awareness of fostering increased and the Irish Foster Care Association was established (Gilligan, op.cit.,p.7). Chapters 2 and 3 include some further comments on developments in foster care.

Research Questions of the Study

Overall, the study focused on seven questions:

(i) What are the socio-demographic and familial characteristics of children in care as compared with the general population in the area? These demographic characteristics would be expressed in terms of the age of the child, birth status of the child, family background which would include socio-economic status of the parents, education of the parents, age of the parents and family size.

(ii) What are the main official "reasons" why children are admitted to care? Are the reasons for care due to structural factors in the family's background (e.g., poverty, unemployment and alienation resulting from it), or are they due to personality problems of the parent/parents? Do the families have problems such as chronic illness or handicap, mental or physical, and are the parents involved in drug abuse, alcohol abuse or gambling? Is there neglect or abuse of the children, and if so, what are the dimensions of this abuse, for instance, its type and severity?

(iii) How long do children spend in care and why are some retained in care for long periods? Who are these children who stay in long-term care in terms of: (a) their reasons for being in care; (b) their socio-demographic characteristics age, sex, birth and family status, area and family size, and (c) the reason for their staying in care? Is the reason the child has not been returned home the same as the original reason for placement in care?

(iv) What type of care is regarded as most suitable for the particular child? Is this the type of care the child is

presently experiencing? If not, why not? What care career has the child had, e.g., previous admissions and care type changes in present and previous admissions?

(v) When children are discharged from care, have the families they return to sorted out their problems or been assisted to do so? What happens to young persons, for instance, those leaving care having reached the legal age limit?

(vi) Can any explanation be found for the likely differing rates of children being placed in care in three Community Care areas of the same Health Board? What influences have such factors as unemployment levels, the existence of voluntary agencies in an area, and the provision of day-care facilities on the probability of a child being admitted to care?

(vii) What are the perceptions of the family regarding the problems which led to their child being taken into care? What types of stress have they encountered, either personal or environmental? What possible statutory or voluntary-based interventions could have reduced their vulnerability to their child being placed in care?

Methodology

The previous study of children in care undertaken at the ESRI (O'Higgins and Boyle, 1988) completed an analysis of the data provided by the Department of Health from their Child Care returns. These data treated the child in isolation giving no details of his/her background. This child-centred approach is understandable in terms of the Child Care Division which is dealing with the reality of the child already in care and requires broad details of numbers, ages and, in general, reasons for placement, discharge or retention in care. However, the child is part of a family and the reason for its admission and retention in care is seldom attributable only to the child and/or his or her siblings who may also be in care. Inevitably it is due to circumstances in the child's family which could range from a minor temporary illness of the mother to, for instance, complete homelessness of the child and/or its parent(s). To reiterate then, these earlier data ignored the reality that any attempt to understand the

nature of the vulnerability of particular children to placement in care raises questions relating to their family background and environment. Having a child placed in care is an indicator of the likelihood of serious problems in, or confronting, that child's family. Thus, while certain useful information was gained from the analysis of the available data, a large area was left unexplored and thus unexplained – that area being the vital one in building up a picture of why some families have the experience of their child being taken into care while others do not.

An ideal study would have been of certain chosen Community Care areas, contrasted by (a) urban/rural divisions; (b) high/low levels of placement in care; (c) different socio-economic composition, and (d) high/low population density. The study would thus have been representative of a broad spectrum of social conditions and geographical locations. Also it would have provided a national representative set of data both in respect of numbers of children in care and a number of key social indicators. For resource reasons, however, this did not prove possible.

In 1989 resources became available from the Programme Manager, Community Care of the Mid-Western Health Board Region to conduct a study of the families of children in care. Initially a study confined to Tipperary North Riding/East Limerick and Clare Community Care areas (CCAs) was agreed upon. A questionnaire, a copy of which may be obtained from the author, was formulated on the basis of the main research questions. As both funding and social worker time were equally limited no control group could be involved. Consideration was given to the range of information to be collected. Preliminary discussions with two of the senior social workers from the Health Board were held. It was decided the best method of collection of the data would be by the relevant social workers who would complete a questionnaire for each child in care during 1988. In Tipperary North Riding Community Care area, the senior social worker and five social workers were involved in the collection of data. In Clare CCA two social workers completed the questionnaires. However, in January 1990, the Programme Manager, Community Care took the view that a more accurate picture of the situation of children in care in the Mid-Western Region could be gained by the inclusion of the Limerick CCA. The year chosen for the study of the three areas was 1989. New sets of the same questionnaire were then prepared. Each social worker in both Tipperary North Riding Community Care area and Clare again completed a questionnaire for each child in care, this time for 1989. In Limerick, a social worker, now engaged in administration, was assigned the task of overseeing the collection of the data. Finally, a total of 461 completed schedules were returned from all three areas by November 1990. Children

placed for adoption were included at that stage. Subsequently, it was felt that these children could not be defined strictly as "in need of care or protection". Thus they were excluded from all but the preliminary analysis. It is hoped to write up a separate account of them later.

The community care social workers are the key workers with children in need of care or protection. Thus, as the main source of information on children placed in care, they played the crucial role in the collection of the data.

The questionnaire dealt with a number of factors critical to an examination of the subject of children in substitute care and enabled two levels of analysis to be used to examine these factors. These levels are: (i) the macro level or external context of stress on the family, i.e., impact of unemployment, lack of kin support or formal support services; and (ii) micro level or internal context of family stress, for instance, poor mental or physical health of parents, abuse of alcohol and inter-familial traumatic events such as the death of a parent.

A number of families were interviewed by the author both to ascertain (a) their perception of their situation *vis-à-vis* their child being placed in care and (b) to record the researcher's impressions of the kinds of problems encountered by these families, leading to their vulnerability to having a child placed in care. These families were chosen by the social workers. Families who, for instance, had a Court case pending could not be interviewed. The main criterion for the interview was the co-operation of the family. Thus, the families are not representative but are examples of families whose children have been placed in care.

Some small discrepancies occurred between the number of cases mentioned in the returns to the Department of Health from the Mid-Western Health Board and the questionnaires returned to me.[3]

[3] The total number of questionnaires returned to me from all areas was 461. That number included children in care at any time during 1989, and adoptees. The comparable figures from the Department of Health's survey is 448 children. However, if one excludes the returns for adoptees 461 minus 69 (my figures) and 448 minus 57 (Department of Health figures) one is left with totals of 392 and 391 respectively. Originally there was a problem with 16 cases in the Limerick area which had been incorrectly assigned by a social worker as children placed for adoption. When these were reassigned to their correct section, the figures emerged as above. The difference still remains of the 12 extra children in my returns said to have been placed for adoption. However, since most of the analysis was undertaken on 392 children, none of whom had been placed for adoption, the problem is not serious at this stage. As already noted, I do not intend to consider children placed for adoption as a group in this study but expect to deal with them in a separate account when these discrepancies will be explored further.

In some instances responses to questions were missing when the questionnaires were returned. When this occurred the relevant social workers were contacted. Despite these repeated attempts in some circumstances no further information could be obtained as it was not on the child's file. In a study such as this, the fact that no information was available to the social worker from the files seems to be significant in itself, in that it points up the difficulties of planning any interventions to support these families when full information on them is not available. Probably the largest area of missing information concerned the fathers of the children in care. For instance, information on the age of the fathers was available in only 67 per cent of cases; on fathers' education level in 64 per cent; on their occupation 56 per cent and on fathers' source of income information was available in only 64 per cent of cases.

Farmer and Parker (1989) had a similar experience in collecting data for their study of children home-on-trial in Britain. They pointed out (p. 64) that part of the problem is that few social workers remain responsible for a child in care or their family over long periods. The turnover of staff inevitably fragments the official record of a child's career. It was plain, they said, from the time that it took them to thoroughly read and digest the material on file that new social workers must face major problems in acquainting themselves with the recorded history. Even then there may be gaps in what is available and some important matters will simply not have been written down.

Throughout the study for the sake of clarity the Mid-Western Health Board is referred to as "Region" while the Community Care areas are referred to as "area".

Chapter Details

Chapter 2 places the study within the framework of the socio-historical evolution of the care of children inside and outside their families of origin, either in other families or institutional or other residential facilities.

Chapter 3 looks at the patterns of placement of children in care in the Health Board, in terms of their numbers, the inflows and outflows to care, some demographic details – age and gender; birth status; legal basis of placement, type of care placement, and assessment and criteria for placement in care.

The family of origin of each child is the focus for Chapter 4. Here the demographic characteristics of the parents, in terms of age, education, social class by occupation will be noted. Other characteristics such as the type of housing in which they live, family size and family type will be discussed. The level of kinship and neighbourhood support will be

examined, followed by formal support networks. The agency through whom the family initially came to the attention of the Health Board will be noted.

Since all children are, or have been, part of some type of family structure, one cannot treat the child in isolation. In this study the child has been removed from its family of origin for some reason or reasons, and either has been returned to that family or has been retained in care for some reason or reasons. Chapter 5 deals with the underlying, internal family and child-centred problems leading to placement in care, and the reasons for retention or discharge. The analysis here will provide important information to enable strategies or interventions to be suggested which could modify the vulnerability of the families to their children being taken into care.

Chapter 6 charts the experiences of children in care in terms of suitability of placement; length of time spent in care; number of moves while in care; links with family and contact/access of parents to children and vice versa.

Chapter 7 summarises the findings and draws conclusions, as well as making recommendations for future action.

The data collected and analysed in this study provide analysis of not previously assembled material on a specific group of families with major personal, social and economic problems. The study deals with children in care and their families in one Health Board Region. In drawing conclusions from the data, its geographically restricted character must be taken into account when considering the generalisability of the findings. None the less, as will be clear in relation to the important substantive issues covered in the study, the findings are entirely consistent with those from the broader international literature.

Chapter 2

SOCIO-HISTORICAL BACKGROUND TO CHILD CARE

In order to understand or appreciate the present situation of State care for children in Ireland some brief discussion of the social history of substitute care for children is needed. First, a description will be provided of the manner in which over the past millennium the care of some children was taken out of the hands of their immediate family and placed either in that of (a) another family or (b) some type of residential or institutional care. In particular, it is useful to chart the more recent evolution from what O'Sullivan (1979) termed the "social risk" model of children in care to the present-day "developmental model". Second, developments in child care services in general will be discussed, and finally this chapter will explore briefly the evolution of the place of the child within the family.

Foster Care

There has been a long tradition of fostering in Ireland. Indeed one of the distinguishing features of the Irish social life during the currency of the Brehon Laws was the fosterage of children, a practice aimed mainly at strengthening the cohesion of the tribe, and contributing to social order (Robins, 1980, p. 3). The Brehon Laws were in force as the native legal system and prevailed in Ireland for an estimated 700 years (Ginnell, 1894). These laws provided a complex and flexible structure of constraints and regulations affecting family, community and society. Robins observes that these laws reached their fullness before the ninth century and although disturbed by the subsequent Danish and Norman invasions and English settlements, remained in operation until stamped out as the English strengthened their control on the country in the seventeenth century.

An unusual feature of the Old Irish language illustrates the importance of fosterage in early Irish society. Kelly (1988, p. 86) comments that in most Indo-European languages the words "father" and "mother" have intimate forms, used particularly in childhood. In Old Irish, on the other hand, the intimate forms were transferred to the foster parents.

The laws distinguished two types of fosterage. One was fosterage for affection *(altramm serce)* for which no fee was paid. The other type was

fosterage for a fee. The foster parents were required to maintain their foster child according to his or her rank. The arrangement to place a child in fosterage was a legal contract and the child had to remain with the foster parents until the period of fosterage was complete. It was only in the case of a child being improperly treated that he or she could return to his or her parents (see Kelly, 1988, pp. 86-90).

Powell (1982), writing on social policy in early modern Ireland, notes that under English law fostering assumed a politically oppressive purpose, for it was used to regulate Catholics and the poor. These two groups were usually the same people.

However, the foundations for what is the present system of foster care were laid in the Irish Poor Law Amendment Act, 1862. Under this law, the administrators of the Poor Law were given the power to "board out" children up to five years of age with families outside of the workhouse. The introduction of this system of boarding out was one of the first and most notable steps away from the stern principles of the early Poor Law (see Robins, 1980). However, the Infant Life Protection Act of 1897 contained the origins of the present-day social work in foster care. This Act gave to local authorities the power to appoint female inspectors. These inspectors could visit children placed with families and if conditions were not satisfactory, they could remove the children. The present system of foster care operates under the Health Act, 1953, and the Boarding Out Regulations of 1954 and 1983. Although the foster-care system has been modernised, to date the training needs of child care personnel working with families have not been fully recognised either by the Department of Health or by the Health Boards (NESC 1987, Report No. 84, p. 70). A more detailed account of the system in operation at present is outlined in Chapter 3.

Residential Care

With respect to institutional or residential care, the evolution of the State control of child care in general in Ireland starts after 1838 when

> ... the workhouses became the main centres for charity children of all categories. While these new institutions were harsh and punitive in concept, the Irish Poor Law Commissioners and their successors, the Local Government Board for Ireland, were humane in outlook and genuinely concerned about the welfare of the workhouse child. But the Famine years of 1845-1849 and their dreadful consequences created conditions in the workhouses which took a long time to mitigate (Robins, 1980, p. 9).

The workhouses found it impossible to cope with the number of Famine victims. Some workhouses were so much in debt that they had to expel some of the paupers in their care (see Robins, op. cit., p. 190). The availability of so many Irish orphans coincided with the orphan emigration scheme whereby female Irish workhouse orphans were transported to Australia. This scheme provided an answer to the desire of the Colonial Land and Emigration Commissioners to find suitable single females to transport to Australia to further the development of the colonies and to provide a better balance in the ratio between men and women.

"As the nineteenth century progressed, the contribution of private charity grew and the religious-controlled institutions came to care for many of the children in need of help" (Robins, 1980, p. 8). After the middle of the nineteenth century the establishment of reformatories and industrial schools was a response to the increasing awareness of the need to provide for delinquent children or those exposed to vicious influences. On the introduction of the Industrial School system to Ireland in 1868, various religious orders were requested to undertake the work. Where the Order was willing to do so, and where it provided suitable premises, these premises were certified as fit for the reception of children into care. Both Government and Local Authorities contributed towards the maintenance of the children.

Children were placed in Industrial Schools for a variety of reasons. Some were there because of family circumstances (e.g., poverty, illegitimacy), others had been deserted, while others still had been committed to these schools as a result of a variety of offences. No differentiation was made between the groups. All were treated to the same three-part programme, comprising (i) physical care, (ii) literacy and manual instruction, and (iii) moral formation (Ireland: Cussen Report, 1936).

O'Sullivan (1979) sees the changing philosophical or ideological background to alternative child care as changing from the "social risk" model of the child in care, that is, where a child was regarded as a danger to society, to the "deprived model", where the welfare of the child predominated. The Industrial School System, when first introduced into Ireland in 1868, emphasised almost entirely the "social risk" model of the child in which society's interests were pre-eminent. (O'Sullivan, ibid., p. 210). Child care was seen as a means of social control (and containment) and an important way to prevent future pauperisation rather than an opportunity for children to develop and to have individual fulfilment. The transition to the deprived model resulted in the predicament of the child being seen as an affront to the tenets of social justice.

The change in the image of the industrial school child as a delinquent began in 1928 with the transfer of responsibility for industrial schools from the Minister for Justice to the Minister for Education. Gradually, the link was broken with the prison system which had previously given rise to the notion of industrial schools as being milder forms of reformatories. Probably the first really fundamental change in emphasis with regard to orphans, neglected and illegitimate children is to be found in the above-mentioned Cussen Report of 1936. However, it was not until the late 1950s that institutionalisation was formally and finally regarded as undesirable, and alternatives such as adoption and fostering advocated for children who had not committed crimes but were in need of care or protection.

The Reformatory and Industrial Schools Report of 1970 (Ireland: the Kennedy Report) was the result of the response in 1967 of the then Minister for Education, Donagh O'Malley, to the realisation that not only were the powers vested in him by the 1908 Children Act limited, but also that the Act was not suitable to an era of changing conditions. With the Kennedy Report of 1970, the "developmental" model had finally arrived. Psychological and emotional needs were now to be taken into consideration. However, the fact that child-care definitions in official reports or social movements change is no indication that child-care practices will be harmoniously modified. "Indeed, the phenomenon of cultural lag is relatively predictable in essentially conservative organisations such as child-care institutions" (O'Sullivan, op. cit., p. 213).

However, some worthwhile changes have been made by the transformation of residential care from the large institutions of the past to small units. Training courses for child-care workers are now in operation with the emphasis on working with family-sized groups in residential settings. The absolute number in all types of residential care has declined dramatically over the years, so proportionately foster care has become more important.

While commenting that the inadequacy of existing services for homeless children and children in need of alternative residential services has been evident for many years, the study *At What Cost?* (Streetwise National Coalition, 1991) notes that the Irish child care residential system is a system which has changed dramatically, particularly over the past 20 years. Residential care units in Ireland face immense challenges in dealing with new demands in a rapidly changing society, which the above report says, include the intensification of long-term unemployment, the decline of the traditional family structure and increasingly alienated youth. Traditional forms of residential care can no longer cater for the needs of children in need of residential care and new forms need to be tried to

ensure that the rights and needs of the child are sensitively and comprehensively provided (p. 45). Further comments on other aspects of residential care are included in Chapter 3.

General Development in Child Care Services

At a general level it should be noted that, in an effort to bring the health services up-to-date, 8 Health Boards were established in 1971 under the Health Act, 1970. In 1974 the Government assigned the main responsibilities in relation to child-care services to the Minister for Health. Following that decision, the Task Force on Child Care Services was established against the background of a continuing development of our health, education and social services; a growing concern for the well-being and development of children and a growth in knowledge concerning children's needs. This Task Force was given the following terms of reference:

(i) to make recommendations on the extension and improvement of services for deprived children and children at risk;

(ii) to prepare a new Children Bill, updating and modernising the law in relation to children;

(iii) to make recommendations on the administrative reforms which may be necessary to give effect to proposals (i) and (ii) above (see p. 26).

In its final report in 1980, the Task Force indicated that the responsibility in relation to child-care services had not yet been translated into legislation and that the legal responsibilities of the Minister for Health in relation to child care were somewhat limited (1980, p. 52). In the same year the Department of Health issued guidelines on dealing with non-accidental injury to children and child abuse. Two years later a Fostering Resource Group was established in the Eastern Health Board, which also opened a residential child psychiatric facility. In 1979 a Child Care Division was established in the Department of Health. The Irish Foster Care Association was founded in 1982 and a year later responsibility for the Adoption Board was transferred from the Department of Justice to the Department of Health. In the same year the Department of Health replaced capitation funding for residential care with a new system of annual budgets for individual centres; a new set of regulations governing foster care replaced the 1954 regulations, and the Department of Health

also began to collect annual statistics from the Health Boards on non-accidental injury.

The National Plan, *Building on Reality* (Ireland, 1984) in its section on Child Care legislation, stated that the intention of the then Government was to introduce three Bills in relation to the care and protection of children. It was acknowledged that much of the existing legislation in this area was now outdated and not sufficiently in keeping with current concepts in regard to the well-being of the child (1984, p. 98).

These three Bills were, (i) *Children (Care and Protection) Bill 1985* (which, with a number of changes, became the *Child Care Act, 1991* and emphasises the importance to the child of his/her own family); (ii) *Adoption Bill, 1986* (now *Adoption Act, 1988*) which aimed to extend the categories of children who may be legally adopted, and (iii) a Bill concerning juvenile justice to update legislation on children who came to attention through involvement in crime. Another piece of legislation introduced was the *Status of Children Act, 1987* which came into effect in January 1988. The purpose of that Act is to remove as far as possible provisions in existing law which discriminate against children born outside marriage.

Increasing concern about child sexual abuse led to the revised detailed guidelines being issued on 29 July 1987 (the first were issued in 1978) to help professionals identify, investigate and treat child abuse.

Some other changes have taken place in terms of the provision of services. The services provided for children as part of the Community Care Programme fall into two broad categories: Child Health Services and Personal Social Services. Obviously, the more relevant to this study is the Personal Social Services category. Its sub-divisions are:

(i) Social Work Services

(ii) Services supplementary to family care
- (a) Domiciliary services, i.e.,
  - Child care workers with families
  - Home help services
  - Home management advisers
- (b) Day Care, i.e.,
  - Day-nurseries/child minding/play groups
  - Day fostering
- (c) Community Projects

(iii) Alternatives to own family care:
- Adoption
- Fostering
- Residential Care

The NESC Report No. 84 (1987) noted that a major review of personal social services for children was undertaken by the Task Force on Child Care Services (1980) and summed up the situation at that time by stating that the development of the services was uneven and that no community care area had a comprehensive range of services for children. "In general", the Report added "services tend to be established in a piecemeal fashion in response solely to immediate need without taking a preventive orientation or considering the range of services needed in an area" (p. 80). No really significant change has occurred up to the present. As regards the development of services, the NESC Report concluded that, until the present administrative structures are reviewed and the issues resolved, the development of services will be impeded.

So far this account has focused mainly on formal legislative and policy developments. The most significant has been, of course, the passing of the *Child Care Act, 1991*. Some sections have already been implemented, but full implementation is planned over a seven-year period. One of the sections that is already implemented permits, but does not oblige, Health Boards to arrange for voluntary bodies to undertake child care work on their behalf - a move which does not involve any practical changes.[4]

The evolution of the place of the child within the family up to the present day will now be explored briefly.

The Evoluation of the Place of the Child within the Family

Langer (1974, p. 1) argued that "the direction of human affairs was never confided to children". Historians who concerned themselves primarily with political and military affairs and with the intrigues and rivalries of royal courts, paid almost no attention to the ordeals of childhood. On the whole educators themselves devoted to the organisation and curricula of schools and with the theories of education, seldom made any reference to what happened to the pupils at home or outside of school. As Demause (1974) so strikingly expresses it, the history of childhood is a nightmare from which we have only recently begun to awaken. The further back in history one goes, the more likely children

[4] A detailed list of developments in child care plus changes connected with children's services, but not necessarily children in need of care or protection, is contained in Gilligan (1991, pp. 229-231).

were to be killed, abandoned, beaten, terrorised, and sexually abused by their parents. This pattern was not previously noticed by historians, Demause contends, because "serious" history has long been considered a record of public, not private events. Historians generally ignored what was going on in the homes around the playground.

This lack of interest in the lives of children seems odd given that, ever since Plato, it has been known that childhood is a key to understanding continuity and change over time. It is strange that only in this century has the study of childhood become routine for the psychologist, the sociologist and the anthropologist.

Peter Laslett in *The World We Have Lost* wondered why the

> ... crowds and crowds of little children are strangely missing from the written record ... It is in fact an effort of mind to remember all the time that children were always present in such numbers in the traditional world, nearly half the whole community living in a condition of semi-obliteration (1965, p. 104).

Demause (op. cit.) reviews the works of social historians and comments that masses of evidence of cruelty and abuse are hidden, distorted, softened or ignored. The child's early years are played down, formal educational content endlessly examined and emotional content avoided by stressing child legislation and avoiding the home.

The evolution of the place of the child or ideas about it obviously will proceed at varying rates in different countries. Even with the growth of individual responsibility and the enlargement of individual liberty, many social situations remain to be regulated and the State must interfere when duties are neglected.

Some other very important considerations must be mentioned here: the life expectancy of children, advances in industrial technology and the improving status of women. It is in the context of the history of poor life expectancy of young children in general that their exploitation, abuse and neglect have to be seen. Even with improving public health measures, plus improvements in medical knowledge and the better health of mothers, infant and child mortality rates only began to fall to any appreciable degree in European countries well into the twentieth century. With the advances in industrial technology, as Anderson notes (1979, p. 65) children have almost totally ceased to be part of an interdependent resource-generating system. The consequent diminution of the need for child labour influenced attitudes towards children with respect to their

contribution towards domestic economies. It should also be noted that the histories of children in the family and of women run parallel. The course of the two progresses in close association. In almost every country the history of maternity and child health services had been closely allied. The rights of mothers to the custody/guardianship of their own children was not finally established in Ireland until recent times.

While there is still no *written* agenda of the rights of children in Ireland, and indeed no absolute consensus as to exact definitions of these rights, efforts have been made to improve children's services and provide supportive services to families who find themselves in difficulties. The emphasis on family support services in the *Child Care Act, 1991* is a case in point. On the whole, attitudes have become more sensitive to children, more tolerant of different family life styles and more aware of children's disadvantaged position *vis-à-vis* adults. The ratification of the United Nations Convention on the Rights of the Child gives a firm base for a future Charter of Children's Rights. This brief account of the principal changes which have occurred in Ireland in the areas of both State and family care for children indicates that an increasing emphasis has been placed on the rights of the child and that care or protection rather than containment informs policy and practice. It is in this changed and changing climate that the study is set.

Chapter 3

PATTERNS OF PLACEMENT

This chapter describes children placed in care, their numbers, the inflows and outflows, their demographic characteristics such as age, gender and birth status. Then variables such as the legal status of the placement; the type of care placement; supply/demand on places; assessment and criteria for placement in care are examined. To provide a framework for these regional figures, I will first discuss the national figures.

Numbers

The basic "children in care" figures from the Department of Health returns for Ireland over a number of years are shown on the following tables. Both admission and discharge figures are given here together with "census-in-care" figures (defined as all in care on 31 December) for each year.[5]

As is indicated in Tables 3.1 and 3.2, the number and proportion of admissions to care seem to have decreased between 1984 and 1989, as had the rate of admissions up to 1990. However, with regard to discharges (Table 3.3), although the proportion discharged in 1988 and 1989 has decreased considerably, further information would be needed to enable comment to be made on whether or not the decreases in admissions and discharges indicates the start of a trend. Also, multiple admissions and discharges, e.g., a child re-admitted to care during the year, are not noted. Proportionately, however, these would be of little significance. The point is, if discharges are decreasing or remaining static, there will be a build-up of the numbers and rate of children in care, and this does seem to be occurring (see Table 3.2).

Since few children are admitted to care at 15 years or over, rates for *admissions* to care are calculated on population figures for children 0-14 years. The figures for the three Community Care areas of the Mid-Western

[5] Of necessity where comparisons with, or trends over, a number of years are given, children placed for adoption are included, since the Department of Health data do not clearly differentiate between adoptees and others in all years for all the figures.

Table 3.1: *Admissions to Care: Ireland*

Year	*Number of Admissions*	*Children Admitted as a Percentage of All in Care on 31 December*	*Rate per '000 under 15***
1980	1,249	53.8	1.1
1981	1,381	55.9	1.3
1982	1,282	52.4	1.2
1983	1,335	52.7	1.2
1984	1,153	48.0	1.1
1988*	1,138	43.5	1.1
1989	998	36.2	0.9
1990	1,085	37.6	1.1

Source: Department of Health, *Survey of Children in Care of the Health Boards*, various years.
Note: * Because of a backlog, figures were not published by the Department for the years 1985-1987.
** Calculated from 1981, 1986 and 1991 *Census of Population figures.*

Table 3.2: *Number of Children in Care on 31 December, Ireland, 1980-1989*

	Number in Care	*Rate per '000 under 19*	
1980	2,322	1.6	Calculated on the 1981 *Census of Population* figures
1981	2,471	1.8	
1982	2,446	1.7	
1983	2,534	1.8	
1984	2,400	1.7	Calculated on the 1986 figures
1988	2,416	1.7	
1989	2,756	2.1	Calculated from 1991 *Census of Population* figures
1990	2,885	2.2	

Source: Department of Health, *Survey of Children in Care of the Health Board*, various years. Also *Census of Population 1981 and 1986*, Volume 1, and Preliminary report, *Census of Population 1991*.

Table 3.3: *Discharges from Care: Ireland*

Year	*Number of Discharges*	*Children Discharged as a Percentage of All in Care on 31 December*	*Rate of Discharge per '000 under 19*
1980	1,249	53.8	1.1
1980	1,143	49.2	0.8
1981	1,276	51.6	0.9
1982	1,229	50.2	0.8
1983	1,061	41.9	0.7
1984	1,271	52.9	0.9
1988*	914	34.9	0.7
1989	935	33.9	0.7
1990	959	33.2	0.7

Source: Department of Health, *Survey of Children in Care of the Health Boards*, various years.
Note: * Because of a backlog, figures were not published by the Department for the years 1985-1987.

Health Board will now be considered (Tables 3.4 and 3.5). Children placed for adoption also were included here since, as noted above, for some of the years Department of Health returns do not differentiate sufficiently for this group to be discounted when comparing different years. Looking at the breakdown by Community Care area within that Health Board, the constant rise in the number and proportion of all admissions to care in the Limerick area since 1982 is obvious. In 1989 the proportion had almost doubled that of 1980. The rate of admissions reached its highest in 1983, but has not reduced to any great extent. O'Higgins and Boyle (1988, pp. 103-109) provide a discussion on the likely reasons for area differences. Using Packman's 1968 and 1986 studies in Britain in particular, they pointed out that the problem posed by variations in numbers in care between areas was too complex to permit any simple explanation. O'Higgins and Boyle concluded the most likely explanation in Ireland was to be found in the policy preferences and decisions of Programme Managers, along with differences in social work practice. However, here only one Health Board area is under consideration, and even within that, admission numbers and proportions differ from year to year.[6] The rate of admissions to care are calculated for the Health Board, and from Table 3.4

[6] In Limerick, a partial explanation may be that the number of social workers has risen from 9 in 1982 to 18 in 1989. Thresholds for entry to care may have been lowered by this increase in personnel.

Table 3.4: *Admissions to Care by Community Care Area (Percentage by Row)*

Year	*Area 20 Limerick*		*Area 21 Tipperary*		*Area 22 Clare*		*Total Admissions*		*Admissions Percentage of all In Care on 31 December*	*Rate Under 15 per '000* MWHB*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*%*	
1980	35	33.0	26	23.6	46	43.4	107	100.0	41.9	1.1
1981	59	42.4	18	12.9	62	44.6	139	100.0	51.7	1.4
1982	55	37.2	31	20.9	62	41.9	148	100.0	45.2	1.5
1983	60	34.5	31	17.8	83	47.7	174	100.0	52.2	1.8
1984	81	49.1	18	10.9	66	40.0	165	100.0	48.1	1.7
1988	82	53.2	18	11.7	54	35.1	154	100.0	49.2	1.6
1989	96	62.7	24	16.7	33	21.6	153	100.0	48.6	1.6

Source: Department of Health, *Survey of Children in the Care of the Health Boards. 1989:* Present study data.

*Based on *Census of Population* figures 1981, 1986 and 1991.

Table 3.5: *Discharges from Care by Community Care Area*

*Year**	*Limerick*	*Tipperary*	*Clare*	*Mid-Western Area on 31 December Total Discharges*	*Discharges as a % of All in care on 31 December*	*Rate Under 15 per '000** MWHB*
		Number of Children				
1980				97	37.6	0.7
1981				148	55.0	1.2
1982				133	40.7	1.0
1983				131	39.3	1.0
1984				156	45.5	1.2
1988	60	17	61	138	44.1	1.1
1989	74	29	43	146	46.3	1.2

Source: Department of Health, *Survey of Children in the Care of the Health Boards.* 1989: Present study data.

Note: * No information available on discharges by Community Care Area for 1980-1987.

** *Based on Census of Population* figures 1981, 1986 and 1991.

it may be seen that the rate of entry to care has increased, although falling from the peak it reached in 1983.

Looking at the rate (per '000) of children in care in each of the areas in 1989 (Table 3.6), the rates were based on 1986 Census of Population of Ireland (Small Area Statistics) figures for the number of children 0-19 years in each of the relevant Community Care areas. For most of the areas the Census of Population figures will apply, but in the cases of Limerick and Tipperary North Riding there are significant differences between the Census of Population by County and the Community Care area population. For instance, the published 1986 Census of Population figure 0-19 years for Tipperary North Riding is 17,595, while the Community Care area population (Tipperary North Riding) 0-19 years is 40,450, the reason being that CCA incorporates part of Limerick. This was occasioned by a desire, for administrative purposes, to have a fairly similar population figure in each Community Care area. The eastern side of Limerick city, plus some of the rural areas surrounding it were regarded as being in the Tipperary North Riding Community Care area. This gave a more even population distribution in each of the three areas. The relevant population was calculated for the two areas from the Small Area Statistics Section in the 1986 Census of Population of Ireland. When the rate per '000 of children in care is calculated for the Community Care areas on the basis of the newly calculated populations, the result is as follows.

Table 3.6: *1989 – Rate per '000 Children in Care*

	No. in Care on 31.12.89	*Population 0-19 MWHB**	*Rate per '000*
Limerick CCA	177	46,623	3.7
Tipperary NR CCA	84	40,450	2.0
Clare CCA	54	33,240	1.5
Mid-Western HB	315	122,313	2.5
Ireland	2,756	1,355,801	2.0

* The small area statistics for the 1991 Census are not available yet, hence the population numbers here are from 1986 *Census of Population.*

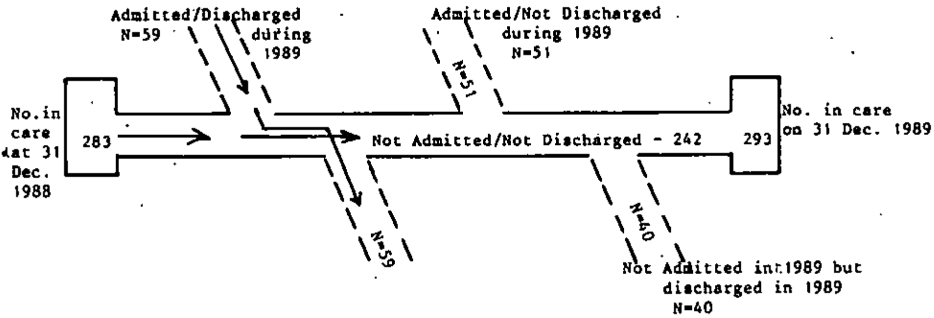
The differences in the rates between the areas are remarkable. Some explanation may be forthcoming through the further analysis of the data, or by consultation with the relevant people in the areas. At this stage, it

might be argued that the problems encountered by families leading to the placement of their children in care may be more frequently encountered in an urban setting; indeed Limerick had the highest rate of children in care (3.7 per '000), higher than the rate for the Mid-Western Health Board region as a whole or for Ireland. If one compares the Mid-Western Health Board rate with a Health Board with no large urban area, e.g., Midland Health Board, the rate for that Board is 2.0 per '000, so the argument of the effect of a large urban area on the rate may be plausible. Additional "local" reasons for higher numbers in Limerick, such as the location of the Regional Maternity Hospital, the main adoption agency and the CURA residential home in Limerick Community Care area may account for some of the differences.

Inflows and Outflows to Care

The children referred to here are all children with a care experience in 1989, whether it commenced and ended in 1989 or commenced before 1989 and continued on afterwards. Figure 3.1 shows the flows of children in and out of care during 1989 in the Mid-Western Health Board region. This figure breaks down the total number of children with a care experience in 1989 into different groups by their differing experiences. As already mentioned, children placed for adoption are excluded from all the following analysis.

*Figure 3.1: Inflows and Outflows to Care 1989**



* Details of re-admission in 1989 of children discharged in 1989 are not available exactly. It is unlikely, however, that they would exaggerate the above figures to any significant extent, being small in number.

(a) Admissions beginning during 1989 and continuing into 1990 (n = 51).

(b) Admissions beginning during 1989 and ending in 1989 (N = 59).

(c) Admissions beginning prior to 1989 and continuing into 1990 (n = 242).

(d) Admissions beginning prior to 1989 and ending in 1989 (n = 40).

Supply/Demand: Places in Care

It is difficult to ascertain the ability of a Health Board or Community Care area to supply enough places in care to meet demand at a particular time. For instance, it is impossible to estimate the number of foster home places potentially or actually available at a particular time, since in many cases demand may stimulate supply. At any rate, it is conceivable that certain areas would have an "under-supply" at a given point. There is no provision for what might be termed "retainer fees" for foster parents. Certain information on the number of residential places available in each Community Care area of the Mid-Western Health Board in 1988 is available. The emphasis on the availability of places in a child's own Health Board or Community Care area is guided by the research findings which stress the importance for a child of retaining contact with its parents while in care. In this case, only Limerick has places in residential care, so children from Clare and Tipperary North Riding would have to be placed outside their Community Care area. A residential home in Galway has been used for placements from these areas as have other residential homes elsewhere. Of course, a child from north Clare would be nearer his/her own home in a residential home in Galway than if placed in Limerick. Therefore, placement in a child's own Health Board region does not necessarily guarantee proximity of the child to his/her own home.

Assessment and Criteria for Placement in Care

Prior to reception into any type of care, an assessment of the case is usually carried out by the social worker in charge of the case, in consultation with a senior social worker. The essential criterion for placement in care is that the child is in need of care or protection which he/she cannot receive in his/her family home. The social workers decide what type of care the child needs and try to place the child in that type of care. The type of care selected depends on the needs of the child as perceived by the social workers from their training and expertise. Since in only a small number of cases are social workers dissatisfied with placements, it must be assumed that suitable placements are found in most instances.

Where it is felt necessary, a case conference on a plan for the child is held. At present, parents can refuse to consent to the placement of their child in foster care. Where the child is committed through a Court Order, a case conference is usually held. With regard to guidelines, the guidelines for Health Board field workers in the case of non-accidental injury to a child has been published (Department of Health, 1987). These guidelines

are used in cases of abuse but may be used in all cases where a child is to be placed in care, with the appropriate changes for each set of circumstances.

In this study, a decision to take a child into care was made by a case conference in just over 40 per cent of the cases. In 29 per cent of cases the relevant social worker and his/her senior agreed the decision. Social workers on their own did decide to take a child into care in 1 in 7 cases. In the remaining cases decisions were made in varying ways which could not be categorised into any of the three above. For instance, in some cases where a single mother was involved, the social worker made the decision in conjunction with the mother. Other cases involved public health nurses, paediatricians or juvenile liaison officers. It must be emphasised here, of course, that only in cases of voluntary care can the social workers make the final decision. For compulsory cases, it is the Court that makes the decision, albeit on the basis of recommendations or application by social workers. The question asked by this study referred to all cases but would apply to the early stages in cases which subsequently went to Court.

Clare appeared to use case conferences either to decide on admission or on a form of placement or plan more often than the other two areas. Here 62 per cent of decisions were based on case conference discussions, whereas in Limerick it was 41 per cent and it was 27 per cent in Tipperary (Table 3.7). There, however, the senior social worker was more likely to have taken the decision in conjunction with his social workers (44 per cent of cases). Clare had no senior social worker in the Health Board until late 1989, consequently only 1 case appears in Clare under that heading. It may

Table 3.7: *Who Made the Initial Decision to Place Child in Care?*

	Community Care Area			*MWHB*
	Limerick	*Tipperary*	*Clare*	*Per cent*
Case conference	40.7	27.1	62.2	41.5
Senior social worker + social workers	33.2	43.8	1.4	29.5
Social worker alone	9.5	17.7	27.0	14.6
Other (e.g., mother and social worker, care worker and social worker; Court Order following contacts with Gardai contacts with Gardai and local agencies)	16.6	11.5	9.5	14.4
Per cent	100.0	100.0	100.0	100.0
N =	199	96*	74	369

be remembered, however, that Clare is a special case because of the functioning of the extremely active voluntary social service council, Clarecare, dealing with, among others, families of children in need of care or protection. The professional social workers in Clarecare would be involved in any discussions with the Health Board social worker over the best plan for any child vulnerable to placement in care.

Whatever the combination of reasons for taking the decision to place a child in care, the legal basis of placement – Court Order or voluntary – may be a factor in that combination. With a case likely to be the subject of a Court Order, a case conference might be more appropriate and that indeed proved to be true. In 69 per cent of the instances where a case conference was held, it was decided to apply to the Court for an Order and the child became the subject of a Court Order.

Age

Age at Admission

Turning first to age at admission of children in care during 1989, Table 3.8 gives details by Community Care area. Although differences between the areas are not significant, it is important to know the proportions in each age group for each area to enable resources to be channelled to groups with most need of them. The age groups are of course arbitrary, but do indicate that, for instance, one-fifth of all children in care during 1989 had been admitted aged less than 6 months. They do not include pre-adoptive babies.

Table 3.8: *Age at Admission of Those in Care During 1989 by Community Care Areas*

Age at Admission to Care	*Community Care Areas*			*Mid-Western*
	Limerick	*Tipperary*	*Clare*	*Region*
			Per cent	
0-6 months	20.7	23.4	24.3	22.1
7-11 months	7.2	2.4	5.4	5.7
1 year	12.0	7.5	8.1	10.0
2-3 years	17.8	16.8	13.5	16.7
4-6 years	17.8	20.6	20.3	19.0
7-11 years	15.9	17.8	21.6	17.5
12+ years	8.7	11.2	6.8	9.0
Per cent	100.0	100.0	100.0	100.0
Total	208	107	74	389

The proportions of children of different ages which an area admits to care will be affected by many factors; for example, by the area's own policies and provision. Policies or provisions likely to affect age at admission are preventive services for young families and the policy and practice of other agencies, e.g., courts, police. The influence of these factors cannot be weighed accurately, but when the descriptive and statistical data are brought together, they will be seen at work. (Appendix A gives a pictorial breakdown of the age at admission figures.)

Present Age in 1989

More relevant to patterns of placement and area differences might be the present age of children in care. Table 3.9 (and Appendix B) give Community Care area breakdown by present age. Tipperary has a much higher proportion of children in the older age groups in care – 53 per cent in 12 years and over group, compared with 37 per cent in Limerick and 35 per cent in Clare.

Table 3.9: *Present Age by Community Care Area*

Present	*Community Care Areas*			*Mid-Western*
Age	*Limerick*	*Tipperary*	*Clare*	*Region*
			Per cent	
0-11 months	9.5	0.9	14.7	8.2
1 year	7.6	4.7	4.0	6.1
2-3 years	5.2	3.7	4.0	4.6
4-6 years	14.8	12.1	10.7	13.3
7-11 years	26.2	25.2	32.0	27.0
12-15 years	22.4	32.7	18.7	24.5
16+ years	14.3	20.6	16.0	16.3
Per cent	100	100.0	100.0	100.0
Total	392	210	107	75

Comparing ages at admission with present age for the Mid-Western Region and the Community Care areas, Table 3.10 shows that the build-up in care appears to be confirmed. Children were more likely to have been admitted from the younger age groups while their present ages are far more likely to be in the older age groups. This is particularly true in Tipperary where over 50 per cent of the children in care are aged 12 years and over.

Table 3.10: *Age at Admission and Present Age by Community Care Area*

Age Groups	*Mid-Western*		*Limerick*		*Tipperary*		*Clare*	
	Admission Age	*Present Age*	*Admission Age*	*Present Age*	*Admission Age*	*Present Age*	*Admission Age*	*Present Age*
				Per cent				
0-11 months	27.8	8.2	27.9	9.5	25.9	0.9	29.7	14.7
1 year	10.0	6.1	12.0	7.6	7.5	4.7	8.1	4.0
2-3 years	16.7	4.6	17.8	5.2	16.8	3.7	13.5	4.0
4-6 yeas	19.0	13.3	17.8	14.8	20.7	12.1	20.3	10.7
7-11 years	17.5	27.0	15.9	26.2	17.8	25.2	21.6	32.0
12 years +	9.0	40.8	8.7	36.7	11.2	53.3	6.8	34.7
Per cent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total	389	392	208	210	107	107	74	75

Overall, there appears to be a preponderance of older children in care. Sixty-eight per cent of all children in care during 1989 were aged 7 years and older. The breakdown by area is: Limerick 63 per cent, Tipperary 78 per cent, and Clare 67 per cent. This suggests long stays for most children since, if ages at admission are younger than present ages, then children once in care experience long stays. The situation of these children in long-term care will be examined more fully in Chapter 6.

Table 3.11 compares age at admission and present age with the age breakdown of the Census of Population, 1986 for the Mid-West region. The information here points up that children under 4 years of age have a higher incidence of admission to care than their proportion in the population would warrant, while children's present age in care is more likely to be in the older age groups, for instance, an over representation in the 10-14 age group.

Table 3.11: *Comparison of Age Groups of Children in Care, on 31 December 1989 and Census of Population 1986 in Mid-Western Health Board*

	Age at Admission (Children in Care)	*Census Age*	*Present Age (Children in Care)*
0-4 years	63.5	23.8	12.6
5-9 years	20.1	26.3	26.3
10-14 years	13.0	26.3	37.2
15-19 years	3.4	23.7	23.9
Per cent	100.0	100.0	100.0
Total	293	122,413	293

Birth Status

A lengthier discussion on the vulnerability of single parents to their children being placed in care, and the reasons this is so, will be undertaken in the later chapter on the familial characteristics of children in care. Here it is necessary to give some demographic information on the birth status of the children in care. Children are classified here in one of three ways

- marital, i.e., children born to parents married to each other,
- non-marital, i.e., children born to single parents,
- extramarital, i.e., children of married parents but parents are not married to each other.

The *Status of Children Act, 1987* placed children born outside marriage on the same footing as those born within marriage in the areas of guardianship, maintenance and property rights, and set up a statutory procedure to enable any person to obtain a court declaration as to his/her parentage (see Explanatory Memorandum – *Status of Children Act, 1987*). Prior to the passing of this Act, children born outside marriage were termed "illegitimate".

It would be almost impossible to estimate the proportion of the child population which stood as "non-marital" in Ireland in 1989, since accurate information on a number of key questions is not available. To assess the size of the non-marital child population one would have to take account of:

(a) the inflow of non-marital children to the population in the previous 15 years, i.e., the actual number of non-marital born in each year;

(b) the reduction of this non-marital inflow in terms of:

  (i) adoption, either by own family or other couples,

  (ii) subsequent legitimation by parental marriage,[7]

  (iii) mortality rates of non-marital children.

The numbers in group (iii) in particular would be difficult to ascertain with accuracy. For all non-marital births official figures show a range from as low as 1.6 per cent rising to 13.6 per cent in the 1960-1989 period. The number of non-marital children as a proportion of the overall child population is likely to be significantly less, given adoption and subsequent

[7] A fairly substantial number of parents of non-marital children apply for re-registration of their children after they marry. Not all children are re-registered on their parents' marriage so there is probably an underestimation of the figure of children legitimated by their parents' subsequent marriage. The number of children re-registered on their parents' marriage under the *Legitimacy Act, 1931* was 1,110 for the year 1989. This information was supplied by the General Register Office.

legitimation. Births outside marriage as a percentage of total births in the Mid-Western Health Board region increased from 7.4 per cent in 1988 to 12.8 per cent in 1990. (Health Statistics, Department of Health, 1989, 1990).

As regards non-marital children in care in the Mid-Western Health Board Region (MWHB) during 1989, the proportion is 30 per cent, that is about 2.5 times the proportion that would be expected had it reflected levels within the general child population of the region (*Source* Department of Health: Health Statistics, 1990).

Table 3.12: *Birth Status by Area*

Birth Status	*Limerick*	*Tipperary*	*Clare*	*MWHB N*	*Per Cent*
Marital	59.5	61.7	72.0	245	62.5
Non-Marital	32.9	28.0	25.3	118	30.1
Extramarital	7.6	10.3	2.7	29	7.4
Per cent	100.0	100.0	100.0	100.0	100.0
Total	210	107	75	392	100

Gender

In a previous study by O'Higgins and Boyle (1988), gender was not significant in relation to placement of children in care – the proportions in care matched those in the population. In this study females represented 54 per cent of the total. This reverses the proportions in the population aged under 19 in the Mid-Western Health Board area – 51 per cent males. It would appear that females are slightly more likely to be placed in care than males in the area under study but not significantly so. This is true in each of the Community Care areas. In Limerick, 54 per cent in care were females. Figures for Tipperary and Clare were 51 per cent and 60 per cent respectively. These are in comparison with 49 per cent females in the overall under 19 population.

Legal Status

The term legal status means the basis on which a child was placed in care, whether on foot of a Court Order (CO) or voluntarily. As may be seen from Table 3.13, half of the admissions had been voluntary. (The figures in this table include children placed for adoption, since these children are included in Department of Health figures. Where these

children are excluded, the proportion of voluntary admissions for the Mid-West drops to 47 per cent.) In considering possible area differences here, Limerick has the highest proportion of children in care through Court Order admissions – 55 per cent; in Tipperary 38 per cent of the children in care were admitted by Court Order, with Clare having 52 per cent. If we exclude children placed for adoption, in the 1989 figures some variation is apparent: the proportion for Limerick increases to 59 per cent Court Order admissions, with Tipperary increasing only slightly to 40 per cent and Clare moving to 56 per cent. Overall, the ratio for Court Order : Voluntary admissions (excluding adoptees), is 1 : .9. A retrospective look at the preceding years where information is available shows a dramatic increase in the proportion of children in care through Court Order admissions (Table 3.13).

Table 3.13: *Percentages of Court Order and Voluntary Admissions for those in Care on 31 December*

	Mid-Western Area		*Limerick*		*Tipperary NR*		*Clare*		*Ireland*	
	Vol.	*CO*	*Vol.*	*CO*	*Vol.*	*CO*	*Vol.*	*CO*	*Vol.*	*CO*
1980	93	7	94	6	86	14	100	0	88	12
1981	92	8	92	8	88	12	95	5	84	16
1982	89	11	87	13	89	11	95	5	79	21
1983	87	13	85	15	87	13	92	8	76	24
1984	81	19	Not available		Not available		Not available		74	26
1985-1987	Not available		Not available		Not available		Not available		73	27
1988	52	48	48	52	61	39	50	50	51	49
1989	50	50	45	55	62	38	48	52	49	51
1989 (excl. adoptees)	47	53	41	59	60	40	44	56	Not available	

Source: 1980-1988 – Department of Health; 1989 – Present study.

The figures show the trend over the years. They are not actual admissions in any one year. They seem to indicate a build-up of children who had been admitted through Court Orders, particularly in Limerick and Clare, the proportion in the Clare area going from zero to 56 per cent in 10 years. Tipperary had the slowest build-up of children in care by Court Order admission going from 14 per cent to 40 per cent in the same 10 years. Given that children admitted to care through Court Orders seem more likely to remain in care than children placed voluntarily, it is not surprising that over a 10-year period a cumulative figure will emerge (Table 3.13).

In a discussion with the respondent social workers it was established that because of changes in practice, i.e., fewer cases being brought to court for

committal to care, significant reductions are likely in 1990 and 1991 and subsequent figures for Court Order admissions, but unless discharges also increase this will not be reflected in the figures for some time.

The legal route by which a child enters care is important on several counts. It is likely to affect the way the child and the family feel about the admission. It would also affect the Health Board's powers and probably social workers' attitudes to care. Recent studies stress the strong association between legal route of entry and length of stay in care.[8] This was confirmed in the present study. In particular, children in care between 1 year and 12 years were more likely to have been placed in care by Court Order than voluntarily (see Table 3.14 below). Perhaps when a child is admitted through a Court Order, it is more difficult to solve family problems to enable a speedy return of the child, because the problems had been more serious in the first place. Also there could be a disinclination to discharge a child because of the seriousness of his/her case.

Table 3.14: *Legal Status by Length of Stay in Care – Children in Care on 31 December 1989*

	Length in Care							
	0-6 mths	*7-11 mths*	*1 year*	*2-3 years*	*4-6 years*	*7-11 years*	*12+ years*	*Total*
				Per cent				
Court Order	32.0	47.6	60.0	72.1	72.3	53.8	17.9	52.9
Voluntary	68.0	52.4	40.0	27.9	27.7	46.2	82.1	47.1
Per cent	100.0	100.01	100.0	100.0	100.0	100.0	100.0	100.0
Total	25	21	25	43	47	93	39	293

Rowe, *et al.* (1989, p. 52) also discuss how the Dartington research team in the Millham, *et al.* (1986) study and Packman (1986) have both highlighted the feelings of anger and outrage raised in some parents whose children are compulsorily removed, and no doubt young people on Court Orders may often feel equally angry and unco-operative. The studies conclude that it seems inherently probable that the method of entry to care affects both duration and outcome. They caution against a cause and effect view of legal status for admission given the subtle interaction of family and child problems and attitudes, social work and Court interventions and the cumulative effect of the care system on all those involved. However, what can be expressed is a reaffirmation of the links between legal status and length of stay which appeared to be significant in all three areas.

[8] See, for instance, Rowe, *et al.*, 1989, p. 41, Millham, *et al.* 1986, and Thorpe, 1974.

Type of Placement

What are the criteria used for placement in either foster or residential care? Are there any specific criteria documented for the guidance of the social workers involved, or is it merely a case of selecting the type of care according to availability? Do any assessment procedures exist? What are the main distinctions between the children placed in each type of care in terms of age, sex, birth status and area?

Patterns of placement vary to some extent from one Community Care area to another. However, the most likely experience for a child in any of the three areas is that he/she is in long-term care, defined as 6 months or more. Table 3.15 demonstrates that long-term care predominates. The variations between the areas are obvious from the table – children in Clare are least likely to be in long-term care. Long-term care has profound implications for the economic resources of the Health Board, and for the resources of the family, emotional and economic, in maintaining contact with their child. A discussion on family contact takes place in Chapter 6.

Table 3.15: *Community Care Area by Type of Care – Short-term or Long-term*

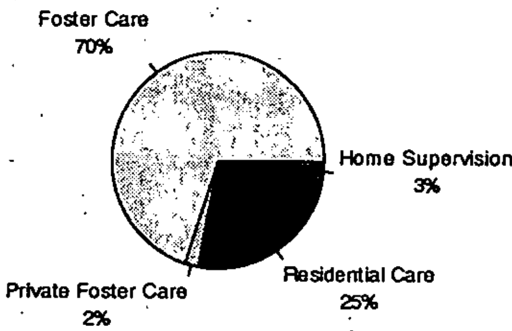
Area	*Short-term Care*	*Long-term Care*	*Total Per cent*	*(N)*
			Per cent by row	
Limerick	27.9	72.1	100.0	201
Tipperary	21.3	78.7	100.0	103
Clare	33.3	66.7	100.0	75
MWHB Region	27.2	72.8	100.0	379*
Total	103	276	100.0	379*

* Not including children under supervision at home.

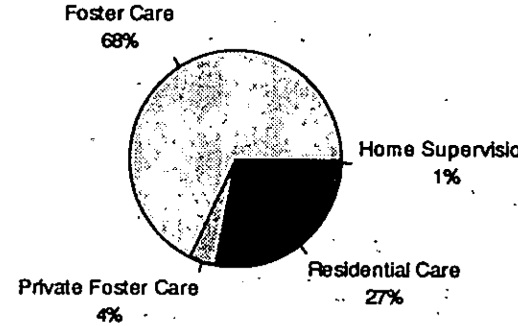
As regards care type Table 3.16 indicates that the majority of children's experience of care is of foster care. Tipperary shows the highest proportions of children in long-term care and in residential care. The pie charts (Figures 3.2 and 3.3) provide a quick way to compare the types of admissions by age at admission and present age. As may be seen, most pre-school admissions are in foster care while from 7 years old upwards residential care is dealing with 50 per cent of admissions. In only 6 per cent of all the cases did social workers consider the placement unsuitable for the child. These cases were mainly where the social worker felt that to benefit from a stable family situation the child should have been placed in

FIGURE 3.2: AGE AT ADMISSION BY CARE TYPE

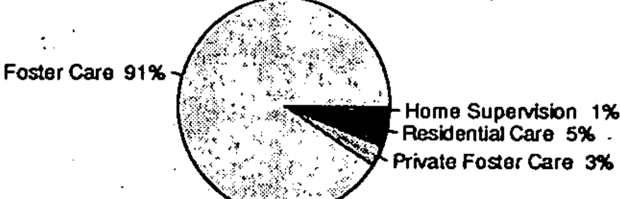
Mid-Western: All Ages



Mid-Western: Age 2-6 Years



Mid-Western: Age 0-23 Months



Mid-Western: Age 7 Years+

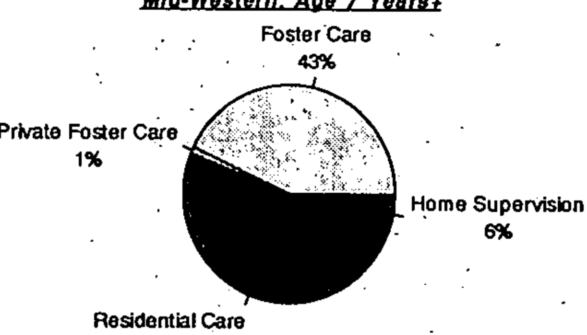
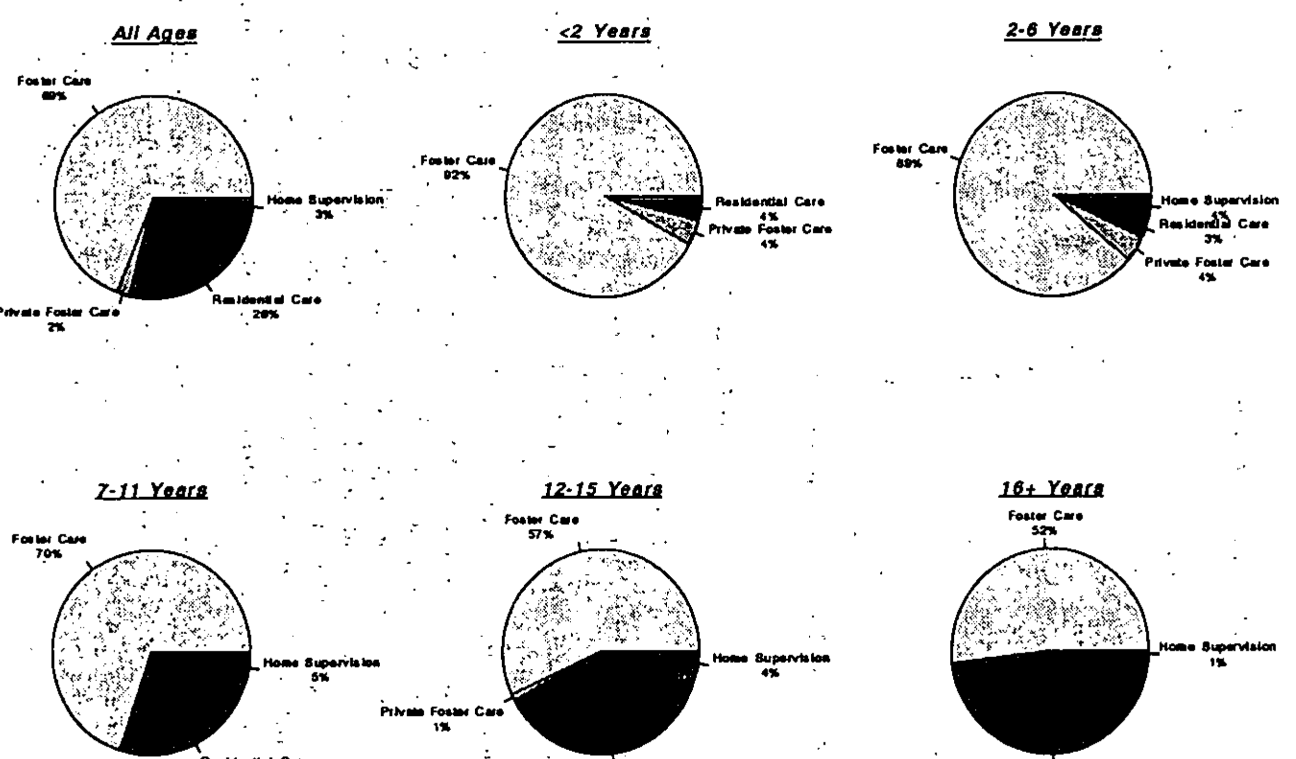


FIGURE 3.3: PRESENT AGE BY CARE TYPE DURING 1989



foster rather than residential care. Figure 3.3 shows care type by present age of children in care, indicating the changing proportions in types of care as age of children rises.

The main types of care will now be considered separately.

Table 3.16: *Community Care Area by Type of Care – Foster or Residential*

Area	*Foster Care*	*Residential Care*	*Total Per cent*	*(N)*
		Per Cent by Row		
Limerick	73.1	26.9	100.0	201
Tipperary	68.9	31.1	100.0	103
Clare	85.3	14.7	100.0	75
MWHB Region	74.4	25.6	100.0	379*
Total	282	97		379*

* Not including children under supervision at home.

Foster Care

Foster care is defined in the Task Force Report (Ireland, 1980, p. 161) as "the care of a child by persons other than his own (or adoptive) family in their own home". The report goes on to explain that in this country such care, where arranged and paid for by Health Boards, is normally called "boarding out".

Under the Boarding Out of Children Regulations, 1983, the Health Boards are formally required to place a child in foster care and only where this is not possible to place him/her in a residential home. Although these regulations had only been passed in 1983, the idea that foster care was preferable to residential care had long been accepted. As mentioned in Chapter 2, Robins (1980) spoke of the beginnings of a boarding-out system for infants in Ireland as early as 1862, and the 1954 Boarding-Out Regulations contained a requirement that foster care should, if possible, be considered for all children.

When the Health Board social worker teams began to develop from generic social work to specialising in dealing with children in need of care or protection in the early to mid-1970s, a new move forward in the provision of foster care was initiated. The new initiative, called Fostering Resource Group, was introduced to the Eastern Health Board area. Other

areas have been involved in their own initiatives to a greater or lesser extent.[9]

The *Child Care Act, 1991* updates the law in relation to foster care. The new provision will enable, and indeed dictates, that a Health Board must consider foster care for all children in its care (Section 36). Prior to the passing of this Act, only children who were orphaned or deserted, or whose parents were destitute could be placed in foster care by Health Boards without their parents' consent. Another change to be introduced by this Act is that whereas the Courts could commit deprived children directly into residential homes, in future any child coming into care through a Court Order will have to be placed in the care of a Health Board. That Board will decide what type of care is most suitable. A Health Board can apply for a Care Order and if granted, the Health Board will have the same authority in respect of the child as his or her parent (Section 18). It would seem from the above that up to the present not all children entering care were available for foster care, since for instance, parents could refuse to allow their children to be fostered. However, in the section on Residential Care in this study there is evidence that only a very small proportion of parents refused permission. Therefore, present numbers in foster care are probably total possible numbers in this particular Health Board.

The remuneration of foster parents is a matter for concern in that it is essential to recognise that fostering is a difficult task and that foster parents cannot be expected to persevere without adequate support – the foster care allowance being the practical part of that support. The value of the present rate of allowance, Gilligan argues (1990, p. 20), actually declined relative to the cost of living in the period 1982-1987. The rate of allowance, he continues, has not only declined in value relative to the cost of living, it has also declined as a proportion of weekly average industrial earnings. In 1991 the basic weekly allowance was £38.80 per child. This allowance is not included as part of income by the Department of Social Welfare in any means testing. In some Health Board areas, but not in the Mid-Western, foster parents also receive a clothing allowance, payable twice yearly. From the point of view of the Revenue Commissioners, the Boarding-Out allowance is regarded not as income of foster parents but as income of the child, who would not be liable to pay tax.

[9] The Fostering Resource Group set up a Parenting Plus course in an adult education context. This consists of the Health Board social workers holding public meetings for prospective foster parents. All comers are accepted at that stage and data on fostering given to them. A six-week course is then arranged using adult education techniques, including videos and participation by both the prospective parents and the social workers. After the six-week course, an assessment is made of those who stayed until the end of the course, and suitable foster parents are chosen. Preparation groups for foster parents are standard practice in the Mid-Western region in Limerick and Clare since 1990.

Private Foster Care

The Task Force Report (Ireland, 1980, p. 173) noted that the *Children Act (1908)* as amended by the subsequent *Children Acts of 1934 and 1957* and Section 10 of the *Adoption Act of 1964*, is the current legislation governing the supervision of children under 16 years of age, placed in private foster care by agencies and individuals other than the local authority. That situation will apply until the implementation of the *Child Care Act, 1991*. Children in private foster care are referred to in the legislation as children "at nurse". Children may be placed privately by parents, relatives or voluntary child care agencies. These agencies are mainly adoption agencies which place children in foster care while awaiting adoption or pending a return to their parents. However, as may be seen from Figures 3.2 and 3.3, some children regarded as in need of care or protection had been placed in private foster care and were being supervised by Health Board social workers.

The duties imposed on Health Boards relating to nursed-out children required them to make regular enquiry as to whether children are being nursed out within their area and, if so, to appoint Infant Protection Visitors to visit such children and the premises in which they are kept. In practice, nowadays, Health Board social workers perform the duties of Infant Protection Visitors and this latter title is no longer in common usage. The Health Board may limit the number of children who may be kept in a premises and may also give exemption, with the approval of the Minister, from the visitation of the premises which it regards as not requiring such visitation (see Task Force Report, p. 174).

Returning to foster care in general, such care supplies, at least temporarily, a family setting for the child instead of institutional care. Berridge (1985, p. 5) comments that (in Britain) it is now generally considered inappropriate for children in care to live for long periods in a residential setting and, instead, more children are being placed with foster families. It would not be reasonable to assume that foster care is suitable for all children in need of care or protection. The reasons why children have been placed in residential care in preference to foster care are noted later in this chapter.

Age at Admission to Foster Care

Information on age at admission is important because it reveals the strong association between age at admission and type of placement. Two questions need to be considered. First, what proportion of admissions in each age group become foster placements? Second, what is the age distribution of children going into foster homes?

The pie chart previously presented showed how the proportion of children placed in foster homes drops rapidly with increasing age. In spite of emphasis on family care, older children are more likely to go into residential care. The percentage of children in residential care who are there for reasons such as no suitable foster home being available, or breakdown of foster home is 25 per cent and 10 per cent respectively. Table 3.17 compares the age at admission and present age of foster care placements for the whole group and by area.

Table 3.17: *Age at Admission and Present Age for Children in Foster Care*

Age Groups	*Mid-Western*		*Limerick*		*Tipperary*		*Clare*	
	Admission Age	*Present Age*	*Admission Age*	*Present Age*	*Admission Age*	*Present Age*	*Admission Age*	*Present Age*
			Per cent					
0-11 months	39.1	11.3	43.5	13.6	33.8	1.4	34.9	17.2
1 year	11.7	7.8	12.9	10.9	11.3	4.2	9.5	4.7
2-3 years	17.1	6.4	17.0	7.5	18.3	5.6	15.9	4.7
4-6 yeas	16.4	16.7	14.3	18.4	19.7	16.9	17.5	12.5
7-11 years	11.4	26.2	8.8	23.8	9.9	26.8	19.0	31.3
12 years +	4.3	31.6	3.4	25.8	7.0	45.1	3.2	29.7
Per cent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Totals	281	282	147	147	71	71	63	63

Legal Basis for Admission to Foster Care

Forty-one per cent of children in foster care had been placed in care on the basis of a Court Order, and the vast majority of these were in long-term care (90 per cent). Whether this was the original intention or not is unclear. In only 6 per cent of all cases did the respondent social workers feel that the type of care was unsuitable for a particular child, and this reservation applied mainly to children in residential care. According to social workers, no suitable foster home was available to 25 per cent of children in residential care but the number of children involved (25) was 6.4 per cent of the total of children in care in 1989. For children placed voluntarily, the proportion in long-term foster care was 55 per cent, and 45 per cent were short-term placements. This again clearly indicated a greater likelihood of long-term care for Court Order admissions.

Birth Status of Children in Foster Care

Irrespective of age, around 90 per cent of non-marital children in care are in foster care, in contrast with 62 per cent of the marital children in care. The 90 per cent figure demonstrates that non-marital children are more likely to be placed in foster care than residential care. Although the most often chosen type of care for marital children is also foster care, it is somewhat less likely to be so. Age at admission by birth status may explain this, as it has been shown that marital children are more likely to be older at admission and older children have a higher probability of being placed in residential care.

Table 3.18: *Birth Status by Care Type*

	Marital	*Non-Marital*	*Extra-Marital*	*N*	*Per cent of N*
		Per cent			
Short-term Foster Care	18.4	33.1	6.9	86	21.9
Long-term Foster Care	42.9	52.5	79.3	190	48.5
Private Foster Care	0.4	4.2	–	6	1.5
Short-term Residential Care	4.1	4.2	6.9	17	4.3
Long-term Residential Care	29.0	5.9	6.9	80	20.4
Supervision at Home	5.3	–	–	13	3.3
Per cent	100.0	100.0	100.0		100.0
M. West Total	245	118	29	392	

Residential Care

The general title "Residential Homes" used here describes a type of care for the sole purpose of providing for children who need care or protection alternative to their family and for whom foster care is either not appropriate or possible for whatever reason; for instance, parent(s) refusing to consent to foster care, or no suitable foster home being available.

The majority of Residential Homes for Children are run by Roman Catholic religious orders, but some are administered by Protestant and non-

denominational committees. The proportions are 84.4 per cent Roman Catholic, 7.4 per cent Protestant and 6.2 per cent non-denominational and other bodies. The Health Boards are responsible for the remaining 2 per cent of places (see Gilligan, 1991). From former large institutions they have gradually broken down into group homes where small numbers of children are cared for by child care workers and assistants. Boys and girls are both accommodated in Children's Homes up to the age of 16, at present the upper age for admission of children to substitute care in Ireland. Application may be made to the Minister for Health for support for a young person up to the age of 18. This application is regarded as a formality, as an extension is always granted when applied for by a Children's Home. If suitable accommodation is no longer available at the Home, alternatives such as a hostel have to be found for the young person.

Dilemmas and uncertainties appear to surround residential care. Davis (1981), for instance, outlined some of the reservations against residential care. In Britain, Rowe, *et al.* (1989) saw residential care as being under fire both from those who saw it as an ineffective response to delinquency and those who saw it as an inappropriate milieu in which to bring up children.

A broad definition of residential care is taken here as being any type of care outside the child's home of origin, other than a boarding school, not designated as foster care or private foster care. This is because, as Rowe, *et al.*, have demonstrated, the residential scene would be difficult to write about due to its complexity and variety. Many different types of establishment may be included. A variety of family group homes (which may closely approximate a large foster home) exists in housing estates or in old institutions, adapted for the purpose of catering for smaller groups. Therapeutic and assessment centres would also be included under residential care.

The transfer of functions relating to a number of residential homes run by religious orders from the Minister for Education to the Minister for Health in 1983 has placed statutory and administrative responsibility for all children's homes in one department.[10]

Like foster care, residential care may be short-term or long-term. From time to time, certain homes could have the services of a social worker on secondment from the Health Board, but this is by no means the general rule or practice. Ideally, child care workers should link up with social workers in the Health Boards. It is now likely that each child being placed in a residential home has a named social worker, and if that social worker

[10] See Address of Mr Barry Desmond, the then Minister for Health and Social Welfare, to Conference. *Future Directions in Health Policy, Council for Social Welfare, 1984.*

resigns, the case load is given to the person taking over. If operated successfully, no child would be in care without some connection between the residential home and the family.

The basis on which children's homes have been financed since January 1984 is overall a budgetary one. Prior to that date, the basis was *per capita*. This latter method of financing may have encouraged the admission and retention of more children in residential care than perhaps was necessary, as it was important to have sufficient numbers to keep the income of the home at an acceptable level. The present budget system had set out to provide funds based on needs as they arose and might have been regarded as a better method of funding. However, the report *At What Cost?* (Streetwise National Coalition, 1991) points out that one of the major anomalies in the residential care system relate to funding. There are enormous variations in the distribution of the statutory funding. Such variations, the report says, cannot simply be explained by the numbers of children catered for, and gives examples of this anomalous funding in the residential care area.

While being in substitute care, particularly residential care, may have been regarded as detrimental to the well-being of a child, current research indicates that it can be, and often is, a positive experience for some children especially older children, sibling groups and children with special needs.[11] In the Aldgate (1977) study, when parents' preference in care type for their children was asked about, residential care was the much preferred option. Parker (1988, p. 91) supports Aldgate's view which suggests that residential care may help to promote (or sustain) a child's sense of family identity as well as enhance the competence of parents, "by not placing them in direct competition with another family". In Britain where "home on trial" is a possibility for a child, the greatest likelihood of a child being returned "home on trial" was from a residential home, not a foster home (see: Farmer and Parker, 1991).

Our data disclose a considerable reliance on residential care as an option for children. Twenty-six per cent of children were placed either in long-term or short-term residential care. Many more children may have experienced residential care at some time. So, despite the reduction in the proportion of children placed in residential care during recent years, residential care clearly continues to play an important role in child care services.

The functions of residential care are many. It may be used as a reception service for children needing immediate removal from their families. More

[11] See, for instance, Mid©Western Health Board *Child Care Practice Policy Statement* (1991, p. 5).

long-term functions are the care of sibling groups or care for children who reject fostering. Residential care has also been used where a foster placement has failed.

In its research study on residential care for children and adolescents in Ireland, Streetwise National Coalition (1991) observed that there was a feeling of change taking place and even greater changes on the way within the residential care system. Debate and discussion about the work are taking place at many levels and new methods of work are being tried in a small number of homes. They also found that the general level of physical and emotional care witnessed during the visits was of a very high standard and carried out in a professional way in most cases. The data for the study emerged from visits to residential homes and from the formal questionnaire interviews undertaken by a researcher. However, the research also uncovered a certain amount of tension on the ground between the residential care staff, social workers and Health Board administrators. The report speaks of the frustration expressed by the care workers over relationships with social workers, probation officers and policy makers and administrators in the Health Boards and the Departments of Education and Justice.

Residential care staff expressed a feeling of being undervalued by other professionals and a level of dissatisfaction with the fostering system because of the feeling that the residential care system was left to deal with the consequences of fostering breakdown to an increasing extent. Care staff recognised that social workers have very heavy workloads, but expressed the view that social workers did not always share essential information with them about the children's families. They often assumed that their job was largely done when the child was placed in care. Insufficient contact between care workers and social workers was a fairly constant theme.

Referring to Britain, Berridge (op. cit., p. 6), remarks on the paucity of information about children in residential care there. Little is known of their backgrounds, how they arrive in care and what responses the homes make to the children's needs. Richardson (1985) tries to fill in some of the gaps in the information on the Irish scene, but nevertheless, comments on the lack of any substantive detail on the children in her study.

To somewhat redress this imbalance in accessible information, at least for one region, a number of variables are considered here. First, the proportion of children in residential care in each area: Tipperary ranked highest with 31 per cent, then Limerick with 29 per cent, and Clare with the lowest proportion, 15 per cent, of its care population in residential care. Availability of places in each area does not account for these differences since Limerick has the only available residential places in the

Mid-West region. Thus, explanations in terms of attitude in the areas to residential care may be more useful.

One argument for the need to maintain a strong residential sector is the greater capacity of residential establishments to cope with difficult behaviour. I cannot comment on the difficult behaviour element among the children in this study, except to say that 27 children were said to have been placed in care as "out of control" to some degree.[12] Of these, 15 had been placed in residential care (56 per cent). Although the number is small, it does indicate that, as might be expected, children out of control are proportionately more likely to be placed in residential care. There appeared to be no gender bias – similar proportions of girls and boys were in residential care as in care in general.

If a child was placed in care through a Court Order, he or she was only slightly more likely to be in residential care than a child placed voluntarily. Twenty-six per cent of children placed in care by Court Order were in residential care and 23 per cent of children placed voluntarily in care, so there was no great difference there. The age profile of children in residential care was skewed towards the older child. Almost 80 per cent of children in residential care were 4 years old or older at admission. Following on from that, of course, was the evidence that 96 per cent of children in residential care were now 7 years old or older. These were the percentages for age at admission and present age respectively. The most common family type for children in residential care was that of "married two-parent" (55 per cent), with "married one-parent" comprising 28 per cent. It follows that the vast majority of children in residential care were marital children.

One of the often cited advantages of residential care over foster care is its capacity to provide for groups of siblings without having to split them up. Indeed this was the most often cited reason in this study. Such an attitude reflects the appreciation of the vital importance of siblings to each other. Wedge and Mantle in their conclusions (1991, p. 83) say:

> Wherever practicable, in all social work activity with children and families, sibling relationships should be enabled to take their natural course in recognition of the (sometimes closet) importance of brothers and sisters to one another. When siblings must be separated then there remains a powerful case for ensuring that links between them are maintained so that in due course if they so wish, the individuals can re-write and re-locate themselves and their identity in that culture where their social understanding was begun.

[12] This was a category on the questionnaire and was understood to mean that the parents were unable to control the child for whatever reason. It is not a legal term.

Table 3.19: *Reason for Child Being in Residential Care*

	Reason of Children	*Per cent*
1.	Child placed with siblings	29.6
2.	No suitable long-term foster home available	19.4
3	No suitable short-term foster home available	6.1
4.	Child out of control	15.3
5.	Breakdown in foster placement	10.2
6.	Parents refuse to allow child to be fostered	4.1
7.	Residential Home nearer own home than any available foster home	2.0
8.	Miscellaneous (including most suited to child's needs because child mentally handicapped etc.)	13.3
	Per cent	100.0
	N =	98

Earlier Berridge (op. cit., p. 124) had argued that a particular strength of children's homes was in keeping siblings together or in re-uniting them when they have been split up. He maintained that siblings are usually separated for administrative rather than welfare reasons, and since the alternative care experience is not always stable and fulfilling, it is important to stress that for many children in care, the natural family – including brothers and sisters – often provides the strongest basis for long-term support. Close to one-third, (30 per cent) of the children in the present study in residential care were reported to have been placed there to be with siblings.

In a quarter of the cases, where the placement was in residential care, no suitable foster home was available but yet social workers felt that in only 6 per cent of cases overall was the placement inappropriate. So it seems that little dissatisfaction is expressed about the residential home chosen. In only 4 cases did parents refuse to allow their children to be fostered.

A far more serious reason for residential care would be the breakdown of a foster care placement and for 10 per cent of the children in residential care this was said to have occurred. These breakdowns involved only a tiny proportion of the children in foster care (3.5 per cent). For that

proportion of children in foster care, however, the breakdown meant a double disruption, first from their family home and then from a foster home.

In Chapter 6 foster care breakdown is discussed. If levels of breakdown proved to be substantial it would serve to draw attention to the relationship between foster care and residential care in a way that is relevant to planning, as Parker (1988) states to be the case in Britain. In the case of Ireland the question must be asked: how long can a high level of foster care be maintained without the backing of residential care, where a very limited Supervision at Home system exists? However, the *Child Care Act, 1991* (Section 19) now provides for a new Supervision Order, thus enabling the Courts to place in the care of, or under the supervision of Health Boards children who have been assaulted, neglected, ill-treated, sexually abused or who are at risk. The Act imposes a statutory duty on Health Boards to apply for a Supervision Order when it appears to a Board that the conditions required for the making of an Order exist in respect of the child. An important innovation is that the Act makes it possible for a Health Board to obtain an Order when children have not yet been harmed. Hopefully, when the Child Care Act is fully implemented, a more extensive use of Supervision Orders will enable children to stay in their family home under the protection of such an Order.

While various commentators have classified residential care by the purposes it serves, few, according to Parker (op. cit.) have distinguished between the functions residential care fulfils for the wider welfare system and those for individual children. The distinction is stressed and is vitally important in considering the future of residential care. One example, illustrating the complexity of the purposes served by residential facilities beyond their stated primary aims, is the use of residential homes as the main destination for children who have been removed from foster homes for one reason or another.

Parker (ibid) concludes that the evidence from his own and others' research indicates a close relationship between certain parts of the residential child care system and foster care. It is obviously inappropriate, therefore, to regard them as exclusive options. "Seen from a child's viewpoint, residential care and foster care are often sequential episodes in a string of different placements" (p. 73).

A number of principles are set out in the *Child Care Practice Policy Statement* (1991) of the Mid-Western Health Board. There is little doubt that implementation of these principles would have contributed positively over the past two years to a new and more rigorous enquiry and planning for children entering care, for their stay in care and return to their

families, if that is in their best interest. The main emphasis is on point of entry to care. However, children in this present study had all been placed in care during or prior to 1989, in a large number of cases many years prior to 1989. Thus, the present principles were not underlying practice at the time of their entry to care. This would magnify already serious problems for present social workers dealing with these families. Less initial planning than at present would have taken place and social workers are now trying to cope with cases where if the present principles had been laid down at the time of the child's entry to care, a clear plan for the care experience of that child would have been available. Any new social workers would be able to follow through on a previous colleague's work with the child, knowing what the care plan was for that child.

Relevant to this chapter also are details of the arrangement for a pre-placement meeting involving all who are working with the child. If such a meeting is not possible, a planning meeting will be held within one week of admission. Thus since 1991 all children have a pre-placement discussion on their care plan.

Summary

In this chapter we have given details of numbers of children in care, their demographic characteristics; area differences; types of care available, with breakdowns of numbers in each type; supply and demand for places in care and assessment and criteria for placement.

Considering admissions and discharges for a moment, the proportion of admissions hovered around 38 per cent of all children in care on 31 December. Discharges have been around 34 per cent. If these proportions were consistent over a number of years, it would lead to a slow build-up of children in care. Certainly, there seems to be evidence of long stays in care, with a higher proportion of children, initially placed in care on foot of a Court Order, being retained in care. With these long-term episodes in care comes the lessening of proportions in foster placements as age rises. Relative to the British scene (see, for instance, Parker, 1987, Rowe *et al.*, 1989), the length of time spent in care is protracted. The vast majority of children placed in care in Britain spend less than 6 months in care. The implications for children in long-term care and impact on resources will be examined in Chapter 5.

No significant differences appeared between gender but the legal basis for entry to care was regarded as being important to the child, the family and the Health Board. The extraordinary rise in the cumulative numbers of children in care who had originally been admitted through Court

Orders is commented on – a sixfold rise in the Health Board as a whole over 9 years.

The possible differing types of care were described and some demographic details of children placed in each type were noted. With residential care, the majority of children were older marital children who had spent a long time in care. However, parents had seldom objected to foster care, other reasons for residential care almost always applied, e.g., to keep siblings together. As regards birth status, non-marital children were over-represented and were more likely than marital children to have been in foster care. Assessment and criteria for placement in care, in terms of likelihood of a case conference being held and in what circumstance, were discussed.

It should be noted that the children studied here represented various lengths of stay in care. The span was from less than 6 months to more than 12 years. Thus, the population under discussion was a heterogeneous one age-wise and in the length of time spent in care. Reference has already been made to changes in social work practice and this, together with older files being incomplete along with pressures on social workers, may have led to emphasis on present admissions and possibly a poorer service to children who had already spent a long time in care.

This chapter concentrated on the children in care as individuals. From here on the child will be considered as a member of a family.

Chapter 4

FAMILIAL AND KINSHIP CHARACTERISTICS

While no recent or comprehensive study of the socio-demographic backgrounds of children in care in Ireland had been undertaken, certain empirical indicators from studies elsewhere[13] pointed to there being structured, patterned deprivation leading to vulnerability to placement in care. This vulnerability was generally agreed to follow social class lines. In this chapter social class will be based on the occupation category of the child's father. Mother's occupation will be used where information on father's occupation is unavailable. Other social class variables such as, source of income; education level of parents; type of housing; living arrangements – whether the "family" lived as a unit on its own or as part of another household unit will be included. The extent of kinship and neighbourhood support will be examined as will the extent of formal support services available to the family. How the family came to the attention of the Health Board is a question which might provide some further answers to the reasons why the child needed to be placed in care. Finally, did the parents have a care experience themselves as children? If a high proportion of parents did experience care as children, this might contribute to the possibility of a care experience for their children.

At this stage I will consider household units. From the data it was obvious that in some cases the child in care came from a household comprising various relatives, such as siblings, aunts, uncles, grandparents. For instance, some single mothers were living with their parents, some lone parents had returned to live with their parents. Consequently: (i) households with children in care as individuals or with siblings in care and (ii) households and the total number of children in them were noted. The number of households is obviously the same in both cases. There were 258 household units – defined as separate groups of children and adults. Table 4.1 indicates that in 189 of those households 1 child was in care; in 35, 2; in 16, 3; in 11, 4; in 5, 5; in 1, 7 and in 1 household 8 children were in care – a total of 391 children in care. The second group included all the children in the 258 families, that is, both the children in care and children who had

[13] For instance, Packman (1968); Berridge (1985) and Packman, *et al.* (1986).

Table 4.1: *Households of Children in Care*

No. of Children in Household	*All Children No. of Households*	*Children in Care No. of Households*
1 child	91	189
2 children	45	35
3 children	37	16
4 children	22	11
5 children	23	5
6 or more children	40	2
Total	258	258
Total No. of children	791	392

siblings in care but were not in care themselves. Of these 91 were only children; in 45 households there were 2 children in the household; in 37, 3; in 22, 4; in 23, 5; in 14, 6 and in the 26 remaining households 7, 8, 9, 10 or 11 children in each. Overall, 791 children were involved. The unit of study in this chapter will be the household unit.

The family types by the size of the family are set out in Table 4.2. "Family type" is the marital status of the parents, irrespective of where they

Table 4.2: *Family Type by Family Size of Children in Care in the Mid-Western Health Board Region*

Family Size	*Family Type*				*N*	*Per cent*
	Married Two-parent	*Single One-parent*	*Married One-parent*	*Other Family Type*		
1 child	27.4(25.0)	55.1(72.8)	36.4(50.7)	46.1	91	35.3
2 children	17.0(30.8)	20.3(19.8)	27.3(24.5)	30.8	45	17.4
3 or 4 children	26.4(35.2)	14.5 (6.6)	20.5(19.9)	15.4	59	22.9
5+ children	29.2 (8.9)	10.1 (0.7)	5.9 (4.8)	7.7	63	24.4
Per cent	100	100	100	100		100
N =	106 (464,300)	69 (13,600)	44 (47,700)	39	258	

Note: The figures in parentheses show the proportions of the family units by marital status of head of household and number of children from Table 2(a) special analysis of the Labour Force Survey 1989 commissioned by the Combat Poverty Agency.

were living. As might be expected, as the number of children in the family increased the proportion in the group – married two-parent – also increased. Only in the single child household was the proportion in the single parent group larger than any of the others.

A rough comparison of family types in this study with family types in the population in general was attempted with the analysis specially commissioned by the Combat Poverty Agency (1991). The analysis was of the Labour Force Survey and it was commissioned with a view to identifying some of the broad characteristics of different family types. Combat Poverty identified a significant limitation in their data: Children were defined as persons of any age who had never been married and were living with their parent(s). As a result the data did not identify families with economically dependent children in each category. Nevertheless, Combat Poverty pointed out that the data were useful as an identification of the order of magnitude of the different family types and of their variability on a number of characteristics.

In the comparisons with the data in the present study, it is acknowledged that the comparisons are of necessity very rough, an example being that children in this study are, with only one or two exceptions, under 16 years old. Also, the differences in the numbers must be noted. Given these constraints, the figures in Table 4.2 provide some modicum of information on how representative the family types are in this study. The most notable is the over-representation in "married two-parent families of 5 children+" family units in this study. The lack of comparability with any other data must be stressed. No corresponding data exist for comparison purposes.

Social Class by Occupation

As far back as 1971, McQuaid had shown that of the 20 children admitted to Artane Industrial School in that year, none belonged to the farmer or non-manual socio-economic categories. In fact, two-thirds belonged to the unskilled manual or unemployed categories. Richardson (1985, pp. 105-116) reviewed certain indicators of the socio-economic backgrounds of a sample of children in residential care in Ireland. Her findings suggested an over-representation of the lower socio-economic groups among her sample. Both the McQuaid and Richardson studies were of children in residential care only. Until now no similar information was available on children in other types of care in Ireland. In Britain Packman (op. cit., p. 51) writing on the social class of the children in her study argued that the pattern of the lower social classes, particularly manual workers, being heavily over-represented in care, does not mean that

families in the higher social classes do not break down nor that their children escape deprivation or, indeed, avoid Court appearances. What it does suggest, Packman goes on to say, is that these families rarely approach the local authority in times of trouble but find other means of coping with their difficulties; for instance, boarding schools or private foster homes (see also Packman, *et al.*, 1986: and Parker, 1987).

Both the scale of problems encountered by different families and their resources to counteract the problems are obviously dissimilar. Families in poverty have fewer resources to offset their likely vulnerability to their children being placed in State care. However, since only a tiny minority of all children are placed in care, any straightforward argument in terms of class background being influential in determining whether or not a child will spend some time in care is clearly inadequate. Whether the answer lies in the direction of multiple deprivations or the interaction of class with other variables remains unclear. However, all the evidence from other studies indicates that children in care appear to be overwhelmingly from deprived backgrounds, and therefore from the lowest social classes.

The social class by occupation of the parents of the children in care in this study will now be presented.

Table 4.3: *Social Class of Fathers by Occupation, Comparisons with Census of Population Data for Mid-West Region*

*Social Class**	*1986 Census of Population*	*Present Study*
1. Higher Professional, etc.	9.3	2.7
2. Lower Professional, etc.	13.3	2.3
3. Other Non-manual	18.6	7.4
4. Skilled Manual	25.4	7.7
5. Semi-skilled	13.5	9.7
6. Unskilled Manual	11.6	26.0
7. Unknown	8.2	44.2
Per cent	100.0	100.0
N =	159,946	258

* For fuller details of social class categories, see Ireland: Census of Population, 1986.
Source: Small Area Statistics, Ireland: Census of Population, 1986, Mid-Western Health Board Region.

In the analysis of social class by occupation of fathers, a number of men were in the category "long-term unemployed" and "no information" on occupation available. In some cases there was a comment that the father had never been employed. These two groups – "long-term unemployed" and "never worked" comprised 44 per cent of fathers. Where there was no information on the father's occupation but information available on the mother's, her occupation category was used.

Table 4.3 indicates the comparisons in the data from the 1986 Census – Small Area Statistics for the Mid-Western Health Board Area. The problem of missing information must be borne in mind and the vast differences in the totals have also to be considered. However, there appears to be a distinct bias towards the lower end of the scale in the social class of parents of children in care.

Where source of income/current status of mothers was examined, home duties had the largest proportion, being 38 per cent, while 13.5 per cent of the mothers were in categories full-time (8.0 per cent) or part-time (5.5 per cent) employment. Mothers on State benefit (widows, deserted wives, single mothers) accounted for 26.5 per cent of the mothers. A further 20.5 per cent were obtaining unemployment benefit or assistance. Therefore, up to 47 per cent of the mothers were obtaining State benefit as their main means of support. Two per cent of the mothers were students. The picture emerging on the mothers' employment and social class status was one of low levels on both counts.

Where fathers' current status was examined and information available (on 165 fathers) (Table 4.4), 56 per cent of fathers were unemployed; 31 per cent in full-time employment; 5 per cent in part-time and the balance of the fathers were students or on disability benefit. In the vast majority of cases, therefore, the father's source of income was State benefit of one kind or another.

Table 4.4: *Source of Income Fathers of Children in Care*

Source of Income	*N*	*Per cent*
Full-time Employment	52	31.5
Part-time Employment	9	5.4
Unemployment A/B.	93	56.4
Disability, students, etc.	11	6.7
N =	165	100.0

Employment Levels

Some comparisons on employment levels of the males and females in the Mid-Western area and the particular population under study are attempted in Table 4.5. These data are extremely rough comparisons and serve only as a guide to the likely differences between the population in general and the population under study here.

Table 4.5: *Comparison between Census of Population Data on Percentages in Employment and Percentages in Present Study*

Mid-Western Health Board		*Present Study*	
Males	*Females*	*Males*	*Females*
63.9	28.8	31.5	8.0

Source: Small Area Statistics, Census of Population, 1986.

While a large number of people may have been affected by unemployment, one important aspect of the problem is that the worst effects would have been felt disproportionately by different groups in different areas. Remote rural areas and socially disadvantaged urban areas would be more likely to have concentrated incidence of unemployment. The above levels of employment for the Mid-Western Region conceal huge differences. For instance, a study of one urban socially disadvantaged area in Limerick (O'Gallagher, 1990) showed an unemployment rate of 82 per cent.

Age of Parents

The present age of parents, that is in 1989, is an important demographic variable in that if parents were either very young or elderly, certain implications would follow – possibly immaturity would cause social workers to think again about returning children to parents, or older parents might not be able to handle difficult children who had spent some time in care (Table 4.6). No comparable data are available in this form for the Mid-Western Region as a whole.

Education

Before examining the general education levels of the parents, attention should be drawn to Appendix Table C where the groups of parents are divided into those educated in pre– and during the 1960s, and during the 1970s and the 1980s contrasted with the general population. During the 1960s a series of changes was set in train in Ireland which greatly increased State involvement in education. Breen, *et al.* (1990) comment on the

changes in the three decades, 1960s, 1970s and 1980s. The best known change, as they report (p. 123), was the introduction, in 1967, of free post-

Table 4.6: *Age – Mothers and Fathers in 1989 of Children in Care*

Age Group	*Mother*	*Father*
	Per cent	
< 20	3.1	1.7
20-25	14.2	8.7
26-30	15.9	10.5
31-35	19.0	12.8
36-40	24.3	23.8
41-45	13.3	20.3
46+	10.2	22.1
Per cent	100.0	100.0
Totals	226	172
Mean age	33.6 years	38.9 years

Note: No comparable data for age of "mother" or "father" are available for the Mid-Western Health Board Region.

primary education and free school transport. Other important innovations were the opening of the first comprehensive school in 1966; the extension of the main national public examinations to pupils in all types of post-primary schools in 1967, the raising of the school leaving age from 14 to 15 in 1972. As Breen, *et al.* (op. cit.) point out, it was hardly surprising that public expenditure on education grew very rapidly from just over 3 per cent of GNP in 1961/62 to 6.3 per cent in 1973/74. The point most relevant in considering the data in this study is that prior to the reforms of the late 1960s, the great majority of the Irish population experienced only primary education. Breen, *et al.* show the participation rates and numbers in full-time education 1963-64 and 1984-85. They comment that Irish post-compulsory participation rates, as Tussing (1978, p. 90) and Murphy (1983, p. 3) had noted, now compare very favourably with those of other EC and OECD countries.

> Virtually all pupils now experience some post-primary education, and only about 8 per cent of each year's outflow from post-primary education has not sat for at least one of the national certificate examinations, while roughly one in four post-primary leavers enters third level education (Breen, *et al.*, 1990. p. 129).

Table 4.7 gives overall figures of the education levels of the parents of the children in care. These levels appeared to be overwhelmingly at the lower end of a scale of any academic qualification. Taking mothers first, just 81 per cent had left school without any qualifications; 13 per cent had remained until Group/Intermediate Certificate level; a further 4 per cent had up to Leaving Certificate level and the balance – 5 mothers – had some third-level education. The age range for the mothers in the study was from 17 to 60+.

Table 4.7: *Education Levels – Mothers and Fathers of Children in Care*

Parent	*Education Level*				*Total*
	No Quals.	*Group/Inter. Cert*	*Leaving Cert*	*Third level*	
			Per cent by row		
Mother	80.6	12.6	4.5	2.3	100.0
N =	179	28	10	5	222
Father	83.9	8.9	5.3	1.8	100.0
N =	141	15	9	3	168

Table 4.7 shows that where information was available, fathers' education levels were skewed towards lowest education levels. The age range of the fathers at the time of the study was from under 20 to 80, so the figures were also broken down into age likely to have been at school in the 1960s or earlier; 1970s and 1980s. Appendix Table C shows the differences in education levels. When these are compared with levels in the Department of Labour's School Leaver's Survey, quoted in Hannan and Shortall (1991), the levels show how dramatically different the education levels are between this group and the general population, particularly for the mothers. Comparable data for the Mid-Western region is not available, so, of necessity, comparison must be made with the general population.

Single and Lone Parents

In all EC countries, the number of lone-parent families has risen sharply in recent years. They have therefore become the focus of attention within individual countries and this is reflected in the interest which is now being paid to them at EC level (Social Europe, 1/89, p. 87). It is clear, even from the most cursory examination of the international data, that most

lone parents are women. At a minimum, Social Europe (1/89, p. 87) indicates, about three-quarters, and in some countries 9 out of 10, are women. The lone-parent family was invariably identified as one of the groups ranking high on the list of those threatened by poverty.

Millar *et al.* (1992) calculate that there are now over 40,000 lone-parent families in Ireland, comprising 10 per cent of all families with children under 15 and involving around 7 per cent of all children. The study on lone parents, poverty and public policy in Ireland commented that these figures show Ireland to be almost average in EC terms in its proportion of one-parent families. Furthermore given the absence of divorce, lone parenthood is almost certainly more of a continuing and long-standing status in Ireland than elsewhere, and there are more lone parents than the figures, on any of the various bases they are collected, are able to show. For instance, young mothers who have not left their family of origin are likely to be undercounted to an unknown degree.

Daly (1989), in her study of *Women and Poverty*, discussed the situation of women as lone parents in Ireland. She commented (p. 17): "Families headed by a woman on her own are becoming increasingly reliant on Social Welfare".

On the aspect of all lone parents and poverty, the Miller *et al.*, (1992) study demonstrated the severe disadvantage of lone parents as far as access to income and hence the quality of life is concerned:

> Lone-parent families, it can be shown, have lower incomes than other forms of family and lone-parent families that are headed by single mothers have the lowest income of all. Opportunities for securing income from employment are very limited; the record of securing any income from maintenance by a former spouse is dismal; and welfare payments, while lifting many lone parents from severe poverty, mean that women and children involved are not generally enjoying a standard of life above the poverty line (p. 99).

There are other more general studies of poverty in Ireland.[14] Here, however, I am specifically focusing on lone parents and poverty.

The connection between lone parents, particularly lone mothers, and poverty is also the subject of Lewis' comments (1989, p. 598). She criticises the developments in Britain and the USA which result in one kind of behaviour being deemed appropriate for women in two-parent families, and another for lone mothers which is premised on a set of dichotomous

[14] Nolan and Farrell (1990) *Child Poverty in Ireland*, and the numerous studies of poverty in general undertaken at The Economic and Social Research Institute by Callan and Nolan, among others.

choices (mothers or workers, dependence or independence) which are in turn inappropriately derived from male patterns of work. She concludes byasserting that greater sensitivity to the problems faced by lone parents over the life-course reveals the artificiality of treating the fundamental questions of employment and child care in respect of one-parent families separately from two-parent. The complex issues arising from the efforts to combine paid and unpaid work affect all parents, especially mothers.

Malcolm (1985) found that children in female-headed households are four times more likely than those in two-parent households to live in poverty. Having noted the above research evidence, Angel and Worobey (1988, p. 39) concentrated on children's health issues where the mother was single or a lone parent. The relevant finding for the present study is that children in female-headed households are more likely than those in two-parent households to live in poverty, and consequently are exposed more often to the health risks associated with low income.

In a study of patterns of food and nutrient intake in a suburb of Dublin with chronically high unemployment, Lee and Gibney (1989) identified single mothers or deserted wives at greatest nutritional risk. Meat consumption among single mothers and deserted wives was well below average which contributed significantly to their lowered iron intake. However, the authors found no evidence that the children of single parents or deserted wives shared the nutritional disadvantage of their mothers.

In *Gender and Poverty*, Millar and Glendenning (1988, p. 363-381) contend that gender differences in the causes, extent and experience of poverty are often obscured in much of the research on poverty. Here, we are only interested in evidence of the existence of female poverty, particularly in relation to single and lone parents. Millar and Glendenning's interest is wider, involving the structural causes of women's poverty. Nevertheless, they confirm that studies in the UK and the US all note the links between gender and poverty.

Another relevant aspect of the Angel and Worobey (1988) study is their assertion that convincing evidence exists that the lack of a confidence hinders a woman's capacity to deal with life stress. They further add that several researchers, for instance, Berkman, 1969; McLanahan, 1983; Ross and Huber, 1985, have found that single female heads of household experience more chronic and episodic life strains than females in intact marriages. "Thus", they conclude, "single motherhood often represents 'double jeopardy': it often results in 'role overload' and increased psychological distress, while depriving a mother of an important source of emotional support to help deal with this stress" (p. 41).

In a study of unmet welfare needs in the Mid-Western Health Board

Region, O'Connor, *et al.*, (1991) noted that for lone parents the frequently mentioned unmet needs were adequate financial support; need for equity and standardisation of Income Maintenance Procedures, need for social acceptance, need for Child-Care facilities, need for appropriate housing. In addition, need for emotional support, need for opportunities to work, need for advice and information, and a need for flexible and accessible services, were all mentioned.

In the area of family poverty, Lambert and Hart's (1976) study showed children of mothers reporting a high level of financial hardship to be 10 months behind in reading and 9 months in maths scores, compared with those who reported no such financial difficulty.

Therefore, from general research findings, one theme appears to recur in all studies, that of the link between one-parent families and poverty and of one-parent families being most likely to be female-headed.

Supporting the argument that the children of single mothers are more vulnerable to placement in care were Crellin *et al.*'s (1971) study in Britain; Graham's (1980) study in Northern Ireland; Richardson's (1985) study in the Republic; the O'Higgins and Boyle (1988) study and this present study, all of which found an over-representation of non-marital children in care. If single parenthood is a significant variable in the likelihood of a child being placed in care, then it is important to enquire if there has been a rise in the number and proportion of single mothers in recent years (or single fathers for that matter, although single mothers are more common). If the number and proportion have increased, this may be reflected in the numbers of children entering care in the future. Although various writers in the area (for instance, Sexton and Dillon, 1984; Clancy, 1984; and Walsh 1980) point to a decline in both legitimate and overall fertility rates, they equally note the increasing proportion of annual births which are classified as non-marital. This simultaneous rise in the fertility of the unmarried is evident from Sexton and Dillon (1984, p. 26). In 1961 illegitimate births, as they were then termed, represented just 1.6 per cent of all births, while in 1989 that percentage had risen to 13.9.

In this time of falling overall fertility rates, and rise in the rates of non-marital births, an increasing number of unmarried mothers are choosing to keep and raise their children as indicated by the falling adoption rate and increase in Unmarried Mothers' Allowance Claims (see Department of Social Welfare records). Therefore, the single mother headed household has become a much more substantial group than before.

Single parent and lone-parent (e.g., married but either widowed, separated or deserted) families comprised 40 per cent of the families in this study and the vast majority of these were female-headed households

(55 per cent – unmarried single mother; 45 per cent – married one-parent, almost always the mother).

Housing

As also pointed out in my earlier study, deprivation and consequent vulnerability to placement in care is not limited to one birth status group, such as one parent family and non-marital children. Wedge and Prosser (1973, p. 11) showed there is even no general agreement about what constitutes a "social disadvantage", but they felt that three factors seemed fundamentally important; (i) family composition, i.e., a large number of children in the family or only one parent figure; (ii) low income; and (iii) poor housing. Here we will consider the housing conditions of the families, by family size.

In this study almost three-quarters (73.7 per cent) of the families irrespective of size lived in a house; 11.3 per cent in a mobile home, either on a serviced site or roadside, and around 1 in 12 lived in a flat. Over half of the accommodation – 61 per cent – was provided by the local authority and 39 per cent consisted of private accommodation. These details are of actual type of housing, but poor quality of housing was seldom mentioned as contributing to the need for placement of a child in care. Where it was mentioned, it nearly always referred to mobile home accommodation, and to the health hazards encountered by the children of parents living in such accommodation. One private house was mentioned as being unsuitable, because of its size and lack of facilities to accommodate what were now teenage children. Except for these cases, most of the accommodation appeared to be of reasonable quality, so could not be regarded as contributing to social disadvantage to any significant extent for the families studied here.

Table 4.8: *Type of Housing*

Type of Housing	*N*	*Per cent*
Room	4	1.6
Flat	21	8.5
House	183	73.7
Mobile Home	28	11.3
Other	12	4.8
N =	248	100.0

Mention should be made that the 11 per cent of families living in mobile home accommodation were Traveller families. A separate account of this particular group is planned, but they are not deleted from the general findings here.

Table 4.9: *Type of Ownership*

Ownership	*N*	*per cent*
Local Authority	149	61.3(18.8)*
Private	94	38.7(83.2)
N =	243	
Per cent =		100.0

* The proportions in parentheses are the proportions found in the Combat Poverty analysis, referred to previously.

To reiterate almost three-quarters of all the families lived in a house and local authority housing was by far the most likely type of ownership for the families. The proportions in parentheses on Table 4.9 are the proportions found in the Combat Poverty analysis. These indicate a dramatic difference between the source of housing for families with children in care and the general population, so far as may be asserted from these figures. However, since the in-care population is from only one region and is of a different structure, the comparison must be regarded as tenuous.

Associated with housing would be whether "the family" e.g., parent(s) and child(ren) operated as an independent unit or lived with other kin. The vast majority, 80 per cent lived as separate units, around 13 per cent lived with either the father or mother's parent(s) – most often mother's parent(s) (11.6 per cent). A large proportion of these latter were single mothers.

Support Networks – Kin and Neighbours

The importance of distinguishing between social support and social networks, the latter being all the people one is in contact with and from whom one potentially gets support, has been stressed by McCubbin and Thompson (1987, p. 19). Social network members may not always provide support and may in fact be more a source of demand than a source of support. Social support in any case, add McCubbin and Thompson, implies more than superficial contact with people; rather it involves a

qualitative exchange of communication in an atmosphere of trust. Support may be available from an intimate (e.g., mother in our case) or weak ties (e.g., a neighbour or friend). This support can be differentially helpful depending on the type of stress and strain the family is enduring. Members of the family can get support from each other – that could be considered a family resource. Other sources of support family members could get would be from relatives, friends and neighbours, work associates, social and church groups, self-help groups, as well as from more formal networks such as physicians and health care providers. McCubbin and Thompson note that there is some disagreement in the literature as to whether the latter should be considered social support since there is usually no mutuality or reciprocity implied (see, for instance; Gottlieb, 1983) and, in fact, exclusive reliance on formal support could undermine development of mutually supportive networks. However, even formal support can be instrumental in providing esteem and appraisal support, add McCubbin and Thompson, especially if they are mindful not to undermine the person's own sense of control over his or her life.

The ability of social networks to inhibit use of formal services is pointed out in a rather intensive study undertaken in Scotland in which 87 women were selected randomly from a maternity clinic and classified as "utilisers" or "underutilisers" of prenatal care (McKinley, 1973). Utilisers were found to visit relatives less frequently than underutilisers. There was also a tendency for underutilisers' friends to be closely interlocked with their kinship network (i.e., friends were "family friends" as opposed to exclusively personal friends). McKinley suggests that the underutilisers' close-knit networks may be operative in a form of social control such that they must take advice given and comply with the wishes of members of their network and conform to their expectations.

Unger and Powell (1980) examined the role of family support networks in mediating the effects of stress caused by everyday situations, crises and developmental changes. They reviewed the research evidence which indicated a strong relationship between a family's response to stress and the aid received from an informal support network of relatives, friends, neighbours, and acquaintances.

In this study the relevant questions asked the respondent social workers to identify the social supports and social networks available to the families.

Implicit in asking a question or seeking information on social support and networks of the families of the children in care is the view that social ties are valuable, both for their useful content as a protection against adversity and insufficient State support, or ideologically, as a contrast to the indifference and materialism of the world outside the network.

While acknowledging that some network members can act as a source of conflict, demand and difficulty, social networks provide essentially three types of aid: (a) instrumental support, (b) emotional or social support, and (c) referral and information. Instrumental support would consist of material goods and services to an individual to alleviate financial and economic situations or crises. This study did not concern itself with instrumental support from kin, neighbours or friends. Its main emphasis was on emotional or social support – who would be available to help in a crisis – major or minor – and what would the extent of that help be?

The question of reciprocity always arises where networks are concerned, since reciprocity has been noted as highly associated with network stability and effective functioning. The reciprocal resources of the poor, the ill, the single-handed, for instance, may be rather limited making it difficult, if not impossible for them to observe the norms of reciprocity.

Another aspect of reciprocity is that the costs involved in the reciprocal nature of informal social networks may at times actually serve as an additional source of stress, influencing the potential beneficial impact of network involvement. For instance, Ackerman (1959) emphasised that the extended family can incite stress, stimulate family conflict, and add undue influential power over family members.

Table 4.10: *Kin Support/Networks – Families of Children in Care*

Support Type	*Per cent*
None	44.3
Own Mother/Father	30.5
Mother-in-law	3.6
Brother/sister	4.1
Other Near Relative	10.6
Combination of More than One	6.9
Per cent	100.0
N =	246

The families in this present study appeared on the whole to have very little support from kin and/or neighbours to protect them from the danger of being left outside the "gate to health and well-being" as Gove (1978) terms it. This was reported by the social workers dealing with the families. They reported that as high as 44 per cent of the children's families had no kin support whatever. Around 30 per cent did have the support of one or other of the parent's mother and/or father, while the

remaining 25 per cent had support from wider kin. Combinations of near kin, parents, sisters and brothers of the families, were available with help of one kind or another.

An even larger proportion of the families in this study had no social support from neighbours or friends – 68 per cent were said by their social workers to be in that situation, but 32 per cent did have some support from a neighbour or a friend. I remarked to some of the social workers on this circumstance of little social support either from kin or weaker ties. Their view was that the families whose children had been taken into care were most likely to be those whose kin, neighbours or friends had given up on them, having tried to help them without success over a long period, or those generally out of range of families or neighbours. These social workers expressed the view that kin and neighbourhood contact and support would have been much greater in families other than those with whom they had contact.

Table 4.11: *Neighbourhood/Friends Support – Families of Children in Care*

Support Type	*Per cent*
None	68.0
Neighbour	20.7
Friend	11.2
Per cent	100.0
N =	241

There is then the question of reciprocity. What had these families got to reciprocate any help given? Very little it would seem and mutual support is governed by the norms of reciprocity. These families had most likely offended against the norms of reciprocity in that they failed to come up to expectations, given that they had no resources on which to draw to reciprocate any support which might have been offered.

When help was available, it could be the taking over of the house, or all day help, in 24 per cent of the cases, or daily checks or occasional help in another one-third of the cases. In discussions with the author the impression given by the social workers dealing with the families was that, where help was available it was valuable in sorting out some of the crises that arose. For instance, a mother becoming ill – her mother would take over and only short-term care would be needed for the children in that case. Without help the care might have been long term.

Unger and Powell (op. cit.) are of the opinion that interest in factors that influence a family's ability to cope with normative stress and crisis situations has focused largely on attributes of a family and its members. "Although these variables are of extreme importance in understanding adaptation to stress", add Unger and Powell, "they contribute to a 'closed system' view of families if considered as the exclusive or primary determinants of a family's response to stress". They advocate an "open systems" perspective of the family which emphasises the embeddedness of a family in a social environment that has a major influence on family functioning. One factor external to the family which plays a critical role in facilitating adaptation to stress is emotional and material support from formal and informal sources. There appears to be a strong positive relationship existing between social networks and a family's adaptation to societal crisis, life transitions and family conflicts.

It should be emphasised in this context of support, as Berridge (op. cit., p. 18) does, that care provided by local authorities, voluntary organisations and independent establishments makes but a small contribution to the overall substitute care of children. "Generally", says Berridge, "children whose parents cannot provide for them are looked after by their wider families or close friends". He adds that it is only when these networks of alternative care are broken, allowed to wither or fail to intervene that dependants, particularly children, come to notice (p. 19).

The notion of social class and social support as overlapping categories achieved particular notoriety with the "community studies" of the 1950s and 1960s in Britain. "These", say Oakley and Rajan (1991, p. 31) "evoked an appealing caricature of working class communities revolving around the emotional and practical sustenance of Mum". This social support was envisaged by such authors as Young and Willmott (1957) and Rosser and Harris (1965) as largely mobilised by young married women who called on the female kinship network for practical assistance and emotional help with child rearing. Oakley and Rajan (op. cit.) point out that by comparison, middle-class households were identified as more likely to be cut off from the support and help of relatives (either as cause or consequence of geographical mobility) and therefore more prone to be dependent on friendship ties. There was an implication in studies such as those of Bell (1968); Firth, *et al.* (1969) and Hubert (1965), that these ties might be a more fragile and less enduring source of support than the biological bonds of kinship. Allan, in 1979, summed up these findings with the words "middle-class people have friends and working class people have relatives".

However, some studies had already begun to cast doubts on this stance – in the US, for instance, Gordon and Noll, (1975), and later the review of

British studies by Willmott (1987). In examining social class and social support, Oakley and Rajan (op. cit., p. 33) concentrated on a subgroup of the child-bearing population. They were of the opinion that their data appeared to conflict with the conventional picture of close-knit supportive social networks based on kin and neighbourhood among working class women in comparison with middle-class women. On the other hand, the findings of the Oakley and Rajan study indicate a level of interaction with kin and neighbours by working class women, which, although similar to middle-class women, yet was a great deal higher than that found in this study.

The inability to cope with stress and the development and learning of dysfunctional coping strategies may be set within a family context. Duncan and Morgan (1977), and Duncan (1978) pointed to the "pile up" of family events and the family's difficulty in managing life strains may contribute to members' abuse of alcohol, drugs and tobacco as well as physical abuse. As McCubbin, *et al.* (eds.) (1982, p. xv) show, whereas social support is used by numerous individuals in many and varied fields, its value to families and individuals in the management of stress has only recently received empirical support.

It is possible that heavy reliance on formal networks, as defined by McCubbin and Thompson above, had undermined development of other supportive networks for the families in this study. Availability of formal family support services will now be examined.

The *Child Care Act, 1991*, stressed the importance of family support services as a preventive measure to taking children into substitute care. O'Connor *et al.*, (1991) undertook a qualitative, exploratory study of the needs and concerns of different client groups in the Mid-Western Health Board Region. The study focused on current needs with the aim of providing information on the adequacy of family support services and on their methods of delivery. As the study points out, fundamental to the provision of Family and Personal Support Services is the identification and clarification of clients' needs. The O'Connor study did not include families with children in care in the groups studied, but nevertheless the study provides an insight into the delivery of family support services to other groups in need of them and all the groups involved were living in disadvantaged circumstances.

Available Formal Support Services

The inclusion of a question on the availability or otherwise of support/preventive services was expected to prove problematic for the analysis in this study. However, the questions were included as they are so

obviously relevant to the area of children in substitute care, and their exclusion would immediately arouse enquiries as to why they had not been included. I appreciate that one could devote a complete study to questions on the availability and take-up of services, but this section was a small part of a larger study where only a general picture could be sought. Time constraints on both the author and the social workers completing the questionnaires precluded desirable detail in some areas.

Information on services is missing in a relatively large number of cases. For instance, social workers completing the questionnaires did not provide information on the availability of some services in an area – in the cases of 86 families there was no information on Youth Club availability; for 71 families there was no information on the availability or otherwise of Day Care Centres. An explanation for this absence of information may lie in the findings of the study by O'Connor *et al.*, (op. cit., p. 271), who spoke of feedback from both clients and service providers highlighting an array of needs which are perceived as being currently unmet. "In some instances" they say "it is perceived that needs are unmet because services which would address them simply are not there. In other instances, however, the services do exist but fail to meet needs either through difficulties of access or through inappropriate delivery mechanisms". These authors speak of the haphazard nature of the services that are available. Their findings seem to confirm the patchy nature of the accessible information on service availability and use gathered for this study.

Where data were present, the services are first commented on and then a following table indicates availability of service and whether used or not.

Home Help

One service which has a preventive role is that of the home help. Home helps can make several different kinds of contributions as well as assisting with housework to be done. Parker (1980, p. 51) sees five areas where home helps are more than just housework assistants. First, they may provide company and thereby a safety valve for mothers who feel too hostile and aggressive towards their children. Second, they may "take over" temporarily and thereby allow mothers to get out of the house and away from the children for a while. Third, they may provide play and language stimulation for the child and, in some instances, for the mother as well. Fourth, a home help may act as a role model for some mothers. Fifth, they can provide a link with other services, so that other help can be mobilised quickly, if necessary.

In Ireland the Health Boards were authorised to provide a home help service to people who are sick or disabled, or their dependants are sick or

disabled. Women in receipt of maternity care would be entitled to home help and also anybody who, but for the service, would have to be cared for outside of their home. This authorisation was contained in Section 61 of the Health Act, 1970.

Gilligan (op. cit., p. 122) notes that in 1972 Health Boards were recommended by the Minister for Health to use the powers given them and the Department of Health recommended that priority be given to the needs of families and also the elderly. Further, Gilligan sets out the needs a home help fulfils in regard to families, which is the main interest in the service for this study. He comments that while the original intention was that the service should primarily focus on families with children, in practice they have made up only a minor part of the total number of beneficiaries. "This frustration of initial intentions", says Gilligan, "would appear to be due to two factors: the heavy reliance on part-time home helps, and the particular challenge of delivering a home-help service to families". He adds that families with special needs make special demands which only a full-time home help might have developed the capacity to satisfy". As Gilligan further remarks, and which is most relevant to the present study, the other factor inhibiting the response of the home-help service to the needs of families is the complexity of their problems which may prove to be beyond the capacity or endurance of the personnel available.

Table 4.12: *Home-help Service 1987*

Health Board	*No. of Home Help Organisers*	*No. of Home Helps* Employed Full-time*	*No. of Home Helps* Employed Part-time*	*No. of Beneficiaries*	*% of Beneficiaries Who Are Not Elderly*
Eastern	77[1]	–	2,965	4,389	29.8
Midland	2	13	323	463	33.9
Mid-Western	6[2]	–	784	1,845	36.3
North Eastern	–	5	684	838	13.5
North Western	7[3]	32	330	979	14.3
South Eastern	4	7	630	766	12.3
Southern	4	–	1,450	1,681	10.1
Western	3	55	738	1,739	12.3
Total	101	112	7,904	12,021	

* Includes those employed directly by the health board and those employed by voluntary agencies which receive grants from health boards to provide a home-help service.

1 Includes 37 part-time organisers.

2 Includes 2 part-time organisers

3 Includes 1 part-time organiser

Source: Derived from Department of Health (1988), *The Years Ahead – A Policy for the Elderly*, Report of the Working Party on Services for the Elderly, p. 205.

Table 4.12 is a copy of Table 13 in Gilligan (op. cit., p. 123) giving details of the home-help service in 1987.

In the context of this study, it is noteworthy that the percentage of home-help beneficiaries who are not elderly in the Mid-Western Health Board region is the highest for any Health Board, just over one-third of the total beneficiaries. There is the question of how much time a home help gives a family, but no information is available. However, the proportionately high level of non-elderly beneficiaries does not seem to agree with what appears to be a low take-up of the service for that group in this study. This may be explained by the existence of other non-elderly users besides families with children, e.g., younger adults with physical or mental disabilities or their carers. However, without a comparison with take-up of services in other regions, this cannot be confirmed or denied.

It would seem that the service was widely available in theory to the families concerned here, being stated by social workers as not available to only about 17 per cent of the families, yet it was only used by 16 per cent of the families. This does not mean that 83 per cent of the families had had home help, but that such a service would have been available, if appropriate. There was a problem here in framing the question to cover various possibilities such as appropriateness to the needs of the families. Also, some families refused the service when offered. It is difficult to interpret the figures regarding availability and use of the home help service in Table 4.13. It would seem that while in theory a service was

Table 4.13: *Family Support Services*

Service	*Not Available*	*Available Not Used*	*Available and Used*
		Per cent	
Day Care Centre	75.7	18.9(84.3)*	5.3(15.7)*
Home Help	21.1	64.3(80.8)	14.6(19.2)
Self-help Groups	56.9	29.9(78.1)	13.2(21.9)
Marriage Counselling	27.8	60.6(86.8)	11.6(13.2)
Youth Club	56.7	35.1(81.4)	8.2(18.6)
Family Caseworker	3.9	13.8(15.3)	82.3(84.7)
Community Welfare O.	6.7	22.8(30.3)	70.5(69.7)
Other Services (e.g., J.L.O.)	7.3	20.2(21.6)	72.7(78.4)

* The percentages in parentheses concern where the service was actually available and used or not used for whatever reason.

available, in practice it was difficult to implement it, perhaps for the reason Gilligan has suggested. Such a reason would be particularly appropriate in the cases of these families – the complexity of the families' problems may have proved beyond the capacity and endurance of the available home help personnel. However, home help being a preventive resource, no doubt when used it had prevented some children coming into care. A good preventive service should be enabled to support the family and act as a buffer to prevent stresses piling up to the extent that a child must be placed in care.

Day Care

Gilligan (op. cit., p. 36) first discusses the concept of day care in general and defines day care types. He then hones in on day care in Ireland, stating that in the Irish context, public policy has taken a fairly clear, minimalist position on the public provision of day care. The State has still not assumed a role in the regulation of provision, although it has acquired powers to do so in the provisions of the *Child Care Act, 1991*. Gilligan (op. cit., p. 138) discusses what he believes to be ideological and practical reasons for the reticence and apparent vacuum. However, he does state that public policy and intervention have been largely confined to deprived children, which is of relevance to this study. The Department of Health, through the Health Boards, has evolved a system of assistance to day care facilities geared to supporting families at risk by providing respite care and/or to offering compensatory experiences to children whose home circumstances may be inimical to their social, emotional or educational development.

It is interesting to note that day care was not available or had not been offered to 67 per cent of the families. A large number of the families in this study would appear to have been particularly suitable for day care services. One possible cause of the low availability of day care may have been the geographic distribution of the families, e.g., those in rural areas might not have the same opportunity to avail of such a service. It is not proposed to consider urban/rural differences here, as more exact detail of the location of each family would be required. Also, in some cases, because of the age of the child or children, day care would not have been appropriate as a service. Again, the question was asked to evoke a general response.

Alongside the deficiencies in provision of day care, there are problems in determining how it does or should fit into a pattern of services helping to prevent permanent separation between children and their families.

Parker (1980, p. 47) notes this, and identifies one problem as being that day care serves a variety of purposes. Another difficulty is that day care is desired by some and not by others. Parker asks the question: "Were those who were not receiving day care (or for whom it was not being sought) in less 'need' than those who were?"

In response to this question, Parker suggests that much of the debate about day care looks at its "purposes" from the standpoint of the child: how his or her emotional, intellectual and social development may be affected for good or ill. While endorsing these concerns, Parker feels that from a preventive perspective, it is equally important to view day care as a means of assisting parents in their tasks of child care. That is the particular aspect of day care which is of interest to this study and as Parker points out, it is a somewhat underemphasised aspect, but one which is crucial in the interests of forestalling long-term separation. The high proportion of children whose reason for care is, for instance, "death of mother, father unable to care"; "single status of mother leading to inability to provide" and so on, leads to the question being asked, as Parker (ibid., p. 49) did "... how many of these children could have been as well or better cared for in full-time day care and with less risk of long-term separation?". In this study many social workers maintained that a proportion of admissions to care could have been avoided had there been appropriate forms of day care available at the right time. This information was obtained from social workers' responses to questions on the questionnaire about their views on substitute care and methods for its prevention. A special section in Chapter 6 is devoted to comments made by social workers. Also, an earlier study in Britain by Davies, *et al.* (1972) found that one of the few factors differentiating proportions of children in care in different local authorities was level of day care provision. An inverse relationship was found.

The National Children's Bureau in Britain quotes what arguably has become the predominant rationale for lack of a clear national policy or resource allocation for pre-school children – "very young children are best cared for at home" (Highlight No. 79.NCB). It hardly needs mentioning that the Irish situation echoes that. The need for child care is usually associated with the achievement of gender equality, in that women's availability for employment outside the home depends to a large extent on the availability of child care. In this study, as mentioned above, the object of promoting day child care is one of prevention of more prolonged and far-reaching separation of children from their families.

As Packman (op. cit., p. 230) notes, it is clearly impossible to look at every influence which helped to bolster families in danger of breakdown. However, an attempt was made to see what services were available in the

voluntary and statutory areas for families with children in need of care or protection.

It should be noted that the category "Available Not Used" covered cases where the service might not have been appropriate to the family, e.g., Marriage Counselling in the case of a single mother. With the exception of the services of family case workers and Community Welfare Officers, social workers were of the view that other available services were little used, irrespective of family size.

The low availability of services such as day care and Youth Clubs needs further examination. These may be more readily available in urban areas, but as noted earlier, exact location for each family would be required to confirm or deny this speculation.

The object of asking questions about service availability and use in a study such as this of children in substitute care is, of course, the preventive capacity of a service. Since the children here had all been placed in care and service availability and take-up were low, it might be speculated that available and implemented services could make a difference. However, without studying the effect of take-up and availability on families whose children were not admitted to care, this must remain a speculation. It may be recalled that the original proposal to the Department of Health, mentioned in the Introduction to this study included control groups of families whose children had not had a care experience.

Parents' Experience of Care

Parker (op. cit., p. 56), in his discussion of the preventive role of improving parental care, argues that parents who have spent part of their own childhood in care, or whose early lives have been disorganised or disturbed, are likely to have missed the good, ordinary experiences of parental care. Their own skills as parents may be damaged as a result. Parker goes on to discuss possible interventions to help parents with a personal care experience to develop skills in parenting. Here we will confine ourselves to noting those parents who did have a care experience.

Fifteen mothers and 4 fathers, and in 1 of these cases both mother and father, had had a care experience as children. Of those 19 adults, twelve had spent time in long-term residential care, three in long term foster-care and four had been only a short time in care. Examination of variables relating to these 19 individuals have not been pursued at this stage. The number is too small for any valid comparisons to be made with the other parents of children in care – the proportion of the total population of the families in this study (258 family units) is 7 per cent (18 family units). This is a high percentage of parents with a care experience relative to the

proportion of parents in the population who would have had a care experience. This may therefore support the contention that parents with experience of care could have damaged their own ability as parents. In addition, it may not truly reflect the number of parents with a care experience. It is likely that, except in the most obvious cases, social workers would not know the family history in the detail to include the childhood experiences of parents. Comment has already been made on the poor quality of information on some files.

Initial Referral of the Family

The route by which the family came to the notice of the Health Board was regarded as important in providing information on community or formal networks in operation in bringing cases to the attention of relevant services.

Health care providers such as hospital nurses, public health nurses and general practitioners were involved in 32 per cent of referrals. Other formal networks such as school principals, non-Health Board social workers, voluntary social services, adoption workers and priests accounted for 21 per cent of referrals. Nine private individuals reported the families to Health Board social workers and relatives reported in 9 per cent of cases (21). As high as 18 per cent of families referred themselves to the Health Board for assistance. This is the initial contact of the family with the Health Board social workers, hence the absence, except in a few cases, of agencies such as Gardai.

It seems evident from the above that a wide variety of people are involved and concerned about children in need of care and protection. Table 4.14 gives the details.

Teacher/School Involvement

The mention in the *Law Reform Commission Report on Child Sexual Abuse* of the need to involve teachers, among others, in the mandatory in reporting of suspected abuse of children or children in need of protection prompted a question as to whether in the past teachers had been consulted about children who were now in care. This question covered all relevant children in care – not just suspected abuse cases. Although I appreciate that nursery nurses and other non-family members in touch with children during the day would be appropriate people to consult, here I confined the question to children attending school and their teachers. Where such a question was relevant, e.g., children attending school, in 71 per cent of cases teachers had been involved in some discussion of the case. The social workers found that discussion helpful in a small majority of cases (59 per

cent). I have no information on the dimensions of the discussion and, no doubt, quite different dimensions were present in different cases. Overall it appeared to be a useful exercise when social workers and teachers engaged in it.

Table 4.14: *Route Through which Family Came to Health Board Attention*

Route		*Per cent*	
Hospital Nurse	Health Care	12.0	31.8
PH Nurse		12.8	
GP		7.0	
Self-referral		18.6	
State Social Services		11.2	
Relatives		8.7	
Voluntary Social Services		8.3	
CURA		6.6	
School Principal		4.9	
Private Individual		3.7	
Priest		0.8	
Other (e.g., Gardai)		5.4	
Per cent		100.0	
Total		242	

This section is limited to the likely involvement of teachers in the reporting of abuse of children. The question of abuse as a reason for substitute care, and the incidence of it, is included in Chapter 5.

In considering lessons for teachers from the now famous Cleveland "crisis" in Britain, Maher (1988, p. 279) suggests that the Cleveland child sexual abuse crisis has generated a whole range of questions for communities, for all professionals and some of particular significance for teachers. Maher quotes Creighton (1987) who has shown, from the NSPCC's statistics, that in 35 per cent of the cases with information, the abuse was discovered by the school or pre-school the child was attending.

Maher, op. cit., believes that given teachers' training in what constitutes "normal childhood development", they are uniquely placed to recognise the abnormal. He warns, however, about the problems faced by anyone making a mistake and wrongly attributing a child's abnormal development to abuse. It is likely to be met with banner headlines, public enquiries and blame. The environment has worsened for all professionals over a period of time, most critically for social workers, but potentially for teachers as well.

The reactive role of teachers, that is, of detecting and reporting child sexual abuse, while vital, Maher (1988, p. 285) argues, should not be seen as the only role for teachers to play. While that role is crucial to the safety of many children, teachers also need to take a proactive approach through work in the curriculum and evolving means of making schools more sensitive to the needs of children who are abused or at risk of abuse.

Summary

Chapter 4 set out to give background data on the familial and kinship characteristics of children in care in the Mid-Western Health Board Region. Given the evidence presented from elsewhere, it was not surprising to find a low level of education, employment and an over-representation in the lower social classes. It is felt that the presumption from the other circumstances of the families that a majority of the missing fathers would have a low occupational status, is a plausible conclusion to reach. As regards employment or indeed unemployment levels, these are quite different from the general population in the Region.

The pressures and stresses encountered by single and lone parents, being most likely female, were commented on, as was the greater likelihood of poverty for lone parents. The over-representation of non-marital children among the group in need of care or protection was noted and with the increase in non-marital births, the question was posed as to the likelihood of the proportion of non-marital children in care increasing in the future.

The poor levels of informal support networks such as family and neighbours might have led to a high level of use of formal support networks but this was not the case, except where the family caseworker and community welfare officer were concerned. Given the population concerned and its needs, the poor provision and take-up of services, such as Day Care and home help, is remarkable.

The broad base from which the family came to the notice of the Health Board gives a picture of a large number of concerned people involved in the welfare of children. Teachers obviously play an important part in discussing the circumstances of children who are in need of care or protection, but they are not involved in reporting to the Health Board on children who might have problems.

It hardly needs to be stated that the findings here are not surprising. Rather it would have been surprising had they differed dramatically from findings in studies elsewhere on the family characteristics of children taken into substitute care. Having said that, this is the first time such information has been either made available or analysed on any families of children in care anywhere in Ireland.

Chapter 5

REASONS FOR PLACEMENT OR DISCHARGE FROM CARE

The previous chapter recorded the familial and kinship characteristics of children in care. There are connections between those characteristics and the reasons for care in that reasons for care are not only specific to the child but emanate from the problems of the family. The reasons chosen are those which suggested themselves from the literature as well as those used by the Department of Health in their annual returns from the Health Boards. Reliance was placed on the professional expertise of the social workers in assessing their cases. Since the statement was made earlier that children in need of care or protection are more likely to be, in Packman *et al.*'s (1986) terminology, victims rather than villains, the likely reasons for care were divided into problems specifically related to (i) the child, e.g., abuse, neglect and (ii) problems in the family such as financial or health problems of parents, which led to the creation of the problems for the child.

First, the discussion will concentrate on the concept of stress, its impact on a family and the likelihood of its causing or contributing to a situation arising where a child or children in that family need placement in care. The possible external and internal nature of family problems as defined by Boss (1988) are observed. Then the detailed reasons for care will be examined, together with the reasons why children have not been returned to their families where appropriate. In cases of children having been discharged, their situation after discharge is considered. I have also included responses to the following questions: does the reason for admission dictate the type of care a child experiences, and in what circumstances? Was a Court Order admission more likely to occur than a voluntary admission and if so, in what circumstances?

External/Internal Context of Stress

Boss (1988), in proposing a model of family stress, divides the sources of stress into "external context" and "internal context". The family has no control over the external context of stress. The environment in which the family is embedded, or as Boss (1988, p. 27) terms it "the family's ecosystem", – the "time" and "place" in which a particular family finds itself, contributes to the stress produced for that family. She adds "The external

context cannot be ignored in explaining family stress, outside the control of family itself, and has tremendous influence on how the family perceives events and manages (or fails to manage) whatever stress is produced" (p. 29). The internal context would be regarded as being under the family's control to a greater degree than the external. The concept of stress pile-up is also important because the determination of a family's level of stress is more often in the nature of the accumulation of several stressor events rather than one isolated event. The family's subsequent vulnerability to crisis and its ability to recover from a particular crisis is also dependent on the level of stress accumulated through several stressful events.

There is also the notion of the precipitating factor, i.e., why now rather than any other time has the stress pile-up come to crisis point? Boss does argue that an event rarely happens in total isolation; at least normal developmental changes are always taking place as family members are born, mature, grow older and die. "Indeed" she adds "families are always changing for developmental reasons, if no other. Perfect equilibrium is never achieved, nor should it be." (p. 45).

The differences in families' reaction to stress is another aspect dealt with by Boss (p. 49). She talks about the likelihood of some families actually enjoying and tolerating more stress than others, of such families actually seeking out new stressors because they get bored. According to Boss, they may engage in all sorts of stressful activities without negative effects.

Chilman, Cox and Nunnally (1988) are of the opinion that external factors affecting families are all too frequently overlooked or brushed aside by human service professionals, especially those in clinical practice. These authors add that viewing families ecologically as open systems leads to the recognition that many factors in the environment have a strong impact on them. "These factors" they say (p. 10) "include the state of the economy, employment conditions, the availability of needed resources in the community, racism and other forms of discrimination and so forth." When environmental conditions are adverse and community resources are inadequate, the stresses on families escalate, especially for families of relatively low income and low educational and occupational status and indeed, I would say, with poor social skills. Chilman *et al.*, in addition feel that

> ... it then becomes the responsibility of professionals to help vulnerable families to develop strategies to deal more effectively with these stresses. Professionals may also need to act as advocates to assist families in obtaining available resources and to work with other local state and national groups to promote improved conditions and resources (p. 11).

The families in this study must be regarded as in crisis, to a greater or lesser extent, as defined by Boss. For one reason or another they have been unable to retain the framework of their family intact and one or more of their children have been placed in care.

Reason or Grounds for Placement of a Child in Care

The reasons why a child was placed in care were divided into (a) underlying problems leading to (b) internal family problems and subsequently to (c) problems or a problem affecting the child which led to the action of placement in care. As has been noted in many studies, for instance, Richardson (op. cit., p. 176) in Ireland, and Berridge (op. cit., p. 35) in Britain, admission to care is seldom precipitated by one reason alone, hence the divisions into sets of problems. The crucial issue here is the transition from the private to the public arena. As Fisher, *et al.*, (1986, p. 1) note:

> The problems of the family have become a matter for public concern. The families have experienced difficulties in the rearing of their children to such a degree that either they or someone else decided it was necessary to have the child or children cared for by a public agency.

In the Irish case, this is a Health Board. To reiterate, we are trying first to look at what underlying problems existed in the family of the child. What led to that problem becoming so serious that it created a situation where either the parent or someone else decided it was necessary to have the child or children cared for by a public agency.

External Context

Problems within the external context of stress on the families could be, for instance, poor housing, unemployment or weak support networks.

As mentioned in Chapter 4, housing or poor quality of housing did not constitute a problem in this study. Therefore in this external context of stress, concentration will be on unemployment as the main stressor, plus weak social support networks.

Unemployment

Moen (1983) observes that most families are supported by one or more jobs, and when the major provider is laid off the financial plight of the family can be devastating.

In the preface to *Unemployment, Jobs and the 1990s*, the Council for Social Welfare noted that throughout the past decade Irish society North

and South has been scarred by persistent unemployment and its consequences, most notably growing poverty and large-scale emigration.

"There is no doubt," the report continued, "as to the depth of public concern about unemployment ... for example, a survey carried out in the Republic on behalf of the Council in December 1988 showed clearly that people saw unemployment as the single most serious social problem facing the country".

The report goes on to look at the negative effects of unemployment on groups such as older workers, young people, people in rural areas and those in urban areas. The report has not singled out the effects of unemployment on families specifically but is clearly making a case at the macro level for changes, suggesting new approaches and fresh initiatives required to tackle the problem of unemployment.

The negative effects of unemployment stressed in the above report are not altogether in agreement with the findings of Thomas, *et al.* (1980). Those authors say that although hardly definitive, their findings suggest that unemployment may now be less damaging to family functioning than it was in earlier decades. They cite three trends which were identified as perhaps being responsible for this change (a) improved financial provision for the unemployed such that families are not brought to financial ruin when the major wage earner becomes unemployed: (b) changes in the psychological importance of work whereby individuals appear to be less threatened by loss of jobs, viewing it as less their own responsibility and not the source of their total identity and (c) changes in sex role stereotyping such that unemployment and a working wife is not so great a threat to the husband's self-esteem and families are consequently able to adapt to changes brought on by unemployment. In other words, unemployment becomes more "normal".

It is interesting to note that a new study in Britain (Loughran and Parker, as yet unpublished) shows an inverse relationship between national levels of unemployment and rate of children's placement in care – in other words, a rise in periods of economic prosperity. Whelan, *et al.* (1991) in their study of Irish data *Unemployment, Poverty and Psychological Distress* are anxious to point out that while separation of effects is somewhat artificial since unemployment is a major cause of poverty, the effects of unemployment and poverty are cumulative with the unemployed being five times more likely to be located above the psychiatric morbidity threshold than those at home or retired or living in non-poor households (p. 137). They also stress that it is primarily current employment status rather than previous unemployment experience which is critical. "The risk of poverty", they add "does rise gradually with length of unemployment".

Aldous and Tuttle (1988, p. 17) report that as early as the turn of the century when some of the first systematic studies of the working class were initiated, observers were already reporting that the number of wage earners was critical for family welfare (Rowntree, 1906).

Less satisfying parent-child relations also appear during periods of unemployment (Steinberg, Catalano and Dooley, 1981). There was some suggestion in that study also that joblessness, along with its anxiety and stress and the greater time parents have to be with their children, may be associated with child abuse.

Chapter 4 showed high rates of unemployment for the parents in this study. Only 31 per cent overall of fathers on whom there were data were in full-time employment. Table 5.1 shows the area breakdown of these figures. The differences between the areas are not significant – Clare has the highest level of full-time employment among the fathers of children in care, Limerick the lowest. How these levels compare with unemployment levels in the region in general was shown in Chapter 4. It is pretty obvious that the rates are higher than for the population of the region. To obtain a true picture it would be necessary to break down the figures into smaller areas, since as was noted in Chapter 4 vast differences could occur and one urban area of social deprivation in Limerick City showed an unemployment rate of 82 per cent.

Table 5.1: *Community Care Area by Father's Current Status*

	MWMB	*Limerick*	*Tipperary*	*Clare*	*N*
		Per cent			
Full time Employment	31.5	23.8	37.5	41.4	52
Part-time Employment	5.4	8.3	5.0	–	9
UB/UA	56.4	60.7	45.0	58.5	93
Other (Students Disability, etc.)	6.7	7.1	12.5	–	11
Per cent	100.0	100.0	100.0	100.0	100
Total	165	84	40	41	165

The Whelan, *et al.* (op. cit. 1991) study (in Ireland) noted that employment provides a variety of benefits both manifest and latent, and argued that it is hardly surprising that unemployment has profound

mental health implications. These authors add that an analysis of variations in psychological distress by labour force status shows that the major contrast is between those at work or retired and all others. Focusing specifically on unemployment, Whelan, *et al.* found that the unemployed were five times more likely than employees to be located above the GHQ (General Health Questionnaire) threshold (p. 2). There were some notable variations in that those seeking their first job were somewhat less likely to be distressed, while those on State training and employment schemes had levels of mental health comparable with employees. They concluded that the impact of unemployment on whether one is above or below the GHQ threshold remains substantial even when they controlled for physical illness or disability.

No doubt the unemployed subjects in this present study had a history of unsatisfactory labour market experiences. Ideally, a study of the labour market experiences of the subjects would have provided a more accurate picture of the interaction between unemployment and poverty. However, it is unlikely to be disputed that unemployment causes distress, deprivation and poverty. In the present study, poverty was not mentioned specifically as a reason for care. As Whelan, *et al.* point out the risk of poverty does rise gradually with length of unemployment. Also another important point here is that unemployment could lead to social isolation because of the costs of socialising.

Social Support Networks

The inadequacy of the social networks, both informal and formal of the families here, has already been commented on in Chapter 4. It is obvious that, for whatever reason, the majority of the families lacked any real kin or neighbourhood support and did not substitute formal support networks for these to any great degree.

Researchers have presented data revealing a strong relationship between social support and the ability to adjust and to cope with crises and change (McCubbin, *et al.*, op. cit. 1982). Socially supported individuals appear to adapt more easily to changes and appear to be protected from the typical physiological and psychological health consequences of life stress. There is no single explanation of how support intervenes to buffer the illness response to stress, but it is widely understood that social support increases coping ability.

Whelan, *et al.*, (op. cit., pp. 105-116) discuss the question of the role of social support in mediating the impact of economic stress. The authors define social support as access to and use of individual groups or organisations in dealing with life's necessities and remark that measures of

social contact have often been found to behave like measures of social support. They argue for the importance of emotional support acting as a buffer against stress.

Internal Context/Underlying Problems

Moving on to the internal context of stress and underlying family problems, the social worker respondents in this study were asked to note all problems likely to have been a base for both the internal family and child centred problems. General family instability, including poor marital relationship, was most often mentioned (34 per cent of cases). Richardson (op. cit., p. 200) talks of her most striking finding being the unsatisfactory or broken home as a major cause of children being admitted to residential care. Her study clearly showed that marital breakdown in 28 per cent of cases was the major reason, and in this study the somewhat similar proportion for children in all types of care appears (34 per cent between instability, marriage breakdown and desertion).

Gambling as a contributory factor to family problems which led to placement in care did feature in 28 cases. There could be overlap here with what social workers felt was general instability in the family.

This generalisation "general instability" which a number of social workers used, is not very satisfactory and it was in an effort to avoid such generalisations that specific problems, e.g., unemployment, gambling, were given as examples. However, it might be argued that the families involved had such an accumulation of problems and were unstable in so many ways that it would have been impossible to list the numerous underlying reasons for the creation of the situation which finally led to placement in care of a child or children.

Internal Family Problems as Reasons for Care

For the questions relating to internal family problems the respondent was asked to rank the problems listed. It was requested that only relevant problems be included, so in most cases, three was the maximum number of problems ranked.

Taking problems ranked as most important, emotional/psychological problems of the parents were the most often mentioned of "Internal Family Problems". In 50 per cent of cases, they were regarded as the major cause for placement of a child or children of that family in care (Table 5.2).

Alcohol abuse was regarded as a primary contributing factor for 35 families (67 children) and 14 per cent of cases. Mental illness of parent or parents was given as a first reason in 10 per cent of cases. Richardson (1985, p. 276) found a much higher proportion of mental illness in the

parents of the children in her sample who were all in residential care. Forty-one per cent of mothers and 18 per cent of fathers were considered to suffer from some psychiatric problems. There may be some definitional differences here. Physical illness was less likely to be a reason for care than mental illness as in only 3.1 per cent of cases in the present study was it noted as a major problem. Financial problems were not ranked first to any appreciable degree.

Table 5.2: *Internal Family Problems as Reasons for Care by Rank of Importance – Family Units*

	Rankings					
Problems	*1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Emot./Psych.	50.4	(1)	72.9	(1)	79.5	(1)
Alcohol Abuse by Parents	13.6	(2)	20.2	(3)	24.4	(3)
Mental Illness of Parents	10.1	(3)	17.8	(4)	19.0	(4)
Financial Problems	6.6	(4)	23.3	(2)	30.6	(2)
Physical Illness of Parents	3.1	(5)	3.9	(6)	5.4	(6)
Death of Parent	2.3	(6)	4.7	(5)	6.2	(5)
Drug Abuse by Parent	0.4	(7)	1.2	(7)	1.9	(7)
Other	13.5	–	21.7	–	27.9	–
Per cent	100.0	–	–	–	–	–
Total number of families	258					

Death of a parent or parents did contribute to the placement in care of 36 children overall but not specifically as a primary reason. Some children's home situation worsened after the death leading to an internal family reason for care other than the actual death.

In five families (affecting 11 children) drug abuse by parents was mentioned but in only one family was it regarded as the principal problem leading to placement in care of a child.

When considering the rankings here, Table 5.2 also gives the position of the problem when ranked first and looks at the changes with the inclusion of the problem in further rankings. While emotional/psychological problems still retain their first position, financial problems become far more important than the first ranking would suggest. Financial problems retain this second position when all three rankings are cumulated. Alcohol-related problems and mental illness of parents follow in third and fourth positions. These are the four main problems in a family leading to the placement of a child in care.

Child-Centred Problems as Reasons for Care

The child-centred problems as reasons for care were ranked where more than one applied. Again only relevant reasons were ranked, so as in the previous section, seldom were more than three chosen.

Table 5.3 gives details of child-centred problems as they were ranked for families, not individual children. As in Table 5.2, the position of each problem and the changes in the positions are noted on Table 5.3. Neglect always remains in first position, but Emotional Abuse becomes much more important in the position of the rankings after Neglect and Family Crisis.

Table 5.3: *Child-centred Problems as Reasons for Placement in Care by Rank of Importance – Family Units*

	Rankings					
Problems	*1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Neglect	29.8	(1)	34.1	(1)	37.2	(1)
Family Crisis	21.7	(2)	25.2	(2)	25.6	(2)
Child Abandoned	11.6	(3)	12.4	(4)	12.8	(4)
Physical Abuse	6.6	(4)	9.3	(5)	10.4	(5)
Sexual Abuse	6.6	(5)	7.0	(6)	7.0	(7)
Emotional Abuse	6.2	(6)	19.8	(3)	22.1	(3)
Child Out of Control	3.1	(6)	5.8	(7)	7.4	(6)
Parent's Death	1.2	(8)	1.9	(8)	1.9	(8)
Other	13.2	–	15.1	–	15.5	–
Per cent	100.0	–	–	–	–	–
Total number of families	258					

Abuse and Neglect

Considerable attention has been directed to child abuse in recent times. It has been found that families who abuse their children are characterised by high levels of stress, social isolation and inadequate support systems. Unger and Powell (1980. p. 567) pointed this out in their work. The families in the present study appear to exhibit these three characteristics.

Child abuse and neglect, say Williams and Money (1980. p. 12) are not inexplicable atrocities far removed from daily life. They become understandable as extreme points on a continuum of socially sanctioned cruelty to children that has deep historical moorings. Already noted is Demause (1974) who felt that some parents were "stuck in earlier historical moulds". Williams and Money (op. cit., p. 2) wrote of the difficulty of

defining abuse – for instance, emotional abuse. Scott (1980, p. 131), in her attempt to relate the problem of child abuse to existing socialisation theories, selected mothers of abused children for her study, rather than abusers. She hypothesised that the mother plays a significant role in abuse, whether she injures or neglects the child herself or fails or is unable to protect him or her from another abuser. In the present study three types of abuse were noted: physical abuse, sexual abuse and emotional abuse.

Physical Abuse

In considering physical abuse I will first look at some of the research on the effects of such abuse. The result of experiencing physical abuse, say Seltzer and Kalmuss (1988, p. 488), suggests that children's early family experiences have enduring effects. The long-term effects of individuals' childhood socialisation exceed the short-term impact of strain caused by employment problems and other stress-producing events. These authors do not claim a definite connection between later violence and early experience but would argue that there appears to be some connection.

The phenomenon of the physically abused child, may occur at any age but Williams and Money (op. cit.) found the affected children to be younger than three years of age. According to Farmer (1979. p. 118) usually the younger the child the greater the risk of violence and the more severe the effects. The most vulnerable Farmer found were those up to 6 months old with a very high incidence also among those up to 2 years old. This was not the case in this study, as for instance 6 of the 21 children admitted to care with a first ranked reason of physical abuse were 12 years old or older at admission. Williams and Money (op. cit.) went on to describe likely characteristics of a battering parent or parents, but more usually one of the parents.

> Often they are described as psychopathic or sociopathic characters. Alcoholism, sexual promiscuity, unstable marriages and minor criminal activities are reportedly common among them. They are immature, impulsive, self-centred, hypersensitive and quick to react, with poorly controlled aggression.

The authors are at pains to point out that the beating of children is not confined to people with a psychopathic personality or of borderline socio-economic status. It also occurs among people with good education and stable financial and social backgrounds. From the scant data that are available, it would appear that in these cases too there is a defect in character structure which allows aggressive impulses to be expressed too freely.

Some level of physical abuse was involved in 36 cases (27 families) in this study but was ranked as a first reason for care in 21 cases.

Looking at violence as a response to stress, Boss (op. cit., p. 66) feels that the phenomenon of family violence should be investigated on a more general theoretical level in terms of family stress and coping. She quotes Richard Gelles (Gelles and Cornell, 1986) who stated that family violence can be a coping mechanism, albeit a dysfunctional one. Violent behaviour can stem from an inadequate repertoire of behaviours with which to manage stress, which means that the process of functional coping never begins. The coping mechanism, i.e., violence, can stimulate the development of even more stress. "Family vulnerability increases with such coping mechanisms" says Boss (op. cit., p. 67) "which are used so frequently that they become stress producers rather than stress reducers for family members." Komarovsky found in her study *Blue Collar Marriage* (1962, p. 191) that "physical aggression is more frequent among the less educated". Toch assumes that "physical force is a characteristic personal reaction, and it is invoked by some people with the same consistency that persuasion, retreat, self-insulation, humour or defiance is employed by others" (1972, p. 10).

Farmer (op. cit., p. 188) adds that violence to children is an all-class phenomenon, but it has been most persistently documented among the working class. It appears that any combination of adverse circumstances which militates against the adequate fulfilment of marriage and family roles can predispose parents to violent behaviour. Among them are low income, job frustration, poverty, bad housing and unemployment. The families studied here would be examples of families predisposed to violent behaviour by Farmer's criteria.

The most likely internal family problem where physical abuse had been ranked first was emotional/psychological problems of the parents. The family type of the physically abused child was most likely to be "married two parent" (67 per cent). This contrasts with 41 per cent of families overall in the "married two-parent" group. Other variables examined in relation to physical abuse were type of housing, parental visits/contact, parents' care experience, support networks. Physically abused children were somewhat more likely to live in a house rather than a flat or mobile home (86 per cent to 74 per cent overall), also the housing was more likely to be private (43 per cent to 39 per cent). These children were less likely to have good contact with their parents (poor or no contact, 68 per cent of these children to 44 per cent overall) although visits were not discouraged by social workers, with a few exceptions. Two mothers had had a care experience but I do not know whether the mother was an abusing parent

or not. Kin and neighbourhood support levels were fairly similar to those in the overall sample (kin: 50 per cent with no support to 44 per cent, and neighbours: 70 per cent with no support to 68 per cent overall).

Thus it could be said that a profile of the families of children in care, whose admission was precipitated by physical abuse, would most likely be that of a child or children of a married couple with emotional problems, living in a house. The child(ren) when in care would have less contact with parents than other children but their parents would have as little or as much kin and neighbourhood support as the other families with children in care. The children were of all ages at admission. No particular age group was over-represented.

Sexual Abuse

There is no internationally agreed basis for deciding what constitutes child sexual abuse. Trowell, of the Tavistock Clinic, in a paper to the 1990 Meeting of the Commission on Marriage and Interpersonal Relations, reviewed five definitions of child sexual abuse currently being used. These encompassed descriptions of specific kinds of behaviour such as incest, as well as the broader issues of abuse of trust and misuse of power. All the definitions concerned preserving appropriate boundaries between generations and members of the same family. The Commission concluded that it is the eroticisation of family relationships by those in a position of power which constitutes the hallmark of sexual abuse. I would add that with the increase in the number of the reconstituted families possibly the weakening of taboos where step-relations are concerned is also a factor.

Child sexual abuse is not a new phenomenon as historical evidence has demonstrated (see, for instance, Demause, 1974; Boswell, 1988). Because it is only in recent times that people have been willing to accept the reality, epidemiological studies in this field are not very common. As the Report of the Meeting of the Commission on Marriage and Interpersonal Relations in 1990 points out, research which has been done has used different definitions and methods, making comparisons between countries difficult.

McKeown and Gilligan (1991, p. 101) analysed 512 cases of child abuse in the Eastern Health Board area of Ireland in 1988. These cases had been classified as confirmed on the basis of nationally agreed procedures. The study is the most comprehensive yet undertaken on the problem of Child Sexual Abuse in the Republic of Ireland and the results provide a picture of some of the salient features of CSA and draw attention to some of the key issues involved in the management of these cases. Further analysis of other variables in the database have yet to be undertaken and this analysis could throw valuable light on the response to CSA from the different health and

personal social service agencies. That such research is essential if effective policies and practices are to be developed to protect children from CSA and to treat those already affected by it, is stressed by the authors.

Regarding this present study, in 17 families (involving 28 children) sexual abuse was mentioned as the first ranked reason for placement in care. In one other case, sexual abuse was ranked second. The figure of 29 children who were sexually abused, was 7.4 per cent of the total number of children in care during 1989. The number of children in care in this study on 31 December 1989 where sexual abuse was the primary reason for care was 23. The number may appear small but it contrasts sharply with the number of cases in other years in the Mid-Western region. For instance, 1980 = 5 cases; 1981 = 5; 1982 = 4; 1983 = 4; 1984 = 3. By 1988 the number had increased to 16 and in 1989 for this study, it was 23. (Table 1 in McKeown and Gilligan op. cit. gives figures for Ireland between 1984 and 1987 showing similar increases.) Whether these increases are an artefact of increased level of awareness and willingness to report possible abuse or a real increase is impossible to say.

The profile of sexually abused children in this study is that they are likely to be female (79 per cent), aged over 2 years – half of the children were from 7 years old upwards at admission, only around 18 per cent being under 2 years old. This information does not allow an estimate of the age at which the child was first abused and thus the length of time the child suffered the abuse before placement in care. The parents were most likely to have emotional psychological problems or alcohol related problems. A higher proportion of sexually abused children came from "Married two-parent" families than for the study population in general (71:41). They were most likely to have lived in a house owned by the Local Authority. A higher proportion of parents had some kin support than the general in-care population (71:56) but a similar level of neighbourhood support (32:32).

The total proportion of children in care in the Mid-Western Health Board Region who were victims of some level of abuse is around 34 per cent. (Some 20 children were victims of multiple abuse.)

Neglect

Kadushin (1988, p. 147) in his chapter on "Neglect in Families" notes that public interest in child abuse and neglect has had an uneven history. "Discovered", or I should say "rediscovered" given nineteenth century activity, as a social problem in the 1970s, there was a sudden and dramatic growth of public concern about the problem. Kadushin noted that while the titles of early protective service agencies emphasised the prevention of cruelty, suggesting a focus on abuse, most of the cases were of neglect. For

instance, when Behlmer (1982, p. 181) examined the case records of the British National Society for the Prevention of Cruelty to Children, he found that by the opening years of the twentieth century a great majority of its cases involved neglected rather than physically abused children. Subsequent to the attention in the early 1900s, a hiatus occurred in public concern and interest in the problem of child maltreatment. Kadushin (op. cit.) records the "rediscovery" in the 1960s which was given primary impetus by radiologists and paediatricians.

> Child maltreatment was "medicalized" and was almost totally identified with physical abuse, the kinds of maltreatment situations most likely to come to the attention of doctors. This tendency to perceive child maltreatment almost exclusively in terms of physical abuse persisted for some time following the rediscovery of the problem in the 1960s, for a number of reasons. As compared to physical abuse, neglect is more diffuse, more insidious, more chronic, more problematic. It is less dramatic, less easily identified, and less easily corrected. (Kadushin, p.148)

One hundred and fifty children from 77 families were said to have been placed in care because of neglect as a first-ranked child-centred reason. A further 19 families had neglected their children but it was not regarded as the first-ranked reason. Thirty-three more children were involved in those families. The incidence of neglect as a reason for placement in care in this study, far exceeds the incidence of any type of abuse (30 per cent of families neglected their children in comparison with 19 per cent of abusing families see Table 4.3). This is in line with studies by Nagi (1977) and Polansky *et al.* (1975) noted by Kadushin (op. cit. 1988). In this study, neglect has been noted separately as a reason for placement in care. It might be argued that abuse is neglect and neglect is abuse, but they are distinct. Polansky, *et al.* (1985) defines neglect as "a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities". Kadushin (op. cit., p. 150) adds to this that a parent who abuses or cruelly mistreats the child is guilty of an act of commission; neglect is more frequently an act of omission.

Katz *et al.* (1985) noted that "neglect" is an uncertain concept both legally and in social application. Thus, says Kadushin, human service professionals are not only required to define in practice what legislatures were unable to define precisely in statutes, they are also required to make predictions of the possible harmful consequences of neglect based on limited information and tenuously validated theories of child development.

Inevitable errors in definition and prediction subject workers to possible public criticism, administrative reprimand and, increasingly, the possibility of legal action against them.

A number of studies were carried out by Polansky and his colleagues during the 1970s and in 1981 on mothers who neglected their children. They were mostly clinical studies identifying the personality types of these mothers. According to the research a combination of poverty with a character-disordered personality and disturbed family system is the most likely equation for neglect of a child or children. Those authors note different typologies of neglectful mothers and the major implication of this chiefly clinical research is that it appears where parents themselves suffered from neglect in their childhood, they in turn are likely to neglect their children. While poverty could contribute to the likelihood of neglect by adding to stress, some basic personality factors that determine neglectful behaviour would still need to be addressed. In other words, while poverty may, in some cases, be a basic contributing factor, it is not by any means the only explanation for neglect.

Previous studies, of a psychological orientation, e.g., Young (1964) and Meier (1964) hold a similar view to Polansky. However, as Kadushin (op. cit., p. 159) points out, psychological "deficits" are often correlated with long-term poverty, unemployment, rejection by the larger society, poor health and the like.

It may be noted that fathers seldom appear in the findings of these studies and the editors of the Kadushin chapter note that, in the whole field of child neglect, there is a tendency to hold only mothers responsible for problems in child care. This reflects the frequent difficulty of working with fathers as well as the sexist bias of the larger society.

In this study I am dealing only with children admitted to care because of neglect. The actual prevalence of neglect of all children either in the Mid-Western Health Board, or indeed Ireland as a whole, is probably impossible to estimate. What is available here is information on a residual group of children and families who have come to the attention of Health Board social workers because of evidence of neglect.

The population of children in care because of neglect will now be compared with other children in care. The profile of the child who was in care in the Mid-West Region in 1989 primarily because of neglect is one where age at admission is more likely to have been between the age of 2 and 11 years than the general population in care. Present age, with the exception of the under 1 year olds, is fairly similar but both proportions of under one year olds are very small anyway – 2 per cent neglected children, 12 per cent in the non-neglected population.

In some respects children in care because of neglect were very similar to other children in care. However, there were one or two areas where substantial differences occurred. For instance, neglected children were far less likely to be children of single parents (9.3 per cent to 27.3 per cent of non-neglected children) but almost twice as likely to be children of married one-parent families (29 per cent of children in care because of neglect) than children in care for other reasons. Fifteen per cent of those children were children of lone married parents.

For those children whose families were living in mobile home accommodation, two-thirds had been placed in care because of neglect. Considerably more neglected children had poor contact with parents (71 per cent) than other children (58 per cent) but probably the most dramatic differences occurred at the level of kin and neighbour support. In 62 per cent of cases the family had no kin support compared with 37 per cent of other cases with no kin support. For neighbour/friend support the percentages were 80 to 64. In a comparison with Family Centred problems neglect, being the most frequently first ranked problem, is dealt with in Table 5.4. The table clearly shows a relationship between parents having emotional/psychological problems and the neglect of their children. Neglect and alcohol abuse are related but to a somewhat lesser extent. Mental illness also appears to be important. Indications are then that a high instance of neglect of children is combined with emotional and psychological problems of parents, and that abuse of alcohol and to a

Table 5.4: *Neglect by Internal Family Problems as Reasons for Care*

	Rankings					
Problems	*1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Emot./Psy.	37.7	(1)	71.4	(1)	84.4	(1)
Alcohol Abuse by Parent	23.4	(2)	32.5	(2)	38.9	(3)
Mental Illness	9.1	(3)	22.1	(3)	24.7	(4)
Financial	6.5	(4)	19.5	(4)	46.7	(2)
Death of Parent	2.6	(5)	5.2	(5)	7.8	(6)
Physical Illness	2.6	(6)	5.2	(6)	9.1	(5)
Drug Abuse by Parent	1.3	(7)	2.6	(7)	3.9	(7)
Other	16.9	–	25.9	–	32.5	–
Per cent	100.0	–	–	–	–	–
N	77					

lesser extent mental illness are also important contributory factors to neglect,leading to need for placement of children in care. As seen in the earlier tables, financial problems become more important in the later rankings, but emotional/psychological problems and alcohol-related problems still retain highest associations with neglect.

From the above it seems that while character and personality factors have been identified as "explaining" neglect, as Kadushin (1988, p. 166) has noted, these factors are most likely to be the result of, and present in, a highly stressful deprived environment that is bereft of a social support system.

Family Crisis or Children Out of Control

Family crisis, such as needing respite care for an ill child, was regarded as being the major child-centred problem in 20.5 per cent of cases (77 children from 55 families). Some children were said to be "out of control", the term used to describe children whose parents felt they could no longer manage them. This was given as the major child centred reason for care in only 2.9 per cent of cases (11 children from 8 families).

Other Child-centred Problems as Reasons for Care

As already observed, in only a very few cases did the death of a parent or parents directly lead to placement in care (3 families). A variety of other reasons, such as "home unsuitable", a handicapped child or parents requesting care for their child were noted as being the immediate reason the child was placed in care.

Combinations of Problems as Reasons for Care

Table 5.5 gives details of the child-centred and internal family centred reasons for care, where unemployment was regarded as an underlying problem. It should be remembered that only those problems appropriate to the family were ranked, so few rankings beyond three occurred.

It seems that neglect is the most likely child-centred problem where unemployment is regarded as a family problem, followed by crisis in the family. In the case of internal family reasons, emotional/psychological problems of parents were ranked higher than financial problems where unemployment was regarded as an underlying problem. This latter finding is in line with Whelan, *et al.*'s (op. cit.) finding on unemployment and its association with psychological distress and financial insecurity.

It is now proposed to look at some of the child-centred reasons for care and check within that group what combination of reasons occurred. In other words, if a pile-up of problems occurred for the child and what these problems were?

Table 5.5A: *Families Where Unemployment was Regarded as a Major Problem by Child–centred Reasons*

Child-centred reasons	*Rankings* *1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Neglect	48.7	(1)	59.0	(1)	59.0	(1)
Crisis in Family	20.5	(2)	25.6	(2)	25.6	(2)
Abandoned Child	7.7	(3)	7.7	(4)	7.7	(5)
Sexual Abuse	7.7	(4)	7.7	(5)	7.7	(6)
Emotional Abuse	5.1	(5)	15.4	(3)	17.9	(3)
Child Out of Control	2.6	(6)	5.1	(6)	10.3	(4)
Physical Abuse	2.6	(7)	2.6	(7)	2.6	(7)
Other	5.1	–	7.7	–	7.7	–
Per cent	100.0	–	–	–	–	–
Total number of families	39					

Table 5.5B: *Families Where Unemployment was Regarded as a Major Problem by Internal Family Reasons*

Family Reasons	*Rankings* *1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Emotional Psych. Problems	46.2	(1)	69.2	(1)	74.4	(1)
Alcohol Problems	23.1	(2)	35.9	(3)	38.5	(3)
Financial Problems	17.9	(3)	46.2	(2)	64.2	(2)
Mental Illness	5.1	(4)	12.8	(4)	17.9	(4)
Death of Parent	2.6	(5)	2.6	(5)	5.1	(5)
Drug Abuse by Parent	–	–	–	–	5.1	(6)
Other	5.1	–	15.3	–	20.5	–
Per cent	100.0	–	–	–	–	–
N	39					

Taking "Neglect" as being the most often mentioned reason ranked number one (77 families – 150 children) the most likely ranked second reason was "Emotional Abuse", (35 children involved). Overall, in 62 cases, a second reason was given – in 12 cases this was crisis in the family, in a further 5 cases physical abuse was mentioned. In a majority of the 150 cases (58 per cent) neglect was regarded as the prime and only precipitating reason for placement in care.

For 7 of the 21 children where Physical Abuse was ranked first, other reasons were also ranked – most often Emotional Abuse. Sexual Abuse had proportionately more problems/reasons ranked with it than any other reason for care. Twenty-one of the 28 cases ranked other problems with Sexual Abuse. For 8 children Emotional Abuse and Neglect were ranked second and third. Some children were said to have been Sexually, Emotionally and Physically abused. Although the numbers of children involved are small, these children are likely to be disturbed and difficult. As will be shown later, these children are more likely to be placed in residential care. The problems for care workers coping with children who have experienced abuse, was a theme in the report *At What Cost?*. That report stated that the realisation of the needs of the child care workers has not yet manifested itself into policy and practice. "Respondents felt counselling services were too hard to get access to, had long waiting lists, were too infrequent, did not give enough feedback to the care staff, and were not available in a crisis" (p. 64). The child care workers further felt that this was particularly the case in relation to counselling for victims of sexual abuse. Many of the care staff had apparently expressed the view that they did not have the skills necessary to deal with the more difficult and damaged children and young people who were being referred to them.

In cases where children were abandoned (40 children) only 8 had more than a first ranking. In 4 cases the child was said to be also Out of Control with Emotional Abuse ranked third. As might be expected in cases where the child was abandoned, little information was available on the family and thus on reasons for care other than abandonment.

Care Type by Child-centred Reason

If one were to consider the type of care allotted to a child by the child-centred reason for care, in all cases where physical abuse was mentioned, long-term care was preferred, either foster or residential care. This also appears to be the case where sexual or emotional abuse is involved. In the case of these three types of abuse, children were far more likely to be

placed in residential care than for the overall placements. Residential care accounted for 25.6 per cent of all placements but where Physical Abuse was ranked as the first reason for care 52.4 per cent of those children were placed in residential care; where Sexual Abuse ranked first, 50.0 per cent and in cases where Emotional Abuse was ranked first, 34.8 per cent of the children had been placed in residential care. The numbers are too small for any tests of significance, but it may well be that children who have been abused in any way are less likely to be considered suitable for foster care, and social workers are inclined to go for the more structured environment of a residential home as being the most suitable type of care. The difficulties which may arise for care workers have been discussed.

Legal Basis for Admission

It has been noted in Chapter 3 that the route through which a child entered care – either voluntary or through a Court Order – affects the placement in a number of ways. Here the basis for admission is correlated with the reason for care. As might be expected, physical abuse of a child as a reason for care is more likely to have been associated with a Court Order admission than, say, a crisis in a family. One might conclude from this that the more serious the problem, as abuse would be termed, the more likely social workers were to use the Courts to enable them to protect children. Whether that is necessarily the case or not, the data showed that where Physical Abuse was the primary reason for admission 76.2 per cent of the admissions were by Court Order; where Sexual Abuse was the primary reason for care 71.4 per cent were Court Order admissions and where Emotional Abuse, Court Order admissions were almost 57 per cent of the total admissions for that reason. Thus it may be presumed that Court action was more likely to be involved in cases of abuse.

Also, in cases where neglect was the principal reason for care, a high proportion, two-thirds, of the children had been admitted through Court Orders, whereas only 18 per cent were placed in care via Court Order where the grounds for care were crisis in the family.

Retentions in Care

Chapter 6 deals with children retained in long-term care from the child's point of view. Here we will look at why a child is not being returned to his/her family.

Questions were asked as to whether or not the parents were *able* to accommodate the child – in other words did they have suitable accommodation and if so, were they *willing* to accommodate the child? First, cases where the parents were able but unwilling to accommodate the

child or children will be considered. An amount of lack of interest in the child/children in care was found. Of the 86 families involved, 64 per cent of parents had no interest in the return of their children.

Some of these parents, when interviewed, did not explicitly admit to total lack of interest in their children, but from their responses it was clear that they were quite happy that the children were not with them. One example of this kind of case was where the parents had separated, the husband deserting and is now possibly in jail in England. There were two children involved, one a daughter, now a teenager, the mother regarded as "impossible". The girl is in residential care and the boy is being cared for by a grandmother – he is not "in care". The children had been left alone on numerous occasions, their mother travelling back and forth to England. The daughter in this case had experienced a number of placements in both foster and residential homes since the mother first left the family home, effectively abandoning the children. There was also a history of physical abuse of the daughter by her mother. Originally the children's school principal had contacted the Health Board seeing that the children were unkempt and hungry. This mother expressed the opinion that her daughter is "now in good hands, and I don't really want to keep in contact with her".

Another example was that of a single mother who no longer visits her child in foster care. The child is now 7 years old. This was a case of difficulties arising because of problems between the foster parents and the mother. She felt the foster parents made the situation impossible for her, watching her every move when she visited. A source of this difficulty appeared to be that the mother often arrived to visit in an inebriated state and the foster parents were very nervous about the child being with her. The mother is an alcoholic and when the child lived with her prior to care she was being neglected. A public health nurse referred the child to the Health Board and the social workers obtained a Court Order for admission to care. This mother told me that if she had been given the option at the time the child was born she would have had the child adopted. In her opinion the foster parents seemed very good to her daughter. She felt she would like to let things lie now and not see her daughter again, admitting that she felt no emotional attachment to the child. The new circumstances in which this mother finds herself indicate that the possibility of the child returning to her mother in these circumstances would seems remote.

Six sets of parents regarded their children as being out of their control as a primary reason for not wanting them home. In another 6 cases, the present partner of the remaining parent was unwilling to have the child or children in the home. A variety of other reasons was noted, for instance,

the parent or parents had left the area, or were being sought by the police, or the grandparents would not allow a non-marital child to be cared for by his mother in their home.

In some cases the parents were able and willing to accommodate the child or children, but the children were retained in care. Numerous reasons were given by social workers as to why this occurred in the 90 families concerned, involving 147 children. In 19 families alcohol or drug addiction was given as the primary reason and in 21 families, mental or physical illness of the parent was the reason given. Social workers felt in some cases that parents exercised inconsistent control over the children, sometimes leaving them alone in the house, other times being totally overprotective. This reason became the most important when the rankings were added together. In other cases there was fear of physical violence. Table 5.6 shows the relative importance of the reasons for retention where parents were able and willing to take their children home. These are cases where no doubt resentments occur. I spoke to some of the parent(s) concerned. In one such case the social worker felt that the parenting by

Table 5.6: *Parents Able and Willing but Children Retained in Care*

	Rankings					
Reason for retention	*1*	*Position*	*1+2*	*New Position*	*1+2+3*	*New Position*
	Per cent		*Per cent*		*Per cent*	
Alcohol Abuse by Parents	21.1	(1)	28.9	(1)	37.8	(2)
Mental Illness	17.8	(2)	24.4	(3)	30.0	(4)
Inconsistent control	11.1	(3)	27.8	(2)	44.4	(1)
Marital Breakdown	8.9	(4)	21.1	(4)	26.6	(6)
Physical Violence in Home	8.9	(5)	20.0	(5)	31.1	(3)
Promiscuous Environment	6.7	(6)	6.7	(8)	11.1	(7)
Financial Problems	5.6	(7)	13.3	(6)	24.4	(5)
Physical Illness	5.6	(8)	8.9	(7)	10.0	(8)
Overprotective Parents	1.1	(9)	2.2	(9)	2.2	(9)
Other*	13.3	–	26.7	–	33.3	–
Per cent	100.0	–	–	–	–	–
N	90					

* The category "Other" needs some clarification. Situations arose such as that the child wanted to stay with his/her foster parents; the parents were regarded as unstable; or that the home conditions were unsuitable for a baby.

the mother was inconsistent. The father of the children was in prison having been convicted of sexual abuse of them. Another mother to whom I spoke was not resentful but hoped earnestly that she would be allowed have her son returned to her. The reason for non-return here was that the mother was mildly physically and mentally handicapped and the child was as yet too young for the mother to cope. The father was an alcoholic but there did appear to be an improvement in the situation and it was being monitored by the social worker.

Reason for Discharge

Ninety-nine children were discharged from care during 1989. Seventy-nine per cent of these (67) were reunited with their families. In the past arguments have occurred among social workers in Britain (see, for instance, Packman, op. cit., p. 196) about whether or not children were discharged precipitately and ill-advisedly before their home circumstances had improved enough to make genuine rehabilitation feasible. Where this had occurred, only further family breakdowns and a greater measure of insecurity and deprivation for the children concerned could result.

Almost one-fifth of discharges were young people who had reached the legal age limit (16 years old at present). The prospects of leaving care can cause insecurity in young people who have reached the age limit to leave care. Berridge (op. cit., p. 34) noted that frequently they have anxieties associated with personal, social and sexual identity, while the prospects of leaving care, leaving school and the likelihood of unemployment and isolation add to their insecurity. The process of leaving care, particularly for these young people, is as important as that of admission. Berridge notes that far from being viewed with eager anticipation and as a break from adult control, many adolescents in his study approached leaving care with considerable trepidation. They sometimes became extremely aggressive or precipitated the situation by running away. Stein and Carey (1986) in their study *Leaving Care,* found that the final picture for those leaving care was a depressing one. "Apart from the experience of a very small number of young people" say these authors (p. 179) "there is little evidence that State care was able to compensate for what was judged by social services to be missing in their background". Berridge also notes that although efforts have been made to reduce the stigma associated with public care in Britain, there has been a diminution in the opportunities to acquire subsequent status, by say employment. The situation is no doubt similar in Ireland, where in earlier times, children from residential homes were often placed in jobs such as domestic service for girls and the Army for boys, giving them at least the advantage of employment. The greatest

need for these young people now leaving care is to cultivate social networks which will ensure long-term support.

Children who are discharged from care because they have reached the legal age limit, whether in foster or residential care, still continue to be the financial responsibility of the Health Board if they are in full-time education. If they are in some type of training where they are paid, they are expected to contribute towards their keep. Young people between 16 and 18 at present receive no social welfare benefit as this only commences at 18. However, provision has been made in the *Child Care Act, 1991* for assistance to young persons up to 21 years of age who have been in care. In some of the cases of foster care where the young person has officially left care, and is not in full-time education, he/she may continue to live with the foster parents, because a good relationship has been established. However, this whole area is a grey one as it is not clear what happens to a number of young persons who leave foster homes and residential homes without definite plans. Concern has been growing about these young people. A discussion of the many reports on the situation of young people and homelessness and the link of youth homelessness with a care experience was undertaken in the O'Higgins and Boyle 1988 study (see pp. 96-99). The National Youth Council sponsored a conference on Young Homelessness in May, 1990, giving evidence of a continuing problem but also an awareness of the extent of the existence and extent of homelessness and a willingness to find a solution.

The British National Children's Bureau Highlight No. 84 (1988) stated that surveys have consistently found that young people who have been in care are vastly over-represented among samples of single homeless people. The Highlight adds that a recent study by Centrepoint showed that the link between homelessness and leaving care persists: 25 per cent of young homeless people had a background of care. The young people not actually homeless were far from being in stable accommodation. The study by Stein and Carey (1986) *Leaving Care* found that "the most remarkable feature of the young people's lives during the study was the amount of moving they did from one new address to another".

That homelessness in the cases of young people who have been in care is due in some cases to loneliness and inability to settle in single person accommodation is implied in the Stein and Carey study. By the end of the first year of the study all the young people wanted to leave single person accommodation despite its satisfactory physical standards. Feelings of loneliness and isolation were accentuated for those who were unemployed and had nowhere to go. It is conceivable that a certain camaraderie exists on the streets among the homeless and people therefore experience at

least lesser feelings of loneliness and regard this as preferable to their previous isolation. These young people would probably not have the contacts, the confidence or the ability to search for more suitable accommodation sharing with others. They need assistance at the stage of leaving care to build this confidence and to identify compatible contacts.

In their study *On My Own. Report on Youth Homelessness in Limerick City*, Keane and Crowley found that in May 1989, 25 young people were homeless – 18 males and 7 females. Some particular groups could be identified and they included children who had been abused, either physically, sexually or emotionally, poor school attenders and children who had been either fostered or adopted. More than a third of the sample of homeless young people, the subject of the Focus Point 1989 study on homeless youth in Dublin, had been in some form of residential care. It could not be argued that all youth homelessness emanated from cruelty or neglect in the young person's home with the possibility of the child having experienced substitute care, but there seems to be a fairly significant number of instances where that is the case.

In an effort to discover what might be in store for those in this study who left care having reached the legal age limit, further questions were asked regarding accommodation arrangements and employment plans, if any. It is appreciated that the numbers here are very small, but there are 17 individuals whose futures are involved. Six had permanent accommodation plans other than family or foster home; 2 had temporary accommodation. Of the 9 remaining, three returned to their families on discharge; two remained with their foster parents. One young man was on a full-time catering course and returned to the residential unit at weekends. Another young girl was regarded as having very unsatisfactory arrangements in that she had been discharged to her family but instead went to live with her boyfriend's family. The social worker was unhappy about this, as the circumstances were not the best for the girl, in her view. There was no information given in the other two cases.

Given the small numbers no definite statements can be made, but if this pattern is repeated in all Health Board areas, it would mean that some young people are still leaving care without plans or security for their futures.

Summary

Chapter 5 set out to consider what problems in general the families had encountered and what specific problems led to the placement of the child in care.

Boss's External/Internal model of family stress was discussed and problems regarded as areas of external stress such as unemployment and

poor support networks were examined. The likelihood of unemployment being linked with poor psychological health was noted. The lack of supportive networks appeared as a notable gap in the lives of the families, adding to their stress.

The internal context of stress on the families did appear to be more important, but as pointed out, the external context is often neglected and is probably more important than it appears. General instability in the family was regarded as being the most likely underlying cause leading to care. This gives a picture of a multiplicity of problems within the families, with poor marital relationships featuring to a large extent.

When one moved on to internal family problems, emotional/ psychological problems of the parents seemed to dominate. Alcohol abuse was also an important contributory factor to the need for substitute care. Eleven per cent of cases where one parent, usually the mother, suffered some psychiatric problem serious enough to necessitate placement in care of the child, could probably be regarded as a high proportion relative to the population in general.

When one moves closer to the point of placement of the child in care, neglect by the parent(s) is the most likely outstanding reason why the child eventually ended up in care. An apparently less serious reason "family crisis" is second. However, if abuse and neglect are added together with abandonment, they account for 65 per cent of primary reasons.

In the 1991 Policy Statement on Child Care Practice the Social Work Department of the Child Care Service in the Mid-Western Health Board (Section 4(ii)) stated that from then on no child would come into care or remain in care on grounds that arise *primarily* from:

- the illness of one parent in a two-parent family (51 children in care in 1989)
- financial problems (25 children in care in 1989)
- disability (4 children in care in 1989)
- housing problems
- medical grounds
- the need to give parents "a break", unless there are compelling reasons to believe that such care episodes will enable a family to continue caring for its children – possibly a number of children where reason for care was "family crisis" would be included here (78 children in care in 1989).

The data show that up to and during 1989 a number of children had been admitted to care for the reasons listed here. If it is possible to implement the above policy then the rate of admissions will drop considerably. I have noted in parentheses the number of children whose primary reason for care – either child centred or internal family – came under these groups above. This gives hope for a reduction in admissions to care where the child could remain with his/her family with supports in the community.

In combining the reasons, underlying, internal family and child centred, where unemployment had been regarded as a major problem, parents were most likely to have emotional psychological problems and to neglect their children. Neglect as a reason or ground for care was dealt with separately and combined with presenting problems. This was done because of the importance neglect of children has, both in the literature and in this study, relative to the incidence of children being in need of care and protection. The high correlation between neglect, emotional/ psychological problems and alcohol abuse was demonstrated.

The chapter looked at the care type by reason for placement. It was evident that where abuse was a reason for care, residential care was more likely to be used. Where the child had been admitted to care because of abuse, it was far more likely to have been through a Court Order, as was the case where neglect was the reason.

The chapter moved on then to consider when families were able but unwilling to have their child(ren) returned to them and the circumstances where these situations occurred. There was an amount of disinterest apparent. No specific reasons for the present disinterest were given, but one could speculate that in some cases anyway, difficulty of contact contributed to what was probably a "tailing off" process which has now become total. On the other hand, where parents were anxious for the return of their child(ren) but social workers were not yet prepared to allow this, a variety of what appear to be very good reasons were noted.

Finally, situations of children leaving care having reached the legal age limit were reviewed and although numbers here were small, the majority of these had some definite arrangements made or made for them.

In summary, the data demonstrated that where a child was placed in care, the parents were most likely to be suffering emotional/psychological problems or problems associated with alcohol abuse. Financial problems came into the picture lower down the rankings. The children were most likely to have been neglected or to have suffered from a family crisis, with emotional abuse becoming important in the lower rankings.

Chapter 6

EXPERIENCES IN CARE

The experience a child has in care after the trauma of separation from his or her family can be vital in the child's adjustment first to care itself and subsequently to the return to his/her family on discharge. Here, suitability of placement will be examined as defined by the relevant social worker; family links and access will be considered; length of time spent in care, number of moves while in care; number of care experiences and characteristics of children in long-term care.

Unsuitable Placements

"Pressure on placement resources of all kinds, and shortage of foster homes in particular, seem to be recurrent themes at social work gatherings and in professional journals", Rowe, *et al.* (1989) declare. Bearing in mind similar views expressed by social workers in Ireland and also, of course, because of the potentially damaging effect of an unsuitable placement on a child, the questionnaire included the topic of appropriateness of care type. As previously noted the present type of care was regarded as inappropriate by the social workers involved in only 6 per cent of cases. This may well be a rationalisation as a result of the placement being due to a scarcity of choice of homes or the placement having been made by the Court or even possibly having been made some considerable time prior to the responding social worker's arrival. The assessment may then have been made that it was best to "leave well enough alone", or that the placement was the best available.

Thus, one of the problems in interpreting the data in this study is that over 55 per cent of the population in care has been there for longer than a year – in some cases considerably longer. Staff movement and increasing numbers of staff between 1982 and 1989 have been such that in a large number of cases the responsibility for placement in care was not that of the currently responsible social worker. This, coupled with scarce information on old files, led to a gap in the knowledge of the latest social worker as to any plan made for a particular child, if indeed any existed at the time the child was placed in care. As mentioned in the Introduction, some of the records, particularly the older ones were, to say the least, incomplete.

There were exceptions of course where the same social worker had worked with a particular family for a number of years and full information was available. The 1991 Statement of Policy and Practice of the Mid-Western Health Board area, affirms that no child will enter care without a specific plan agreed beforehand for that child. The children in this study had all been in care, some a considerable time prior to 1989 so it is unlikely that any definite plan had been made for them on their admission. Since 1991 however, the practice in the area is to prepare a plan for each child at admission.

Parker (op. cit., 1980) in his chapter "Causes of Concern" discusses the problem of mobility of staff and comments that mobility adversely affects standards. In Britain, as Parker points out, economic stringency may now be reducing the rate of mobility there. However, in Ireland the problem may be more one of attempted development of services, in that temporary employment might be offered in case sufficient resources were not available for permanent employment. This could result in almost constant mobility with social workers endeavouring to obtain permanent posts. Also, in recent years, a trend towards secondment for further training may have played a part. The Mid-Western Health Board area has now organised its staff resources to enable a more settled regime to exist, consequently enabling social workers to raise standards in dealing with children in need of care or protection. A further discussion on social worker mobility is included in Chapter 7.

Family Contacts

One of the most important factors in a child's experience in care is contact with his/her family. Children are taken into State care for a variety of reasons, yet they need to retain contact with their families, parents, grandparents and other relatives and friends. The role of care as a constructive family support can be seriously reduced without an emphasis on access of parents and the maintenance of links with the wider family of origin whether or not it is planned that the child return to his/her family. Where possible and appropriate, return would be regarded as the best outcome, but the maintenance of contact with and access to a child in care by the family of origin and indeed neighbours and friends, is important whether or not the child will eventually return home.

Reflecting conviction about the significance of the biological family in human development, others have written extensively about the negative impact of separation and placement on children. Some of the relevant studies will now be considered. It has been stressed that children who are placed away from their parents experience loss related to the separation.

The "tie that binds" (Jenkins, 1981), that is, the tie between parent and child, is like an invisible cord providing the child with a biological, emotional and symbolic sense of connectedness to his or her environment and affecting his or her basic identity. The severing of the parent-child tie has a differential impact, depending on the child and the circumstances (Sinanoglu and Maluccio, 1981, p. 237). In general, these authors feel with Germain (1979, pp. 175-176) that the child who must be placed in substitute care at any age, and regardless of the reason, is torn from the biological and symbolic context of his/her identity. No matter how nurturing the substitute care, the child's ongoing task will always be to reweave the jagged tear in the fabric of his/her identity, to make himself or herself whole again. (See also Packman, *et al.*, 1986; Ayres, 1985; and Rowe and Lambert, 1973).

From a psychoanalytic perspective Littner (1956), for instance, has written about the traumatic effects of separation and placement especially for younger children. In particular, he underscores that unless a child is allowed to come to terms with the internalised image of the parents, his or her identity is impaired. He, therefore, argues that contact with the parent is crucial to help the child deal with feelings generated by the separation experience. Colon (1978), a psychologist and former foster child, echoes Littner's themes, highlighting the role of the child's experience of continuity with the biological family in establishing his or her sense of self and personal significance.

As many writers have pointed out, the natural bonds between children in care and their parents continue to be prominent for parents as well as children long after they are physically separated, reflecting the significance of the biological family in human connectedness and identity formation (Laird, 1979). A key means of accomplishing the goal of maintaining family ties is through consistent parental visiting of children in care. The findings of recent studies have emphasised the crucial role played by parent-child contact or parent visitation in the outcome of the placement as well as the child's functioning.[15]

Marsh (1987) points out that parental access to children in care has many parallels in every family's life. For example, a child at boarding school sees his or her parents for Saturday treats; a child with a childminder leaves and returns to his/her parents every day. For most parents these events are under their control, and this is the vital difference. Access to children in care is a shorthand for a quite common process taking place in difficult circumstances.

[15] See Rowe, *et al.*, 1984; Fanshel, 1982; Aldgate, 1980, Fanshel and Shinn, 1978; Fanshel, 1975.

> The process is about links between parents and children ... Maintaining links is about more than maintaining contact, and for children there are particular dimensions to do with their sense of time, their capacity to remember, their ability to communicate, and their stage of emotional development. ... Access is about a sense of belonging, and a mechanism suitable for age and circumstances, to maintain that sense. (Marsh, 1987, p. 72). (See also Parker, 1987).

Writing on parents of children in residential care, Berridge (op. cit., p. 95) adds to this question of contact between parents and their children in care, the parents' own problems in contact. In his opinion it is clear that many of the parents find visiting residential homes both difficult and painful. Parents often have to make long journeys, bear financial costs and cope with the vagaries of public transport. They also find it stressful to meet their children in strange settings under public scrutiny, where they are given no clear role. Anxiety based on cultural and social class expectations is compounded by feelings of guilt and inadequacy and over time there is often little currency to keep the relationship going. Aldgate (1980) also mentions this difficulty of parents visiting children in residential care.

In a study of parents whose children were in foster care, Jenkins and Norman (1972) found considerable evidence of "filial deprivation" that is, the feelings of loss, sadness, emptiness and depression experienced by the parents. These feelings are poignantly described by McAdams (1972) whose own 6 children were placed in foster care. While appreciating the help provided through placement at a time of family crisis, McAdams captures the pain, turmoil and sense of failure that she experienced, especially whenever she went to visit her children in their foster home. Her feelings of inadequacy and self-doubt as to her ability to match the foster parents' care and material advantages if her children were returned to her are graphically described:

> You see your child in a home situation where everything is apparently orderly and calm, and quite often materially superior to anything you are going to be able to offer them, and you wonder why the hell you are bothering to rock the boat ... maybe it would be better to leave your child there, it would be a lot less upsetting for everyone involved if you would just drop out of the picture. Quite often this is true (p. 53).

These feelings of frustration, sometimes coupled with anger, were expressed by some of the parents interviewed in this study. In a few cases they had lost contact with their children either because of transport difficulties and/or, as they saw it, lack of co-operation from the foster parents. One parent told of not being allowed any more than a glimpse of her child in the church on her First Communion Day. Another parent complained that presents she sent to her child were never given to the child, or were rejected by the foster parents. She believed it was an attempt by the foster parents to distance the child from her mother instead of trying to maintain contact. It must be said here also that a great deal of praise for foster parents was expressed by other parents, for their efforts to keep them in touch with their child, for instance, bringing the child for visits over long distances and/or sending photographs.

In considering differing stresses on parents visiting their children in care Aldgate (op. cit., 1980) contended that parents find foster home visits more difficult and would prefer visits to residential homes which are less critical of their behaviour. One of the main arguments adduced in favour of residential care as a means of achieving the return of children to their own homes is that, unlike foster care, it does not discourage parental contact. "This we know from numerous studies", says Parker, "is a crucial factor in increasing the likelihood of a child's return" (1988, p. 90). The evidence is also reviewed in Millham, *et al.* (1986).

In an earlier study (Aldgate, 1977), interviews were conducted with the parents, and the analysis suggested very strongly that foster homes presented more difficulties for them than children's homes. This applied much more to the mothers than to the fathers – especially fathers who had been left on their own with children. Unlike mothers, Aldgate found, the fathers were often pleased to see foster mothers as mother substitutes. This difference was also found by Colton in his 1988 study. No doubt, the fact that there was no direct competition influenced the fathers' perceptions.

The foregoing discussion coupled with Berridge's findings, suggest that visits by parents to either foster or residential homes can be so difficult, parents gradually lose contact.

For the children themselves there is some evidence that visitation is correlated with the child's well-being and improved functioning while in care. In one study it was found that children who had regularly visited their biological families from foster care did better in their ultimate permanent plans than those who had not had such a chance for parental connection (Fein, *et al.*, 1983).

As noted by Aldgate (op. cit., 1980, pp. 29-30), parent-child contact can have various beneficial effects, such as reassuring the child that he or she

has not been rejected; helping the child to understand why he or she cannot live at home; preventing the child's idealisation of the parent; and helping the parents maintain their relationship with their child. In addition, others have called attention to the often neglected dimension, the significance of sibling relationships and the importance of maintaining sibling ties while children are in placement (Harari, 1986; Ward, 1984).

Marsh (1987, p. 74) argues that good maintenance of links makes it less likely that the interruption will turn into a disruption, with attendant emotional problems. He quotes research on the effects of divorce which emphasises the importance of maintenance of family links. Marsh also notes some experimental research (Stein, Gambrill and Wiltse, 1978) which found that making the maintenance of links a prominent feature of practice may make it more likely that children will be permanently reunited with their parents. Marsh goes on to say that, clearly links should be a prominent concern of social workers for psychological, social and practical reasons. He concludes that the reality of social work practice does not always accord with that logic. A number of studies support that view (see, for instance, Gray and Parr, 1957; Rowe and Lambert, 1973; and Millham, *et al.*, 1986).

In the present study, of the 392 children in care, 37 per cent were visited regularly by their parents and would be regarded as having good contact, a further 18 per cent had some, but intermittent rather than regular contact. This leaves 44 per cent of children in care in the particular area during 1989 with either no visits from parents or very poor contacts.

Because we are concentrating here on the negative aspects of the contact and access between parents and their children in care, this section will address itself mainly to that proportion of children with poor or no contact with one or both parents, but some comparisons with children with good contacts will be made.

The categories where there was poor or no contact between parents and children could be classified into seven groups.

(a) Where the social worker has decided that contact is undesirable (14 per cent).
(b) Where the child does not wish to have contact or is apprehensive and reacts badly (7.6 per cent).
(c) Where parents themselves do not contact, some of these parents having effectively rejected their child (50 per cent).
(d) Where there is ambivalence on the part of either or both parents, and visits are intermittent (8.7 per cent).
(e) Where only one or other parent visits regularly, the non-visiting parent having rejected the child (8.7 per cent).

(f) Where initial contact was good, but now is poor or nonexistent (2.9 per cent).
(g) Where transport difficulties occur (8.1 per cent).

Groups (a) and (b) could obviously be overlapping in the sense that a social worker might prevent access because of the child's very definite wish not to have any contact with parents. Some children had become very fond of foster parents and wanted to be totally identified with them. A few traveller children did not want to return to the traveller life after a time with foster parents. However, a variety of other situations occurred where a social worker decided that contact was undesirable. These ranged from a temporary situation such as the detoxification of parents, to a situation where the child was in danger of either abduction or abuse during visits. These two situations would have been where access was denied to parents when they had wished to contact their child or children.

Considering restriction on access, Millham, *et al.*, found that because of fear of abuse, because of mutual rejection between parent and child, or because of worries that contact would disrupt the placement, social workers restricted access. In cases of parental abuse there are obvious problems. Should access be stopped altogether or be severely limited, asked Millham, *et al.*, who had found in their sample of 450 admissions to care in Britain, 22 per cent had been the result of a place of safety order? However, they indicated that the proportion of children who require clear and absolute separation is far lower and would be in the region of 3 per cent. They distinguished between specific and non-specific restriction on access. Specific restriction could be denial of access between the child and a particular person or persons. Thirty-six per cent of admissions had a specific restriction placed on family members, generally a natural or step-parent. In 61 per cent of specific restrictions, all contact was denied between the child and certain family members, but in the remainder limitations were less severe (p. 84). In this present study specific persons such as abusing fathers and/or mothers, were named as having access restricted, either denial altogether or only when a social worker was present.

The decisions about access between children in care and their families are some of the most difficult and painful for social workers. This is the view expressed by Foord (1987) in her work on access between children in care and their families. Fundamental responses are evoked and there is reluctance to interfere in these primary relationships. Access and lack of access cause great distress to children, their families and their substitute carers. Foord points out that the whole issue of a child's attachment to

his/her parenting figure or figures is central to decisions about access, whether the attachment is based on a loving care experience or not.

Foord also reminds us that a State agency's adverse attitudes towards parents can mask the importance of children's existing relationships with their families and their environment.

Regarding (c) above, a situation which occurred in a few cases was an involuntary one – the parent(s) were mentally ill and patient(s) in psychiatric hospitals, or were in prison. However, in most cases the parents had abrogated their responsibilities to their child(ren), rejecting the child(ren) either explicitly or implicitly. The parents left no instructions as to their wishes for the child(ren)'s future, so the child(ren) were effectively abandoned.

For a minority of children, Richardson (op. cit., p. 151) in her study of children in residential homes in Ireland argues, where parental relationships are of little or no significance, it may be better that there be legal severance of parental contacts and incidentally, in the case of marital children this would in future allow their placement for adoption under the *Adoption Act, 1988.*

Richardson's argument is only one side of the debate on the value of natural parents who may not be very caring *vis-à-vis*, say, caring adopting parents. She also raised the question of how far contact between parents and children should be encouraged by social workers and residential workers when the relationships do not offer the possibility of long-term security or the chance of returning to parents.

Probably one of the most damaging situations for the child was where the parents were ambivalent about access and only contacted their children intermittently or the contact "faded". As I have shown, some of these parents blamed the foster parents for their own lack of contact, alleging that the foster parents made the situation difficult, not trusting them with the child(ren) in numerous ways, e.g., following them if they went walking. As previously mentioned also, McAdam illustrates the difficulty of visiting one's children in a foster home, even where good relations prevail. One of two sets of parents actually did not understand the importance of visiting their child and had to have it pointed out to them by the relevant social worker.

Some situations occurred where one or other parent only visited intermittently while the other was in regular contact. Reasons for this situation could range from a father being in jail to a mother deserting her family. Access was not denied by social workers in these cases and indeed it was actively encouraged by social workers where appropriate.

Richardson (op. cit., 1985, p. 151) asks how important is a sporadic,

on-off relationship with its parents to a child? However, there is firm evidence of the psychological importance and value to children of being with, and knowing, their parents (see, for instance, Gilligan, 1985). Therefore, a dilemma arises here for social workers faced with the decision of whether or not to return a child to its family where only intermittent contact had occurred. It would be accepted that frequency of contact by parents ranks as a major factor in the decision to send a child home. It was also the philosophy underlying sections of the Children Act, 1989 in Britain.

Reason for poor contact could be of a practical nature – no transport either public or private and length of distance to foster home, poor health of parents, or lack of telephone. These reasons concur with Millham, *et al.*'s, descriptions of non-specific restrictions on access. Lack of transport was most likely to occur where children were fostered, since in residential homes the children were older and also arrangements for transport could be made more easily. The situation of poor transport facilities was most likely to occur in rural areas, where in Ireland there is a very sparse and scattered population, with a poor public transport system and, for these families, nonexistent rates of car ownership. In some cases, social workers brought children to visit parents or vice versa but this did not appear to be a general rule. Some social workers did travel even long distances for visits while others did not.

Payment of fares may be made to families to visit their children in some Health Boards but only once a month and a senior social worker must make the case for the payment. Thus, if a child is placed in care a long distance from its home, and its parent(s) are poor, with the best will in the world it may only be possible for one visit per month to be made.

There are few means of discovering the frequency with which the criterion of placing a child near its family is used. Where this criterion is not used, further study would be required to identify the rationale for the placement of children in residential or foster homes many miles from their families if closer ones were available even in other Health Board areas.

When comparing the two groups of children – those with good contacts and those with poor or no contact – the particular variables which appeared most relevant from previous research were examined. These were age at admission, present age; length in care; court order admissions, type of care, and family type.

Table 6.1 gives the details of the proportions of these variables. This table indicates that age at admission has some bearing on whether children have good or poor contact with their parents. Children aged less than 1 year at admission have the best level of contact. Present age does indicate a

Table 6.1: *Parental Visits/Contacts by a Number of Variables*

Parental Visits/ Contacts	*(a) Age at Admission*				
	< 1 year	*1 - 3*	*4 - 6*	*7 years +*	*N*
			Per cent		
Good	44.4	25.0	39.2	39.2	143
Poor or None	55.6	75.0	60.8	61.3	245
Per cent	100.0	100.0	100.0	100.0	
N =	108	104	74	102	388*

* No information on 3 children

	(b) Present Age				
	< 3 years	*4 - 6*	*7 - 11*	*12 +*	*N*
			Per cent		
Good	68.9	28.8	35.8	26.4	146
Poor or None	31.1	71.2	64.2	73.6	245
Per cent	100.0	100.0	100.0	100.0	
N =	74	52	106	159	391

	(c) Birth Status			
	Marital	*Non-Marital*	*Extra-Marital*	*N*
		Per cent		
Good	33.6	49.2	20.7	146
Poor or None	66.4	50.8	79.3	245
Per cent	100.0	100.0	100.0	
N =	244	118	29	391

	(d) Court Order/Voluntary Admissions		
	Court Order	*Voluntary*	*N*
		Per cent	
Good	31.6	41.9	146
Poor or None	68.4	58.1	245
Per cent	100.0	100.0	100.0
N =	174	217	391

Table 6.1: *continued*

(e) Care Type

	Short-term Foster Care	*Long-term Foster Care*	*Short-term Res. Care*	*Long-term Res. Care*	*N*
			Per cent		
Good	62.9	30.1	29.4	32.9	146
Poor or None	36.2	69.9	70.6	67.1	232
Per cent	100.0	100.0	100.0	100.0	
N =	86	193	17	79	378*

* Does not include Supervision at Home group

	Short-term Care	*Long-term Care*	*N*
Good	58.3	30.5	146
Poor or None	41.7	69.5	232
Per cent	100.0	100.0	
N =	103	275	378*

* Does not include Supervision at Home group

(f) Family Type

	Married 2 Parent	*Married 1 Parent*	*Single 1 Parent*	*Single 2 Parent*	*Other*	*N*
			Per cent			
Good	34.3	38.8	45.0	48.1	23.7	146
Poor or None	65.7	61.2	55.0	51.9	76.3	245
Per cent	100.0	100.0	100.0	100.0	100.0	
N =	166	80	80	27	38	391

(g) Length in Care

	< 12 months	*1 - 3 years*	*4 - 6 yrs*	*7 years +*	*N*
			Per cent		
Good	49.5	51.5	32.6	21.1	146
Poor	50.5	48.5	67.4	78.9	245
Per cent	100.0	100.0	100.0	100.0	
N =	101	97	46	147	391

falling off of contact for older children. It has been shown that older children have spent longer in care, so this would seem to indicate a "tailing off" of contact the longer a child spends in care, as (g) demonstrates.

Non-marital children were a little more likely to have good contact than marital children but not significantly so. Extramarital children had the poorest level of contact – just 80 per cent having poor or no contact. The basis for admission either voluntary or Court Order seemed to make very little difference in level of contact.

Care type again indicates less contact for children in long-term care but not much difference in the level of contact between children in foster or residential care.

For family type (f) again no great differences appeared between family types and contact with children.

What seemed to be indicated by the data here is that children under 3 years old at present in short-term care are the group having the best contact with their parents. This again points up the phenomenon of long stay care plus a "tailing" off of contact with length of stay in care and, associated with that, the child growing older. These findings confirm those of other studies, for instance, in Britain, Millham, *et al.*, (1986).

Care Episodes and Moves

In this section a distinction is made between a child having a care experience in only one foster or residential home and a child having a care experience which included at least one change from the original foster or residential home during that experience.

Seventy per cent of the children in care during 1989 had no change in their care situation since their placement, while 117 had been moved at least once. Forty of those latter children had a second change during the placement. Of the 117 children with at least one move, the majority (81) had been in short-term care (41 foster; 40 residential) prior to their present care. This is likely to indicate a temporary initial placement while awaiting their present foster family or residential home. However, 28 children had been in long-term foster care and 7 in long-term residential care. No doubt serious disruption was caused to these children in changing from what was likely to have been a settled environment.

Of the 40 children with more than one move, again the majority had been in short-term care, but 9 children had been in long-term care, again no doubt experiencing severe disruption.

When asked why the change or changes were necessary, the social workers were most likely to respond that the foster home placement broke down and an alternative had to be found for the child.

An enquiry was also made as to whether or not the child had had a care experience prior to his/her present placement. One hundred and two children had had a previous placement. The majority of these placements were in short-term care (56 in foster care; 32 in residential) but 14 children did have a long-term care experience prior to their present placement.

Situations where social workers felt the placement was unsuitable (which, as previously noted, was only in a small minority of cases) included, for example, a child from a traveller background where a placement in her own culture would have been more appropriate. Another reason could be the inability of a parent to cope with the child going to a foster home, seeing the foster home as a threat. In one case the social worker said she would have chosen the same type of care – long-term foster care – but not with the particular foster family.

It is not possible to predict how many future care changes or moves within care some of the children presently in care will have. Also, there is no way of evaluating the benefits or damage that moves might bring. Obviously a straight count of moves may be misleading and we have no information to allow an evaluation to be made. For instance, a child could have been placed in short-term care in a residential home and moved to a loving foster family. This could hardly be compared with a move to a residential home after a long-term foster home breakdown.

Children in Long-Term Care

The length of time children and young people spend in care has been a matter for concern. Various studies have taken this line since it was first pointed out in Britain by Rowe and Lambert in 1973 that children who spend more than a certain length of time (12 months) in care are likely to be left there until it is time for their discharge because of their age (see, for instance, Millham, *et al.*, op. cit.; Packman, *et al.*, op. cit., 1986).

Looking at the children in this study, only 12.5 per cent spent less than 6 months in care, while those, who by Rowe and Lambert's definition would be heading in the direction of being categorised as "lost in care", i.e., longer than 12 months in care, comprised 65 per cent of the children in care during 1989. In the Dartington study (Millham, *et al.*), 38 per cent of their cohort remained in care after 2 years. In this study 66 per cent of the children were still in care after 2 years. However, the two studies are not comparable, as the Dartington study, used a cohort sample, whereas this study's sample was all children in care at any time during 1989. The "stayers" were children admitted prior to 1989 and not discharged during 1989 – 242 children. Subsequent to 1991 a plan is being devised for each

child on admission but the data here are based on admissions prior to and during 1989.

The "Stayers"

Table 6.2 shows present (1989) age comparisons for the region as a whole. If the areas are compared – Tipperary had the highest proportion of "stayers" – 78 per cent of the children in care in Tipperary NR had been admitted prior to 1989 and were still in care at the end of 1989. The figure for Limerick was 73 per cent, and Clare was lowest at 68 per cent.

Table 6.2: *Comparison – Present Age*

Age	*Mid-Western Health Board* *Per cent*	*"Stayers"* *Per cent*
< 1 year	4.8	-
1-3 years	10.4	6.5
4-6 years	13.9	14.8
7-11 years	28.3	28.5
12-15 years	25.6	29.2
16 years+	17.1	21.0

Gender did not appear to be important as a similar proportion of girls were "stayers" as had been found in the study overall (53:47).

Non-marital children were not as likely to be in long-term care as marital children – 63 per cent were in care for more than 1 year compared to 78 per cent of marital children. Extramarital children were the most likely to have spent longer than 1 year in care (86 per cent). However, the total number of extramarital children in care is small (29). Eighty-nine per cent of all Court Order admissions were among this group of "stayers" again confirming that legal basis for entry affects length of stay in care. Twenty children were said to be in short-term care but had been more than 1 year in care. Presumably the original intention was that the placement be short-term care but subsequently became long-term.

Where care type was examined, the vast majority of children in care for less than 1 year (69 per cent) were noted as being in short-term foster care. Of children in long-term foster care, almost three-fifths had spent more than 7 years in care and of children in long-term residential care, 46 per cent had spent a similar length of time in care.

Thus, if we look at the group of "stayers" 67 per cent of them have spent 4 years or more in care. They were somewhat older at admission than

the overall group, obviously older now, and more likely to have been admitted on the basis of a Court Order. As noted in Chapter 5 (Table 5.6) a number of families had no interest in the return of their children. In other cases where parents were able and willing to accommodate their children I gave the various reasons social workers had for not returning the children to their parents. Examples of these reasons were, for instance, mental illness of parents or alcohol addiction. In this present chapter also I have shown that half the parents of children who had poor or no contact with their parents had effectively rejected their child(ren), thus leaving them to drift in care.

Lasson (1980) studied a sample of long-stay children in children's homes, in which she concentrated on their family links. She discovered that natural parents remain highly important for children who live in residential settings. Children who were visited by their parents were more settled in their placements and better adjusted, socially and psychologically, on a wide range of criteria than those of their peers who maintained no such contact. Of course, it may not always be in the child's best interest to maintain contact and be returned home, but it seems to be so in the majority of cases.

Comment has already been made on what appears to be long stays in care for children from the Mid-Western Health Board Region. Whether long-term placement was the initial intention or not we cannot be sure, but in contrast to Rowe *et al.* (1989) where an overall figure of 10 per cent of all foster care placements were long-term, 50 per cent of the children in this study were in long-term foster care, defined as over 1 year in care. There may be a problem of definition here in that long-term placement in the Rowe study may have meant a very deliberate decision and plans made for the care to be long-term while, as far as we know, less deliberate planning occurred around decision-making in our study from all but recent placements. I did not ask whether the initial placement had been a planned long-term care decision or not since few of the present social workers were the decision-makers at the particular time of admission of a large proportion of these children, so such a question would not have elicited useful information. Twenty-one per cent of the children were in long-term residential care. A "drift" in care seems to have been the experience of most of these children. That was the situation in 1989. However since then changes in and additions to personnel have led to a deliberate policy of planning for each child admitted to care in so far as that is possible. Thus likely long-term cases will be assessed and a planned future set out by social workers. However, as pointed out, the data remain as a picture of the situation in 1989.

No residential places are available in Clare. Children from there go to Galway or Limerick for residential care. It could be argued that the lack of residential places in Clare leads to greater efforts to find foster homes for children, but Tipperary likewise has no residential facilities, except for mentally handicapped children, nevertheless 21 per cent of its children in care are in long-term residential care. Tipperary has children in residential care in Galway, Cork, Clonmel, Fethard, Waterford and Dublin. Rowe, *et al.* (1989, p. 130) comment on the continuing major part played by the residential sector and conclude that it is difficult to determine how much the use of residential placements depends on availability, but that it seems likely that "if beds are easily available, they tend to get used".

Summary

This chapter considered the child's experience after the separation from his/her family and placement in care. First, the suitability of the placement was examined and here the low level of social worker dissatisfaction with existing placements was noted. The mobility of staff is commented on together with the poverty of information on some old files, leading to problems with providing accurate data.

The experiences a child had in care are likely to affect his/her future development. If the experience is one where the child feels cared for and secure, obviously its outcome will be positive. In this context family contact was discussed and the importance of retaining links with the family of origin was stressed, whether or not the intention was that the child return home eventually.

Levels of contact between parents and their children in care varied considerably and concern was expressed about the proportion of children with poor or no contact with parents or family. Access was denied by social workers to a small proportion of parents for good reasons, but where it was not denied, a considerable number of children had been rejected by their parent(s). The problems for parents visiting their children in care were noted and the finding that parents regarded visiting children in foster care as more difficult than visiting children in residential care, seemed to be supported by research evidence.

The conclusion indicated by the data was that younger children in short-term care had good contact, and this in turn again emphasised the "tailing off" of contact as the child(ren) grew older and length in care increased.

The concern of various researchers about the length of time children spend in care was noted and the proportion of 87 per cent of children having spent more than 6 months in care was highlighted. Parental

attitudes to children returning home were considered in Chapter 5 and in this chapter comment was made on the high proportion of parents who had rejected their children by not visiting or contacting them in spite of access being available. These would be some of the children who by Rowe and Lambert's definition are "lost in care" – those in care 12 months or more and comprising 65 per cent of all children in care during 1989. Changes in practice post-1989 were noted and the likelihood of a "care plan" being made for each child in present practice is a very positive change.

The particular characteristics of children in long-term care were examined, but because they comprised a majority of the children in care anyway, it was difficult to make valid comparisons with the small group who had spent a short time in care. The need at that time for urgent consideration of these children was stated. Again comment was made on the apparent long-term stays in care for children, but the effect of this would be mitigated somewhat by planned care which seems to be the current practice.

Chapter 7

CONCLUSIONS AND RECOMMENDATIONS

This study has described the demographic characteristics of the children in substitute care in the Mid-Western region in 1989 and the characteristics of their families, outlining the reasons why the children have been placed in care from the standpoint of problems arising in their families. The study went on to sketch various aspects of the children's experience while in care.

Fieldwork for the study was conducted in one Health Board region over a period of 18 months and two research techniques were employed – first, an interview schedule was completed by a Health Board social worker for every child in care at any time during 1989, and second, the researcher conducted a personal interview with 27 of the 258 families of the children in care in the area. This chapter will look at the responses in the study to the research questions which were posed in the Introduction. The first of these questions dealt with the demographic characteristics of both the children in care and their families. These were the children's age, birth status and gender and the parents' age, education levels and occupations. The second question asked about the reasons why the child was taken into care. The length of time the children had spent in care and the demographic characteristics of those children whose stay in care was long-term were covered in question three. Question four dealt with the type of care experienced by the child, and question five asked about the circumstances of children discharged from care. Details on the likely reasons for differences between Community Care areas in the rates of admission of children to care was the subject of question six. Finally, the perceptions of the interviewed families as to the type of stress they had encountered and which led to their child or children being taken into care were the subject of the seventh question. Possible policy and practice interventions aimed at vulnerable families, with particular emphasis on prevention, will be outlined also, as will perceptions of social workers, foster parents and other care workers.

What is proposed first is to describe the children in care as a group and then to discuss them in the light of the responses to the questions relevant

to them. Following on that discussion, the families of the children will be commented on in the same manner.

The Children

The demographic profile of the children in care in 1989 shows that almost two-thirds (63.5) of them were *admitted* to care under 4 years of age. This compares with 23.8 per cent of children under 4 in the population of children under 19 years old in the Health Board area. However, the *present* age profile of the children in 1989 showed a far lower proportion of children under 4 years old in care than the proportion of 4 year olds in the Health Board population. This could mean either that younger children spend a shorter time in care than children admitted when older, or that all children spend a long time in care, those admitted at a young age staying on and growing older in care. This latter did indeed appear to be the case – the majority of children (65 per cent) spent more than 12 months in care.

It was asserted earlier in this study that children of incomplete families, e.g., children of single mothers and broken families were particularly at risk of placement in care. Indeed, as regards admission to care, the most notable group in this study were children of one-parent families who were significantly over-represented in contrast with their proportion in the general population (30 per cent to 12.8 per cent). However, because incomplete and broken families are becoming more common, this factor may be a poor discriminator and the question which suggests itself from the data is which members of these large "at risk" groups actually come into care? No study has answered that question. However, the children in this study whose parents were widowed, deserted, or single, are without question represented to a far greater degree than their proportion in the general population of the Health Board would warrant. Also, taking age at admission, it was found that the younger the child was at admission, and the younger the 1989 age of the child when in care, the more likely he or she was to have come from a one-parent family. This would indicate that one-parent families may find young children problematic. For instance, a single mother who decides to rear her child on her own may experience unexpected problems later on when the child is 1 or 2 years old.

While the children of one-parent families, and particularly non-marital children, are vulnerable to placement in care, marital children of two-parent families are vulnerable also. Marital disharmony, neglect, and abuse of children seem to be the result of inability to cope financially, psychologically or emotionally for two-parent families as well.

Birth status combined with age affected to some extent the type of care experienced by the children in this study, since marital children were more

likely to be older when admitted to care and were more likely to go into residential care. For non-marital children in the study, foster care was the more likely option, but non-marital children were usually younger at admission anyway and it seems overall the younger the child, the more likely he or she was to be placed in foster care. For all the children in care during 1989, where long-term care was required, foster care seemed to be the most likely option for those admitted to care up to 4 years of age, after which residential care became the more likely type of care. It is also likely that foster care placements on a long-term basis may be easier to obtain for younger children, and since proportionately more of the younger children entering care were non-marital – they were more likely to be in long-term foster care than were marital children.

The importance of the basis for admission to care, Court Order or Voluntary, in predicting the length of stay in care was consistent with findings in other studies. There was a yearly increase since 1980 in the proportion of children actually in care who had originally been placed on foot of a Court Order. There is the possibility that some children on Court Order admissions could now be "lost in care". The implications for Health Board and family resources were stressed because Court Order admission indicates that a child is likely to spend a longer time in care. The question of length of stay of a child in care generally, whether admitted through a Court Order or voluntarily, is a vital variable in the area of planning and policy-making. As was evident from the data, some of the children experienced what could be categorised as a "drift" in care. It was not clear whether to allow this "drift" to continue had been a deliberate strategy or not, since long-term care does not necessarily mean a "drift". For instance, some children need a long-term placement. However, as with children "lost in care", the implications of a "drift" for both the financial resources of the Health Board and the emotional resources of the child and his or her family, are obvious.

Access and contact between children in care and their families, both immediate and extended, are regarded in the literature as being essential to the child. From the child's point of view as well as the parents', the dimensions of the contact need to be positive and loving for the child to retain his or her feelings of identity, security and continuity. The study here showed that almost half of the children in care (48 per cent) had extremely poor or no contact with their parents. As regards length in care and level of contact, around half of the children who had spent up to 3 years in care had good contact with their families. However, after 3 years in care, a good level of contact was experienced by only a quarter of the children. Sometimes contact and/or access was denied by the social

workers because of fear of abuse of the child by the parents. The decisions social workers have to make about access between children in care and their parents or other relatives are some of the most difficult and painful they have to take. Perhaps the development by the Health Boards of a policy of actively encouraging foster parents to adopt any child who is in their long-term care might be an appropriate response to the situation of the child in long-term care whose parents show no interest in him or her. In some instances the children themselves did not want any further contact with their families. Where contact and access are otherwise unproblematic, there is a grave need for the development of innovative access visit facilities, e.g., day at seaside, visits to places of interest, use of hotel/leisure facilities.

The majority of children discharged in 1989 returned to a family setting (79 per cent). It is to be hoped that the problems which had caused the admission to care had been resolved. It may be assumed by people outside of the system that when a child is returned home after a period in care, all is well. This may not be so and even if careful work has been done to prepare the family for the return of the child, when the family returns to its original composition and dynamics, the same problem which caused the need for care of a child or children in that family may arise again. Therefore, an effective aftercare service needs to be in force to monitor the dynamics in the family and prevent a recurrence of the previous problems. There are two stages here: similar resources as directed at the child in care should be directed at his or her family to prepare first for the child's return and then to ensure that the problems which led to care have been resolved.

A number of young persons having reached the legal age limit may be discharged from care without any plans for their future, and the likely consequences of this in terms of, for instance, homelessness, needs to be addressed by the appropriate authorities. In this regard, the Streetwise National Coalition Study (1991, p.12) stressed that the inadequacy of existing services for homeless children and children in need of alternative residential services had been evident for many years to those working with children at risk. It has been the cause of much suffering to children whose needs were being ignored or at least inadequately met and much frustration to those trying to work with them.

In its 1991 statement, Child Care Practice and Policy, the Mid-Western Health Board set out a number of principles and consideration will be given to those specifically aimed at admission to care. To summarise, the principles guarantee that the background of each child entering care will be given careful consideration, that a permanent substitute placement will

be considered – either long-term fostering or adoption. Residential care will be considered as an option for children with special needs and children for whom fostering is not an option or who require intensive periods of assessment and/or therapeutic intervention. The rights of the child in care are set out. These are the right to individual attention, skilled care, adequate preparation for entry, moves and return home, consultation about arrangements for care and aftercare, maintenance of contact with their family and extended family and finally the right to have a named social worker.

The implementation of these principles should go a long way towards improving the experience of care for children in care. Particularly relevant to that improvement is the commitment to securing the rights of the child in care.

The children who had spent a long time in care – 12 months or more – comprised 65 per cent of the in-care population in 1989. These are children who have, no doubt, received some special attention under the implementation of the principles of the 1991 Child Care Policy and Practice statement.

A disturbing increase over a number of years appears in the number of children in care because of parental abuse. This category includes physical, sexual and emotional abuse. This increase may reflect a greater degree of reporting and vigilance on the part of the public and social workers rather than an increase in the incidence of abuse. It seems likely that a great deal of abuse, particularly sexual abuse, goes unreported. The proportion of children taken into care in 1989 as a result of sexual abuse was very small but trends in the numbers retained in care showed a dramatic increase on previous years and calls have been made for mandatory reporting of all such offences. The Law Reform Commission *Report on Child Sexual Abuse,* for instance, made such a recommendation and in its conclusion commented that a "degree of procedural informality or even laxity" was apparent in how the law and also the procedures in cases of child abuse were being interpreted by those professionals involved. The Department of Education has recently issued guidelines for teachers regarding reporting cases of child abuse. The reporting of sexual abuse does not necessarily greatly reduce the risk to children of course, and there needs to be a planned programme of intervention including preventive work with parents and families. It should be emphasised that children who are placed in care because of abuse, either emotional, sexual or physical, can come from any stratum of society and are not necessarily victims of social need. Children admitted to care because of abuse are a subgroup of all abused children.

Since this study was completed, a public inquiry was set up into the case now known as the Kilkenny Incest Case. This was the first public inquiry in Ireland into a matter of this kind.[16] Some other private inquiries by the Department of Health may have taken place, but there are no published reports available.

The high proportion of children whose first ranked reason for care was "Neglect" should cause concern. As I noted, neglect could include abuse and indeed appeared to be connected to abuse in some cases. They are distinct phenomena, however. The act of neglecting one's children may be regarded as more culpable in a number of cases than, say physical abuse. Neglect takes place over a long period, is continuous and continually uncaring about the welfare of one's children. Abuse generally occurs infrequently, but at most intermittently and usually takes place in times of crisis. It is commission rather than omission. This is not to excuse abuse in any manner whatsoever, but gives cause for more serious consideration of its position in the hierarchy of offences against children. Neglect would appear to be far more prevalent and may be more serious than abuse, or come from deeper parental needs, while abuse has been given far more publicity. No doubt, this occurs because of the dramatic impact of some cases, for instance the Kilkenny incest case, or in Britain where abuse led to the death of some children. Children would be unlikely to die of neglect, but the damage done to them physically, emotionally and psychologically would be enormous. Of course, only cases of neglect of children where Health Board social workers became aware of a problem could be noted here. The true extent of the problem of neglect is unknown and mandatory reporting on cases of neglect would assist the compilation of a true record of the number of children suffering from neglect. Of course, as the Kilkenny case demonstrates, abuse and or neglect may not be recognised and as I have noted, we cannot assume that anything like the full extent of the incidence is reported.

The Child Care Practice and Policy statement, already referred to, also details the circumstances under which the Social Work Department of the Mid-Western Health Board would see it as necessary to place a child in care. The circumstances they would envisage would be short-term respite type or shared care; or where there was no viable family or extended family available to care for the child. Another situation would be a case where a child was experiencing persistent and severe hostility and rejection from his or her own family. In cases where neglect or ill-treatment of a child was occurring and in cases where the child was beyond parental control were

[16] *Report of the Inquiry into the Kilkenny Incest Case, 1993*, Dublin: The Stationery Office.

the final circumstances in which a Health Board would consider "care". The Statement goes on to detail the grounds under which, in so far as it can be avoided, a child will *not* have to enter care. These grounds are illness of one parent in a two-parent family; financial problems; disability; housing problems; medical grounds and finally the need to give parents "a break" unless there are compelling reasons to believe that such care episodes will enable a family to continue caring for its children.

In this study a number of children had been placed in care on the grounds which since 1991 do not apply. For instance, 25 children had been placed in care primarily because of financial problems in the family leading to neglect of their children in some cases or abandonment in others. Thirty-nine more children had mental illness of parents as a primary reason, and in these cases also this led to half of the children being neglected, and the illness leading to a crisis in the family in another one-third of cases. Where physical illness was a primary reason for care, in the cases of 12 children, this caused a crisis in the family for 8 children, while the other 4 were neglected. It is expected that families like these will now and in the future be dealt with in the community with appropriate family support to prevent the placement of their children in care.

The Families of Children in Care

It was not surprising that the families in this study came from a marginalised working-class group. The characteristics of parents showed a disproportionate representation from these classes. A high unemployment rate coupled with the low social class and poor education convey a picture of deprivation in the families. These characteristics, associated with the finding of weak network support from either kin or neighbourhood, indicate a pile-up of adverse factors for the families. Supports in these families were either inadequate or inappropriate.

Poverty has been identified as a major factor in the vulnerability of families to their children being placed in care. Research on children in poverty carried out by the Combat Poverty Agency *Child Poverty in Ireland* (Nolan and Farrell, 1990) found that households with children were more likely than households without children to be below each of the relative poverty lines they derived from their data. There was a marked deterioration in the position of households with children compared with those without children in the 1980-1987 period. The authors went on to try to explain this deteriorating position of households with children and analysed the factors producing the marked decline in the position of such households. In doing this they concentrated on the classification of households by size/composition and by the labour force status of the head.

The results showed that the principal element was the change in the importance of the different labour force status groups – in particular the sharp rise in the percentage of households with an unemployed head – which produced the increase in the numbers of children below the poverty lines (Nolan and Farrell, 1990, p. 90). Only 31 per cent of the fathers in this present study were in full-time employment. The rate of employment was low and a great deal lower than for the area as a whole (64 per cent in full-time employment). However, as I pointed out, the rate would need to be compared with rates in similar areas, say, one urban working-class area with another. Only general/overall rates for the Mid-West Region were available for comparison here. One study of a socially disadvantaged area in Limerick from which some of the children in care came (O'Gallagher, 1990) found an unemployment rate of 82 per cent.

The paucity of social networks, both formal and informal was notable, and this is also associated with poverty. Although I have no supporting evidence, I would suggest that the lack of resources, both financial and social, in the families under study no doubt affected their ability to reciprocate any assistance that might have been forthcoming from their kin or neighbours. Reciprocity is a necessary component of social interaction. Consideration of the number of households in this present study where either the father was unemployed or there was a female head of household can only lead to a conclusion that a high proportion of children in care are from families below the poverty lines as defined in, say, Callan, *et al.* (1989).

The number and proportion of one-parent families, especially those headed by single mothers, are increasing and the pattern of outcomes of non-marital births has changed over the years. For instance, placing a child for adoption used to be, and is still presumed by many to be, the "normal" course of action for the unmarried mother. However, this trend has changed remarkably since the introduction of the unmarried mother's allowance in 1973 together with changes in sexual mores and parents' attitudes. The number of unmarried mothers choosing adoption as an option has obviously declined. The number and proportion of children placed in care from "one-parent family" and the majority of these children being non-marital gives cause for concern about some single mothers keeping their babies and finding later that they cannot cope and must place their child in care.

No doubt, there is a range of possibilities with regard to all child-rearing circumstances. The fact that the circumstances are unspecified in the published statistics in the case of one-parent families, however, does leave social service planners in a difficult situation. It is impossible to know,

for instance, how many of these "cases" constitute a particularly vulnerable one-parent family. If the number of vulnerable one-parent families is increasing, then difficulties will arise in knowing how to plan supportive services for the appropriate number of, say, pre-nuptial conceptions (Walsh, 1980) or significant changes in sexual mores (Clancy, 1984, pp. 27-28). Changes in sexual mores do not necessarily lead to problems, since a number of stable relationships outside of marriage can be set up, with as much stability as marriage. Nevertheless, the increase in the number of single mother one-parent families, which is one consequence of changes in sexual mores, seems to increase the vulnerable, as these families are over-represented in the numbers of children in care. If our marital fertility continues to decline and the numbers of children born out of wedlock continues even at present levels, then the proportion of non-marital children will increase even though the number of children born is decreasing. Also there is no reason to believe that the proportion of children born out of wedlock has yet reached a ceiling. Whether these latter will be children of stable unions or not is a question vital to planners, since if the number and proportion of one-parent families increases, then the number, if not the proportion, of those regarded as unable to cope will also increase.

Parental Attitudes

The build-up over the past 10 years of children in care who had been placed in care on foot of a Court Order begs the question of the possible feelings of resentment of the parents to their children being committed to care by the Court. Evidence that these feelings existed, sometimes temporarily at the time of the placement, but at other times continuing on during the placement and leading in some cases to loss of contact with their children, was obtained by the researcher from the parents themselves. There was some evidence that feelings of stigma were involved also.

This loss of contact or "tailing off" of contact was also due to numerous other reasons. Sometimes parents were plainly uninterested in their children and had no wish to contact them. Other parents found visiting too difficult and painful and yet others had no means of transport. The provision by the Health Boards of suitable accommodation to facilitate access visits, such as that provided by, for instance, Barnardos in some areas, should be a priority. Children sometimes decided that they did not want contact with their parents, and social workers felt that contact or access would not be in the best interests of the child.

Throughout the study I have commented on the reactions of some of the parents I spoke to about their perception of their situation. The overall

impression from the parents was one of powerlessness to do anything when the situation arose to prevent their child or children being placed in care, whether the children came into care by Court Order or not. This may have been because the parents I spoke to had agreed to speak to me and were not parents in dispute with the social workers.

Rights of Parents

Another section of the principles of the Child Care Practice and Policy statement is given over to a positive affirmation of the rights of parents together with their children. The statement guaranteed that parents and children will be given written information on Health Board Child Care policies and procedures. They would also be given clear written information about their legal status, their legal rights and legal proceedings and be consulted about and kept informed of plans and decision-making on any matters concerning them. Also at the review of the case, the views of parents, children, carers and guardians will be heard, recorded and taken into account as part of the review process. The parents and children will be kept informed of review recommendations and decisions made at the review.

Gilligan (op. cit.) considers the right of parents to information about the child in care. He believes that having a named social worker is no guarantee that the child or his or her family will receive the services of a social worker, and that social workers should be able and encouraged to liaise with the families to ensure the service to the family. A resource group for the parents of children in care has been set up in Dublin. A booklet *Your Child in Care* which details parents' rights with regard to their child being taken into care, and when in care, has been published. Monthly support group meetings are organised, again in Dublin.

Social Workers' Perceptions

The respondent social workers were asked what they would see as the most effective interventions to prevent the placement of children in care. Being service providers closely involved with the families of the children in care, they, along with the families, could be regarded as having one of the best views on what would assist the families most. While in the social worker's judgement material and financial assistance were needed, particular attention was drawn to the need for provision of formal networks for prevention, such as counselling, family therapy, home help, day care such as day-fostering and specialist child-minding. It was also suggested that the promotion of self-awareness within families to enable them to seek help before a crisis point arrived could prove very positive. Of course, parenting

courses were seen as badly needed and a homemaker service where a person goes into a family home and works alongside mother and children. In this way the homemaker trains the mother to care for her children and run the home without usurping the mother's role. This homemaker role, it was felt, should receive official recognition from the Department of Health.

The need for preventive services, then, was emphasised by all the social workers. As one respondent worker expressed it: "Often when a social worker gets involved it can be when the situation is chronic and removal of the child is essential". Training to enable service providers to detect potential problems in a family and have them dealt with by an appropriate service would be an ideal situation. The difficulty, of course, is to achieve this without intrusion and interference in people's lives and imposition of certain values at the expense of others. If there was some way in which a relevant service could be made available and families made aware of its availability, they, in consultation with their social workers, could then benefit from that suitable service.

The social workers were also asked for any general comments they had on the area of substitute care for children. One social worker felt that the perception of social workers by clients appeared to be changing so that the previous perception of the social worker as caring is being replaced by a much more controlling and authoritative approach. This makes preventive work more difficult because it is harder to gain the trust of clients. It is not easy to see where this change of attitude is coming from, but one could speculate that with the rise in the number of reported cases of abuse, clients fear that social workers may be looking for evidence of abuse and clients are resentful of that.

The lack of co-ordination in the provision of services to some families is also a theme running through social workers' comments. They feel families are confused and the services are thus likely to be less effective. Liaison between professionals is extremely important.

It was also felt by the social workers that greater consideration should be given to children's opinions when decisions are being made about them, such as placement in care or type of care placement being considered.

Social workers believed that there are many services and even individuals who could preserve a threatened family unit, even if this were not their primary job, e.g., teachers or priests. Again, the need for in-home interventions was stressed – support for the family within its own community in whatever way is indicated as necessary. The provision in the *Child Care Act, 1991* for the making of supervision orders will not do much for children under supervision and their families unless accompanied by the necessary family support.

One other proposal regarded by some social workers as an absolute need was the development of an out-of-hours service. While some social workers work many more than the required number of hours, a guaranteed out-of-hours service is still badly needed. It must be taken into account that family crises are no respecters of normal working hours.

Foster Parents' Perceptions

I spoke to a number of foster parents about their roles and their concerns. While appreciating the work load and pressures social workers experienced, they felt nevertheless that foster parents were sometimes left without the necessary support and guidance to deal with difficult children suffering mainly from emotional problems. The foster parents considered it would be helpful if perhaps some one definite person in the Health Board apart from the social workers, could be allocated to liaise with them specifically to discuss their concerns and advise them about what action they should take.

Residential Care Workers' Perceptions

With regard to children in residential care, the study of residential care for children and adolescents *At What Cost?* (1991, p. 64) stressed that the realisation of the needs of the child care workers had not yet manifested itself in policy and practice. Respondents in that study felt that counselling services for the children and the parents of children admitted to residential care were too hard to get access to, had long waiting lists, were too infrequent, did not give enough feedback to the care staff, and were not available in a crisis. This, the study continued, was particularly the case in relation to counselling for victims of sexual abuse. Many of the care staff expressed the view that they did not have the skills necessary to deal with the more difficult and damaged children and young people who were being referred to them. A lack of specialist back-up was seen as a major problem throughout the system. This is an issue that the Task Force on Child Care Services noted in their final report twelve years ago.

Formal Interventions

Moving on to discuss in some detail formal interventions aimed at vulnerable families, two strands will be considered here. The first is prevention of care where possible, and if care becomes essential and it is not possible for the child to be returned quickly to his or her family, then some type of permanent plan has to be made for that child.

Family Support Services as Prevention

The way to tackle a child's disadvantages is surely to act on the disadvantages of his or her parents. Families need support and assistance in overcoming problems which lead to their children being taken into care, in other words prevention. In providing services to families, professionals have long concurred with the concept of the family as a central unit of service, but it has proved difficult to implement, in that services are variously aimed at, for instance, children or mothers or adolescents, but not the family as a unit.

This concept of the importance of family-directed care for children was reflected in the principles which informed the *Task Force Report* (1980). That report stressed that our laws and policies should combine to ensure that, in the first place, children receive the care they need in their own families. If deprived children are to be enabled to live at home and to receive adequate care, the report stated, then the social and economic circumstances of their families must be improved substantially – better housing and environmental amenities and better income maintenance services are required. Adequate housing and income are basic necessities and there is very substantial research evidence to show that lack of them results in children being severely disadvantaged in all aspects of their lives (p. 282).

The *Commission on Social Welfare Report* (1986, pp. 11-12) regarded it as appropriate that the State shares with parents the costs of rearing and maintaining children. However, the report sees the need for differential levels of support to different types of families. Families dependent on social welfare should, as far as possible, the report contends, receive a level of support which approximates to the full cost of rearing children and this can be achieved by a combination of the universal children's allowances and child dependent allowances, the latter to be rationalised. Families where the wage earner is on low income should not be disadvantaged *vis-à-vis* social welfare families and should receive support through children's allowances and the family income supplement, the latter to be modified to ensure higher take-up through a less complicated application procedure and improved level of support.

The emphasis in these sections of the above report is mainly on the economic aspects of prevention of deprivation, but deprivation is not always necessarily or only economic, and other supports such as marriage guidance, day-care facilities, improved environmental amenities, and psychological services are vital. Many of these services could be used along a continuum of need to prevent family breakdown. As far back as 1968, Packman (p.17) quoted a British Select Committee on Estimates in this

regard. "Much frustration and suffering might be avoided if more attention were directed towards the means whereby situations that end in domestic upheaval and disaster might be dealt with and remedied before the actual break-up of the home occurs", and this certainly applies today.

The *Child Care Act 1991* specifically requires that a health board shall provide family support services, and may provide and maintain premises, and make such other provision as it considers necessary or desirable for such purposes (Section 3(3)).

Self-help groups when established in an area appear to help women in particular. These groups emphasise assertiveness and empowerment, enabling the elimination of dysfunctional coping strategies in stressful situations. The children benefit from their mothers' well-being, and where they might have gone into care because their mothers were unable to cope in some way, they may now remain in a stable family. These self-help groups, of course, have to have the backup of medical, paramedical and social services.

The importance of provision of fully integrated services for families, defining family as either a two-parent or one-parent unit, not necessarily founded on marriage, has to be stressed. As has been shown, the families in this study have poor kin and neighbour support networks and are therefore more dependent on formal supports such as social services. Within these services, family income, housing, environmental amenities, marriage counselling, day-care facilities, psychological and emotional supports and encouragement to form self-help groups, would all feature. I would see all these factors as being instrumental in greatly reducing, and ideally in the long-term eliminating, the need for children to enter substitute care.

Resources need to be directed primarily at prevention. Resources can affect the quality of parenting, and much greater resources are needed to keep a child in care than to support a family whose problems can be solved by services in the community. Prevention must be both short term and long term. First, what is already known needs to be applied now. Second, there is a need to find out more about possible preventive strategies. Little is known about the value of results achieved by preventive measures already available. Also new approaches must be devised and their application monitored so that their effectiveness can be evaluated. The main difficulty in providing preventive services is that, in the literal sense, there is nothing to show for them in the short term although their action can be seen in long-term results. The details on particular children who do not have to go into care because of a service provided may not show up on any statistics and numbers may not alter immediately as thresholds for care

may lower if some children are taken out of the system. It is felt by social workers at present that thresholds are too high, and more children are in need of care or protection than are being catered for through present rates of admission to care.

Prevention should have three aims (a) to help families through periods of temporary strain, (b) to prevent the disintegration of the family unit, and (c) to improve, and where necessary, supplement the quality of care and education provided for children considered to be "at risk". These would be achieved through support systems in the community. The intervention of the welfare system up to the present seems to be not to support, but to replace. Marriage and parental counselling at community level as well as creche and baby-sitting schemes, could well be incorporated in the Neighbourhood Resource Centre projects which were advocated by the Task Force Report. Some pilot projects have already been undertaken in the Neighbourhood Resource Centres so we may see some progress there. The Community Mothers' Programme in the Eastern Health Board and the numerous ongoing projects initiated by Barnardos are all models of practical and beneficial undertakings. What is needed is an integrated approach by policy-makers. No doubt there are many other schemes and projects which are or could be of benefit. Consultation with field workers and/or the families themselves is obviously the best means of ensuring that the most appropriate interventions are made for a particular area. Different needs are found between say rural and urban areas, so responses must be in terms of variety but directed by an overall integrated policy.

A number of initiatives, under the aegis of the Adult Education Service in Limerick, have been set up to help parents, again particularly women, to cope with family problems that arise. Home Economics courses are one of these initiatives. There is a wider dimension to these courses than, say, budgeting and cooking. Through the use of active involvement in, for instance, budgeting or cooking, development of such skills as problem-solving, observation, discovery and interpretation of information from a variety of sources and ability to evaluate and retain information, is achieved. The ability to discriminate in the use of domestic technology is also taught. These are areas of great benefit to low-income families. However, the families of the children in care had not made use of available services such as these and it is not clear why such families do not seem to take advantage of these services. One possible explanation is that some of these families feel they are despised in their communities because their children are in care. This view was expressed to me by one mother, who said that her neighbours' attitude had changed since one of her children was placed in care.

Children need attachment, continuity of care, predictable secure futures and stable parenting therefore, periods in care can be damaging. It was noted in the Introduction that care is disruptive to continuity and attachment, and is potentially harmful, especially to preschool children (see Crellin, *et al.*, 1971, p. 113). Twenty-two years ago, McQuaid in 1971, wrote that in order to treat deprived and emotionally disturbed children and their families, identification, diagnosis and formulation of treatment goals are a prime prior requirement, and this basic tenet has not changed.

If children must enter care, I would see the desirability of certain practices, namely:

- that the child be provided with a sense of permanence, either by the maintenance of contact with the natural parents and the speedy return of the child to its natural parents, or, where this is not possible,
- the development of a new permanence within another familial setting.

Unfortunately, a huge bulk of children appeared to have been held in care from year to year, up to 1991 when arrangements for a planned approach to their future were set up. The undesirability of the earlier situation is obvious. Clearly, a new permanence had not been granted to these children. Many of them were marital children. The legal provision now stands that they may be adopted, but some are older than the apparent ideal age for adoption, which is considered to be less than three years old. Suitable adoptive parents might be found for these older children, or encouragement given to foster parents to think of adopting an older foster child. An extension of the arrangement whereby payment of foster care allowances would be continued if foster parents wish to adopt the child could be considered as a valuable means of providing permanency for some children.

The need for research on various aspects of family breakdown has been stressed by numerous workers in the field and by various statutory and voluntary organisations. This study will add to the sum of knowledge about the families of children in care. The calls for research to be undertaken must be qualified by a knowledge of what is known and what one needs further to know. The use made of research, no matter how critical the results, must be to provide a base on which to make demands for policy action. Research results must not be seen necessarily as a criticism of field workers who are almost always under tremendous pressure and often are in conflict-ridden situations dealing, on limited resources, with the numerous problems some families encounter.

However, another issue which may be considered here briefly is the nature and purpose of care and its appropriateness as a means of meeting the present social needs that give rise to it. Some families will, no doubt, always have problems, but the drastic action of removing the child from its family and general environment would then only be necessary where, as Packman (op. cit., 1968, p. 203) describes, there comes a point when a child's accommodation, maintenance and upbringing becomes so improper and inadequate, that it better suits his/her welfare to risk deprivation by separation than to allow him/her to continue in his/her current deprived state at home. Although this would be "care" always as "a last resort", yet the balance of this "evil" with the "good" to those children enabled to remain at home because of the supports in the community would, no doubt, compensate. This would seem to be the philosophy informing the principles regarding family support services in the *Child Care Act, 1991* and the previously mentioned policy and practice statement. A final point here, but no less important, is that the increased and increasing costs of maintaining children in substitute care needs to be addressed. In this regard, consideration must be given to the appropriateness of channelling funding through an expensive legal/court system as at present, instead of a preventive/support system.

Permanency Planning

So when discharge from care to a stable home is not possible for a child – and as has been shown in this study 48 per cent of the children in care in 1989 in the Mid-West had little chance of that, in that their parents seldom, if ever, visited them – what other alternatives are available for these children who seem to be drifting along in care, as opposed to those children who have been discharged?

Maluccio, *et al.*'s (1986) proposals for permanency planning for children are discussed briefly. As a basis for proposing permanency planning those authors contended that, in order to grow up satisfactorily, children need to know that life has predictability and continuity; they need the reliability of knowing where they will be growing up (p. 3). Yet still too many children find themselves in uncertain and impermanent living arrangements of varying quality – in settings such as foster homes, group homes and institutions, or in precarious family situations. The plight of these children, say Maluccio, *et al.*, has led in recent years to the emergence of permanency planning as a popular movement in the delivery of services to children and youth in placement or at risk of being placed out of their homes.

> The term permanency planning has been applied to many aspects of child welfare practice, including as already mentioned a philosophical perspective on the primacy of the family as the preferred environment for child rearing; a problem solving process; adoption; a program to reduce the numbers of children in foster care; a case management method; and "good" or active casework (Maluccio and Fein, 1987).

However, permanency planning may be defined more broadly, encompassing attention not only to children and youth in foster care, but also, and perhaps more importantly, to those at risk of such placement.

> We see it as a process of planning for permanence, that is, "the process of taking prompt, decisive action to maintain children in their own homes or place them permanently with other families". The foremost question to be asked and answered in each case is: will the child have a family when he or she grows up? (Maluccio, *et al.*, 1986).

It is not intended here to expand much further on the concept of permanency planning but to suggest it as a possible intervention in cases where children have up to now little hope of having a permanent home. At this stage the emphasis is on the need for goal-directed social work practice, so that, as Maluccio, *et al.*, recommend, planning becomes a central, deliberate, and ongoing component in all aspects of service delivery – from the helping process in a particular case situation to an agency's broader programming.

> The emphasis is on making and implementing case-specific as well as agency-wide service plans, priorities, and decisions about resource allocation that contribute to the goals of continuity of care, stability and permanency in the lives of children coming to the agency's attention (p. 9).

I am aware that social workers are involved in arranging a "care plan" for each child and the discussion here on permanency planning is by way of supporting that measure and emphasising the need for a wider appreciation at policy level for this type of practice. A final remark here would be that in the circumstances where a child has to be permanently removed from his or her home, adoption can now be an appropriate response, if a reasonable assurance of security and continuity for the child could be obtained by the social workers. The supports in the community should be sufficient and efficient enough to cope with all other emergencies.

Social Worker Mobility

The question of movement of social workers is one which needs comment before completing this study. In this study, particularly in Limerick, the responsibility for placement of a number of the children in care in 1989 was not that of the currently employed social worker. Comment was made to me by the present social workers about the number of changes in personnel in a very short time. Standards were improving in such matters as file information, but ways must be devised of lessening the harmful effects of social worker movement. Parker op. cit. (p. 89) suggests four ideas which may be of help:

(i) Crucial decisions about children in care might more often be made by a small *group* of key people.

(ii) By extension of this argument it will be important to consider carefully *who is most likely to remain*, and secure their particular involvement.

(iii) Sharing continuing responsibilities and commitments with *others* – some form of shared responsibility should be examined alongside the problem of mobility.

(iv) Care should be taken that if too much dependence is on senior staff with special skills in the children's field then there may be an even greater upheaval when they *do* move, especially if they are not easily replaceable or if other staff have not extended *their* skill and experience of this aspect of work.

The child care review system of the Mid-Western Health Board, properly implemented, would go a long way to meeting these suggestions.

One further recommendation which I feel needs to be stressed in the context of social workers is that staff mobility problems should be addressed through the development of permanent posts and a proper grading structure for social workers.

Summary

In summary, the object of all social work with children is presumably to keep them with their families if at all possible. In this preventive work, a programme of more family support services is required, so that no child would be placed in care because of inadequate income or accommodation. Marital counselling services including mediation and family therapy prior to or during the break-up of marriage would help first to counter disharmony and, second, to facilitate adequate and appropriate plans for care of the children being made within the separated and extended family and thus avoid reception into care. Where inability to cope has a wider

dimension than an economic one, support and advice should be available, where possible. A holistic approach to the family with problems is required in contrast to the present uncoordinated and inadequate service delivery. A family, however fragile, is embedded in a social and economic framework. Also, a family is a unique unit with unique needs and this has to be recognised if the family is to become the unit of service as envisaged in the *Child Care Act, 1991* through the family support services.

The intransigence of some people, the defeatism and despondency of others, are understandably very difficult to overcome. Social workers should have the resources to act when early warning signs are detected so that they would not have to work at crisis level, leaving them with only one option – to take a particular child or children into care.

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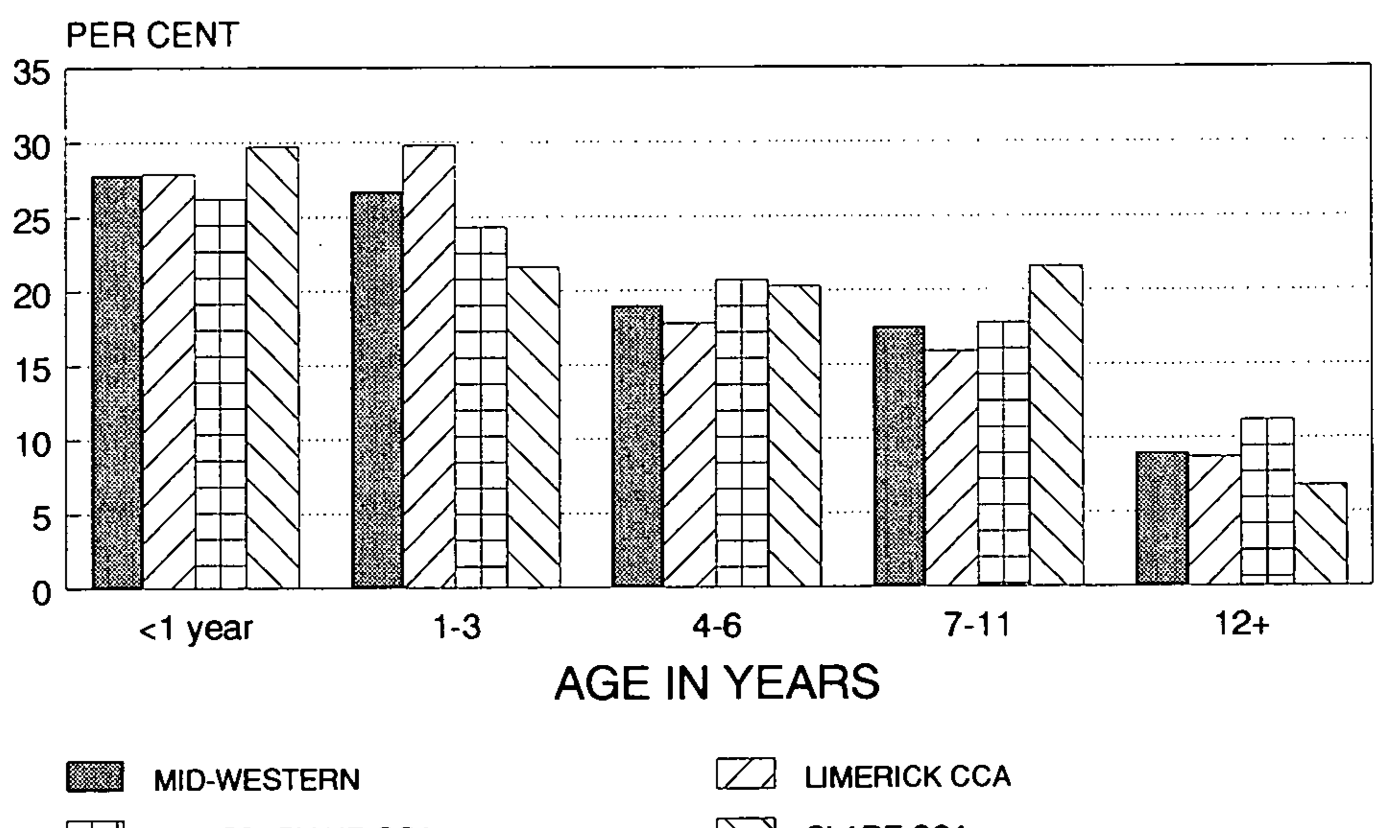
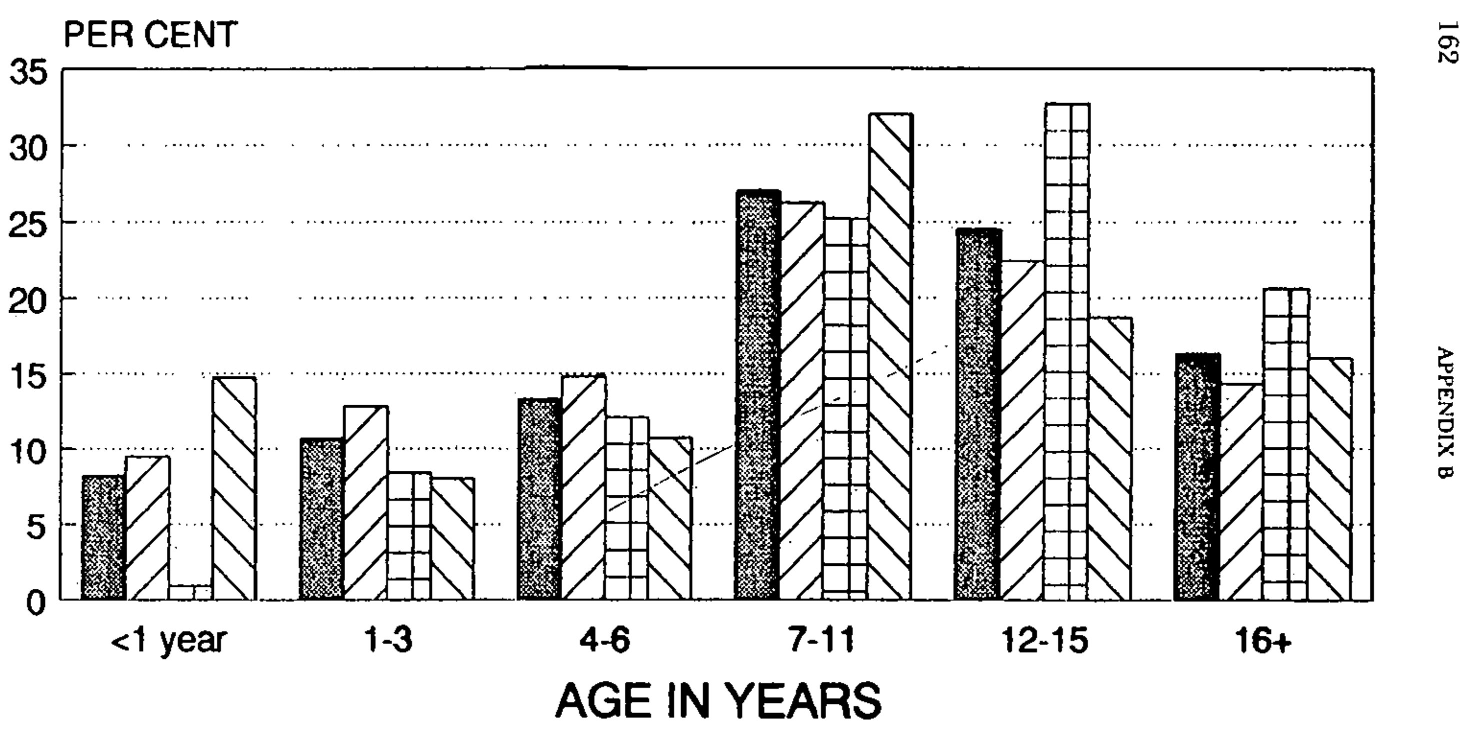

AGE AT ADMISSION
PER CENT
35
30
25
20
15
10
5
0
<1 year
1-3
4-6
7-11
12+
AGE IN YEARS
MID-WESTERN
LIMERICK CCA
TIPPERARY NR CCA
CLARE CCA


PRESENT AGE
PER CENT
35
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0
<1 year
1-3
4-6
7-11
12-15
16+
AGE IN YEARS
MID-WESTERN
LIMERICK CCA
TIPPERARY NR CCA
CLARE CCA

Education by Decade – Mothers and Fathers of Children in Care

	Education Level				
	No. Quals.	*Group/Inter Cert*	*Leaving Cert*	*Third level*	*N*
Mother's					
1980s	29	14	9	2	54
Per cent	53.7 (6.0)*	25.9 (17.0)*	16.7 (78.0)*	3.7	
1970s	87	9	1	–	97
Per cent	89.7 (6.0)*	9.3 (24.0)*	1.0 (70.0)*	–	
1960s	63	5	–	3	71
Per cent	88.7	7.0	–	4.2	
	179	28	10	5	222
	80.6	12.6	4.5	2.2	
Father's					
1980s	12	8	3	2	25
Per cent	48.0 (7.0)*	32.0 (29.0)*	12.0 (64.0)*	8.0	
1970s	52	2	2	–	56
Per cent	92.9 (9.0)*	3.6 (40.0)*	3.6 (51.0)*	–	
1960s	77	5	4	1	87
Per cent	88.5	5.7	4.6	1.1	
	141	15	9	3	168
	83.9	8.9	5.3	1.8	100.0

* Figures from School Leavers' Survey, Department of Labour.

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