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## From Family to Care: Issues for the Child

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**From Family to Care – Issues for the Child**  
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**Abstract**

It is still widely held that the traditional or conventional nuclear family is the only suitable environment in which children can grow up and that any deviation from this norm puts children at a considerable disadvantage (Kahan, 1989).

The vulnerability of children and young people coming into residential care in Ireland due to their dysfunctional family experiences, and how coming into residential care and their subsequent experience therein can sometimes further increase this level of vulnerability for the adolescent child has been well documented.

This paper discusses the question:

What can we, as residential child care workers and agencies, do to reduce the anxiety level of the vulnerable child coming into care, or at the very least, to ensure that this level of anxiety is not increased, during their admission and subsequent stay in care?

Before I attempt to answer this question, it is important to point out that there are many aspects of residential care which can effect the vulnerable child. It is not possible in this short paper to consider all those aspects. However, I concentrate on those issues which I, as a social care practitioner, feel to be important.

I discuss what I term influencing factors or macro issues. These factors can have an adverse affect on good residential child care practice. Next I critically analyse current practices issues in residential care based on my own personal experiences and on discussions with child care workers and students in a variety of settings. The views expressed are not intended to offend but rather to encourage self-evaluation and debate in order to improve our professional practice (see McElwee, 1998). I will conclude with suggestions and recommendations as to how we can endeavour to provide a better service for the vulnerable child in our care.

### **Introduction**

I begin by examining some of the macro issues involved in attempting to construct a National Child Care Policy.

In a recent address to delegates attending the first of a series of Millennium lectures organised by the Lillie Road Centre (a London based group of residential homes for adolescent boys), Gilligan made the following opening statement, “much of our child care system is close to breaking point because of inadequate resources and planning”.

He elaborated “the crisis is such that the state frequently finds itself with no proper placements to offer individual children who are urgently in need of care”.

Gilligan provides some interesting statistics:

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Between June 1995 and May 1997, 135 children in need of care but who were not sick spent an aggregate of more than 3,000 days living in hospital wards. (because the state could offer nothing else).

In 1995, 1,636 referrals were made to the Eastern Health Board's out of hours service. One fifth of these spent the night in B&B accommodation. In 55 cases the child had to spend the night in a Garda station because of no alternative.

Nationally, at least 15 children at any one time are placed outside the state in the North, UK, or USA.

The resulting factor of all this, of course, is that residential care placements are at a premium. Over worked social workers are under severe pressure to find placements and often end up making the same application to a number of different types of agencies without proper regard to the individual needs of the child. Consequently, a child can be misplaced. For example, children who require placement in high support units are being referred to low support residential homes because of the severe shortage of high support units and the consequent long waiting lists. This results in the child's placement breaking down very quickly due to their disturbed behaviour and the inability of low support units to cope with this behaviour.

So what is happening at National level to address these issues? The

implementation of the 1991 Child Care Act is to be welcomed, as are the Dept. of Health Child Care (Standards in Children's Residential Centres) Regulations 1996 and Guide to Good Practice in Children's Residential Centres. The passing of the 1996 Children Bill into law to replace the 1908 Children Act is eagerly awaited by some and dreaded by others!

Unfortunately, however, 28 years after the publication of the Kennedy Report and 18 years since the final Task Force Report, Ireland does still not have a national child care strategy. When recently asked by the UN Commission on the Rights of the Child whether the State "has adopted or is planning to adopt a comprehensive national strategy for children", Liz O'Donnell, the Minister of State with responsibility for child care made the following reply, "To date our concentration has been on dealing with individual issues. Eventually it would be our intention to draw a wide range of individual developments together in the context of a national strategy". In effect she is describing what Mintzberg (1989) terms an "adhocracy" i.e. an ad hoc approach to strategy formulation that is dictated by the next crises to emerge. So how does this affect the domain in which residential childcare workers operate?

**Resources:**

The lack of a national strategy invariably leads to a lack of planning which in turn leads to a lack of or poor distribution of resources being made available to the

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child care system. This squeeze on resources is felt by all childcare agencies and social work areas but is particularly felt by those working in the voluntary sector. These agencies have to justify their existence from year to year in complex negotiations with the various health boards. The shortfall in funds has to be made up through fundraising and generous donations. The upshot of all this is that the vulnerable child in care suffers. This renders many of the excellent recommendations outlined in the Guide to Good Practice redundant. For example, how many child care centres are in a position to offer children a choice of menus for their daily meals; to access medical and psychiatric services when they are needed; or to purchase clothes for a child as and when they are needed and not when the budget allows us to?

Lack of resources in Community Care Areas also impact on residential care. I spoke recently with a Team Leader from a Community Care Area in the Eastern Health Board region who told me that his area alone has 40 children in residential care without an assigned Social Worker. This is poor practice from a child protection viewpoint as a Social Worker may be a child's only advocate outside the residential centre.

Another difficulty with scarce resources is that it can often lead to individual agencies having to make their own cutbacks. Inevitably it is the vulnerable child in care who suffers. A general shortage of resources was identified by the

Staffordshire Child Care Inquiry 1990 as one of the contributory factors, which allowed the “Pindown” regime to flourish. I will return to “Pindown” later.

### Staffing Levels

The current staffing levels in residential care in Ireland are, to say the least questionable. Although the various Health Boards pride themselves on having achieved double cover for all residential units, this is simply not enough if childcare workers are expected to provide proper care and supervision for the vulnerable children in their care. In two of the houses in my own organisation, 2 staff are expected to cater for the individual needs of 10 boys every evening. How can they practically do this? The truth is they can't. If one staff member is dealing with one boys individual needs, it means the other staff member is left on their own with 9 boys! Apart from anything else there is a safety issue here. The only solution is to deal with the boys in groups. Thus we miss the vulnerable child that is being bullied, the one who is worried because his mother didn't phone, the one who needs help with his homework, the one who needs to be specialied because of his aggressive acting out behaviour, the one who wants to disclose that he has been abused, the one who is anxious and confused about having to leave care, etc. The list goes on and on. So in effect through no fault of our own, we are doing little to address the anxiety level of the vulnerable children in our care.

Many of agencies rely on the goodwill of placement students to fill in the gaps in



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their staffing levels, a point noted by McElwee (1996) “they provide a very valuable service to many agencies. They often work for free and return to their placements to assist supervisors if they are called to do so, even when they have moved into another area of work and another year of training”. If this is the case, and I suspect it is in many situations, not only are students being exploited, but also the children in our care are experiencing a transient staffing population. This is hardly conducive to them establishing proper relationships with their carers and thus experiencing some stability in their lives.

### **Gender Balance**

The various cases of child sex abuse that have emerged in residential care in recent years from Madonna House to Dave Murray to St. Joseph’s, Galway and other investigations currently ongoing, has resulted in a decline in the number of male workers applying to work in residential care for fear of allegations being made against them. Indeed this trend is reflected in the third level training colleges. For example, in year one of the Social Care course in WIT out of fifty students only four are male. Compare this to my own class in 1986 in DIT where out of 22 students, 12 were male. McElwee (1997) states, “this has important ramifications for the potential role models for children in care as many have had very negative experiences of adult males in their lives and it is essential that they are shown there are adult males who will give them positive experiences.” In the Eastern Health Board area alone, there are several units operating without any male staff.

This is a trend that needs to be reversed urgently.

#### Practice Issues

##### The Admission Process

Richardson (1985) notes, “there can be little doubt that admission to residential care is a traumatic experience for the child and his parents. The child is separated from familiar surroundings, familiar people and placed in a strange environment”.

So how can we make the experience less traumatic for the child?

It is accepted that at times there will be emergency admissions to care for various reasons, and where possible, residential centres should facilitate these provided that applications to designated emergency units have been made and rejected. In the main however, a child's admission to care should be a planned and structured transition, involving the parents where appropriate, over an agreed period of time to allow the child to adjust to their new surroundings. During this time the child should be invited to visit the house on a number of different occasions in order to meet the staff and other children. The obligation is on the staff to welcome him and sensitively familiarise him with the routines of the house, thus reducing his anxiety level. I use the word sensitively because I have witnessed and heard of situations where a child, during a visit to his proposed new home, has been more or less threatened that if he doesn't adapt to the regime of the house, then he won't last. Not surprisingly, many children in these situations resist coming into care for

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fear of what might happen to them.

If the admission process is rushed, as is often the case, it can have a detrimental effect on the child settling into care. An example of this recently occurred in one of our own units. A young adolescent was admitted two weeks before the agreed date because of pressure from the agency he was moving from. He was not yet used to his new environment or to the other boys in the house. Consequently he engaged in a lot of acting out behaviour in an attempt to impress his new peers. He was expelled from school after just two days for stealing the teacher's purse, the contents of which he divided between his new found friends. Over the following weeks he continued to act out and continued to steal money and other items from the house and from local shops and residents. When attempts were made to limit his behaviour, he ran away from the house. Following some excellent work by his social worker and the care staff in the unit, he returned to the house and thankfully, six months into his placement has finally settled.

### **Institutional Rules**

Following his/her admission to care there will be a settling in period for the child during which the rules of the house will be explained. Settling in periods can vary from centre to centre and can range from half an hour to a week. Some care workers are very eager to tell the new child about "the way we do things around here" and that they "must obey these rules or else". Can you imagine how

intimidating this approach must be for the child? But the reality is that it happens. Others take a more sensitive approach allowing the child to become comfortable with their surroundings and with the other residents and letting them discover what the formal and informal rules and routines are. They will generally find these out from the other residents who invariably know them better than the staff anyway!

Rules are necessary for the smooth running of a group living situation and this should be explained to a child when he comes to live in the unit. Adrian Smith of the Discipline for Learning Programme advises that there should be no need for any more than six basic rules. Any more than this and the child can become confused and frustrated. Yet I have worked in centres and visited others where there are a multitude of rules. And some make no sense whatsoever other than to serve the needs of the staff working there. This is where rules become dangerous, where the needs of the staff are given priority over the needs of the children. Then we are in danger of getting into the realm of institutional abuse. The amazing thing about these rules is that there is always someone who can justify their existence.

For example, I once worked in a setting where everyday at 6.30.p.m. all the adolescent residents had to go to their room for one hour. During this time they either read, listened to music, or slept. The staff would retreat to the staff room to drink copious amounts of tea and coffee, smoke their brains out, and generally have a good old natter about anything other than the children. Believe it or not this

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period was known to both children and staff as the “Happy Hour”. The question needs to be asked who was happiest during the hour? This happy hour was justified by staff and management alike by saying that it was good for the boys to have space to themselves for the hour to give them time to reflect on their day, etc.

Another example of an institutional rule I experienced was where children were not allowed get up before 10.00.a.m. on a Saturday. I don’t know about you, but as a child and indeed a teenager I used to love getting up early on a Saturday to watch TV. Indeed my own kids get up at 7.00.a.m. on a Saturday. I have to drag them out of bed at 7.30.a.m. on schooldays! The justification for this rule was that the children needed their rest. In actual fact it was so the staff could have a big fry up for breakfast before they were disturbed by the children.

Who is to blame for allowing such rules to develop? Is it the management of the agency? Is it the staff? The truth is that is the fault of both management and staff. Management through lack of proper supervision have allowed staff to develop rules which are not always in the best interests of the child. Staff for not questioning their colleagues and management about the purpose of these rules. I remember starting my career as a young care worker and not questioning the ethical principles behind some bizarre rules I encountered, because I was new to the job and was eager to please my colleagues and superiors. I actively participated in enforcing these rules because “that’s the way we do things around

here”. So equally young care workers and students must share some of the responsibility for allowing these rules to continue.

### Caring Styles

Once a child has settled into his new home, the honeymoon period is over, and he begins to feel comfortable with those around him, he will begin to interact more with the staff and other children. This interaction can be in the form of talking or in the form of behaviour. It’s at this stage that comments begin to appear in the daily log or at changeover meetings such as “John is beginning to show his true colours” or “Mary is coming out of her shell”, or indeed “Paul is getting a little too big for his boots. He needs to be taken down a peg or two”. Why do we feel this way? Heuston (1997) notes, “it is a sad travesty of the adult world that it does not enable its members to perceive troubled behaviour as symbolic distress”. Instead we tend to view the behaviour as something negative and thus potentially threatening to the status quo. We become obsessed with “nipping it in the bud” to coin another residential care phrase. (There is an issue here about the language careworkers use but it is not within the remit of this paper). Unfortunately this obsession with just dealing with the behaviour exhibited can develop into a power struggle between us and the child, and consequently, we can very easily lose sight of what is causing that behaviour in the first place. (See Appendix 1)

Dallos (1981) identified three main caring styles that are generally used in

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residential centres. These are a) Love Withdrawal, b) Power Assertion, and c) Induction. Love withdrawal stresses the importance of emotional contact between the child and carer. When a child does something wrong the carer withdraws their attention and lets the child know how personally disappointed they are in them after all they have done for them etc. In other words, emotional blackmail. The aim is to use guilt or shame to induce a change in behaviour. If you use this type of technique you have overstepped the boundaries of the professional relationship into a personal one. Research has shown that the use of love withdrawal can cause acting out behaviour as the child views themselves as having been rejected.

Power assertion involves the use of power and a system of tangible rewards and punishments as a means to effect change in behaviour. Unfortunately as with most behaviour modification systems, it is not used properly and carers tend to concentrate on punishing negative behaviour as opposed to rewarding the child who is behaving well. Skinner (1971) found that the use of force and punishment to repress a response or set of responses will occasion counter controlling efforts on the part of the punished individual. Furthermore, it will induce a hatred of the punisher consistent with associative learning. The most publicised case in recent times of the use of power assertion in an attempt to change behaviour was the Pindown regime investigated by the Staffordshire Child Care Inquiry 1990. Pindown was the brainchild of a Social Worker, Tony Latham. (See Appendix 2)

Induction emphasises explanation and reasoning with children in order to make them aware of the consequences (impacts and repercussions) of their actions. Induction is based on a relationship model wherein the worker takes responsibility for that relationship. Studies have shown that of the three styles, induction is associated with the highest level of learning and moral development. (See Appendix 3). A recent bulletin on the CYC-NET confirmed that the single biggest contributor to a child's positive experience in care is the relationship he forms with his carers (McElwee, 1998).

#### Care Planning

The Guide to Good Practice in Children's Residential Centres states that each children's residential centre should ensure that:

- a care plan is prepared for each child which is tailored to their particular needs and which is reviewed regularly;
- each child's social, personal and practical skills are continuously assessed and any deficits are addressed in the care plan;
- children's views and opinions are sought and help to inform care practices and care planning.

How many residential centres have care plans for their children? I don't have the



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answer, but I do know that in my own organisation we only introduced them recently and are still experiencing teething problems. The care plan is imperative in helping to reduce the anxiety and confusion for the young person in our care and indeed for ourselves. Everybody is clear about the direction the child's life is moving in and what each party involved in the care plan is responsible for doing. The care plan can be divided into short, medium and long term goals.

Who should be involved in the care planning process? In my opinion as many professionals as possible along with the young person and their parents where appropriate. I note the words of Gerry Doyle who opened our conference in Limerick two years ago. For those of you who weren't present, Gerry spoke as a young person who spent most of his 18 years in care. He said and I quote " unless the commitment to progress and improvement comes from the child themselves, all the support, advice and encouragement in the world is futile." So it is of the utmost importance to involve the child in the process. Let them have a say in their future.

When should the care plan be formulated? Some agencies start the process prior to the child being admitted to the unit, while others wait until he is actually admitted and have had a chance to assess his individual needs. The important point is that whichever method is used it must be needs based and it must be reviewed on a regular basis to ensure there is no deviation from the plan. Plans for leaving care

and subsequent aftercare should be incorporated into the long-term care plan.

A good care plan can go a long way to providing a certain amount of stability and predictability for the vulnerable young person in our care.

#### Complaints Procedures

“Children in residential care need to be able to express their unhappiness or complain about their care, where appropriate”

(Guide to Good Practice in Children’s Residential Centres, DoH, 1997).

A lot of child care workers and agencies get frightened when they hear about complaints procedures for children. The fear is that the children will complain about everything and everyone and indeed, this has happened in some cases. A lot depends however, on how a complaints procedure is introduced to the young person and what it is called. For example, in Focus Ireland “Off the Streets” project, the young people are told on admission to the unit that there is an issues procedure that they can use if they have any issues they wish to raise during their stay. Straight away the use of the word “issue” instead of complaint sounds less threatening to staff. It also compels the young person to use the procedure in a responsible manner while at the same time letting them feel they have a voice which will be listened to.

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If there is criticism about some element of our practice or a house rule that makes no sense, we have to be able to hear it, for it is only through such criticism and feedback that we will continue to develop our professional practice. If we were a business, the child would be our customer. What do blue chip companies do? They listen to their customer and tailor their product or service to meet their customers need. Again I quote from Gerry Doyle, “in recent years there seems to have been a move towards utilising feed-back as a means of evaluating residential care and highlighting areas for improvement. I believe this is a very positive activity because it leads to an awareness about where care is succeeding and where care is falling short.”

#### Recommendations

##### Macro Issues

As a professional association the IACW should continue to lobby for the development of a national child care strategy, increased resources and staffing levels. Entering into a partnership or working alliance with Government Departments can do this.

That the IACW launches an education campaign aimed at Leaving Certificate Students to try and redress the gender imbalance in third level childcare courses.

##### Practice Issues

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Standardisation of admission procedures to residential care across all health boards to ensure a child's transition from family to care is as painless as possible.

That care workers and managers begin to examine the rules of their agency using the question "is this rule in the best interest of the child?" If it isn't we have an obligation to change it.

That care workers and students begin to question and challenge colleagues and managers about practices you suspect might be unethical. Don't be afraid because you are new to the job. At the end of the day, regardless of your experience, you must always act to protect the vulnerable child in your care from any form of abuse.

That we try to look beyond the behaviour of the troublesome child to try and understand what is causing him/her to act in that way. That we develop a caring style where we, as professionals, hold responsibility for the relationship with the child. There are many training courses now available, such as TCI, to help us deal with troublesome behaviour in a therapeutic manner.

That each child entering residential care should have a care plan outlining short, medium and long term goals, and that this care plan is reviewed on a regular basis with all relevant professionals and parents present.

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That each child on entering residential care is informed of their right to complain about any aspect of their care and assured that their complaint will be taken seriously.

That we as professional care workers begin to seek and act upon feedback from children in order to improve our practice.

In conclusion, as previously stated, when researching this paper I quickly realised that there is so much to write about in order to cover all aspects of residential care practice, which affect the vulnerable children we work with. I also realised that even though the Government is dragging its heels in developing a national strategy, we as a group of professionals have come a long way in the past 15 years. Our practice is more informed by theory, but equally theory is being informed and updated by practice. Long may this reciprocal learning continue. We must continue to believe in ourselves as a profession and continue to advocate for the children we care for.

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