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STATE CARE – SOME CHILDREN'S ALTERNATIVE

An Analysis of the Data from the Returns to the Department of Health, Child Care Division, 1982

KATHLEEN O'HIGGINS
and
MAURA BOYLE

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Kathleen O'Higgins is an Assistant Research Officer with The Economic and Social Research Institute. Maura Boyle is a former Research Assistant at the ESRI. The paper has been accepted for publication by the Institute, which is not responsible for either the content or the views expressed therein.

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GENERAL SUMMARY

In a climate of increasing concern for the rights of children, the situation of children in State care in Ireland is an appropriate area of study. Research on children in care elsewhere has emphasised the possible serious repercussions, on personality development and the acquisition of social maturity and skills, of separation from one's family, particularly through placement in residential care. The problem behaviour to which this could give rise is a matter of concern for the whole society.

The study of children in the care of the State undertaken here is that of children "in need of care and protection". The data were provided by the Department of Health, Child Care Division, from questionnaires completed by social workers involved in family/child care work in the 32 community care areas of the Republic.

The study concentrated on three groups of critical questions which suggested themselves – (i) what are the socio-demographic characteristics of children in care, e.g., age, sex, birth status? Do they differ from the general child population and if so, is this governed by the area of residence? (ii) what factors combine to culminate in the placement, discharge or retention of a child in care? Again, has area of residence been significant in dictating the probability of placement, discharge or retention in care? and (iii) what types of care are available and what criteria are used for the placement of any child in any particular type of care? How significant is area of residence to the type of care decided on for any child?

From the analysis of the socio-demographic data, the most striking finding was the very large proportion of young illegitimate children in care relative to their proportion in the population. Other findings were that Health Board regions can differ significantly in the ages of children in their care; that the lower the incidence of illegitimacy in an area the higher the likelihood of illegitimate children being in care; and in the case of legitimate children in care, they come from larger than average families.

Turning to the factors that culminate in the placement, discharge or retention of a child in care, the author found that where admissions were concerned, the data suggest that the younger the child at admission the more likely they were to be from a one-parent family unable to cope. Adolescents come into care for different reasons than do younger children and it was found that older children came into care because of being out of control or, almost as likely, to have been victims of an abusive home environment. Although legitimate children were placed in care for a greater variety of reasons than illegitimate children, this

may well be only an artefact of the designation of most illegitimate children as coming from one-parent families unable to cope. The data here were limited in that only one reason for admission was given, and the categories of "reason" were not mutually exclusive. Thus information on the accumulation of circumstances which results in a child coming into care is lost. For instance, illegitimate children could be abused or neglected because single mothers could not cope financially and/or emotionally with them, but they would possibly be included in the category "One-parent family unable to cope". Legitimate children in similar situations, would have been actually recorded as abused or neglected, whichever was relevant. It is felt that the category "One-parent family unable to cope" is a catch-all one. It is highly likely that one-parent families are truly over-represented in the numbers of their children in care, but the category here may not give an accurate reading of the situation.

Some increase in the numbers of children placed in care because of abuse or neglect was recorded. It is to be hoped that this is due to a higher level of reporting than that the actual incidence is increasing. Where active parental abuse was a reason for admission the family was more likely to be a large one.

It seems clear that, overall, most children who enter care do so not because of behavioural problems, e.g., being out of control, but because of situational difficulties that affect their families from temporary illness to homelessness.

Coming to reasons for discharge, the vast majority of children, particularly younger children, irrespective of their birth status, were discharged to a family situation. No significant difference occurred between the reasons for discharge and the sex of the child. In the case of birth status the differences were not highly significant. However, when those placed for adoption were excluded from the illegitimate group, a lower proportion of illegitimate children were discharged to families and relatives than legitimate children and a much higher proportion left care having reached the legal age limit. Children from large families were least likely to be reunited with them after discharge from care.

Significant differences occurred between the reason for admission of those discharged in 1982 and the length they spent in care. A long-term or permanent split from his/her family of a child in care appears much more likely if the child is older at admission. Studies elsewhere have also found that those who linger in care are mostly adolescents irrespective of the build-up of years in care. Children, from families where there was active parental abuse, were orphans or abandoned, spent longer in care than children admitted for other reasons. No doubt, there was a difference in the reaction of social workers to discharging these children, in that those orphaned or abandoned had no families to return to and alternative families would have to be found. On the other hand, with

children from an abusive family background, although their families were available to take them, there was possibly reluctance on the part of social workers to return these children until they were satisfied that the situation in the home was suitable.

An area of particular concern in the discharge of children from care is where young people leave care on reaching the legal age limit. This is a grey area and it is not clear what happens to a number of these young people. *Streetwise,* a symposium on homelessness, pointed out that young people who have been in care form a significant group of the homeless population.

The finding on length in care – that the longer a child remains in care, the less likely he/she is to be reunited with his/her family – confirms the findings of other studies. Length in care was not related to sex or birth status, but significant differences occurred between areas. Voluntary admissions spent a significantly shorter time in care than Court Order admissions but, again, children admitted on foot of a Court Order were older at admission and this may be more important than the basis for admission in predicting length in care.

Significant differences occurred also in the reason for discharge and the type of care in which a child was placed. Where children were discharged to relatives, they were most likely to have been in short-term care, and where they left care because they had reached the legal age limit, the opposite was the case.

Differences in reason for admission, discharge and retention of children in care occurred between all the Health Boards. For instance, differences occurred in the proportions of children placed for adoption, the proportions of children reunited with their families on discharge and the proportions of children retained in care because of being from an abusive family background.

Probably the most serious problem to be considered in a study such as this is that of children in long-term care. A high proportion of children had been in care for more than one year. More information is needed on the "One-parent families unable to cope" from which 44 per cent of these children originally came and why, nearly two-thirds of the parents who could not cope originally are still more or less in that position. It must be asked whether or not these parents were followed up during that time and assisted in their difficulties. If one adds children admitted from an abusive family background (27 per cent) the proportion of children in long-term care from these two categories is 71 per cent.

The author then contrasted children in long-term care with those in short-term care. There were different reasons for admission in each group. Also children in long-term care were older at admission and consequently older now; more were admitted by Court Order than children in short-term care; they came from larger families and had more of their siblings in care.

Following on reason for placement, discharge and retention in care is an analysis of type of care in which children are placed. In the case of residential care the importance of ease of contact for parents must be emphasised. The rationale for this emphasis comes from available evidence that problems arise where contact is concerned (a) for the social workers in finding a suitable placement, and (b) for the parents of the children placed in care. In the cases of children in residential care there are some problems for parents which are not usually taken into account. For instance – something that might be regarded as minor in another context can arouse considerable anxiety in the parent – can the child be kissed and hugged, and should the parent correct her/him if she/he misbehaves or leave it to the residential staff? These and other tacit factors often discourage contact. This is unfortunate since studies elsewhere have shown that visited children are more settled in their placements and better adjusted, socially and psychologically.

Relevant questions on type of care are: (a) what significant differences occur between children in foster and residential care and (b) what are the consequences of those differences. Where age at admission was concerned it became obvious that younger children were more likely to be found foster homes, whereas older children were admitted to residential care. The reason for this was suggested as being that it was more difficult to find foster homes for older children. Since legitimate children come into care at an older age than illegitimate children, they were then more likely to go into residential care. Even though the proportion of illegitimate children in residential care increases with age, it still remains much lower than the proportion of legitimate children in residential care in the same age group. For instance, 36 per cent of illegitimate children in care in the 7-11 year age group were in residential care compared to 71 per cent of legitimate children. Gender appears to be of no significance in the type of care allocated to a child.

The differences between the Health Boards and the difficulties in explaining these differences occur again here on the types of care each Health Board allocates to its children in care. Some Health Boards have much higher proportions of children in residential care than others.

Children in residential care were focused on briefly to establish the reasons why they were in residential care. In only a very small proportion of cases fostering appeared to have been tried and failed and in nearly half the cases (44 per cent) a blanket response that residential care is best suited to the child's needs, giving no detail, is made. It seems, however, from this study that age and birth status are more critical to the type of care than that residential care is most suited to a child's needs. It is possible that older legitimate children are seen as difficult

to place in foster homes. With the possibility also of the child having siblings in need of care, a residential home might be regarded as best suited to the needs of the group of children, if they could all be kept together. This does not always occur and indeed differences of opinion arise on merits or demerits of placing siblings together in care. Some do not regard it as a good reason for placing children in residential care.

Children from small families or lone children were more likely to go into long-term foster-care. However the relationship between size of family and care type may be a spurious one, since legitimate children have a greater number of siblings anyway. It seems that although family size is a factor in care type, age and birth status have a greater effect.

The author examined basis for admission and it seems that children who enter care through a voluntary placement are more likely to be in foster care than children placed in care on foot of a Court Order. Possibly children placed on foot of a Court Order may come from more difficult backgrounds, and are older as has been shown, so may be seen to be more appropriate for residential care.

So what are the likely consequences of any differentiation between children in foster and residential care? It is difficult to assess the consequences for the children of the differentiations in care type. However, studies have continually found that care in general, but residential care in particular, can be psychologically and emotionally damaging to a child. Therefore, it may be accepted that if care is necessary, foster care should be the first option. This has been the case even though some Health Boards appear to have had less success than others in finding foster homes for the children in their care. Now that the provision, allowing a Health Board to place any child in its care in foster care, is included in the new 1987 *Children (Care and Protection) Bill,* an increase in the number of placements may be seen. One group particularly vulnerable to placement in residential care appear to be older, legitimate children, who, almost always, are placed in residential homes. More detail on the reason why this is happening would be useful to enable suggestions to be made on how numbers might be reduced.

Finally on types of care, there was no information available on the different placements a child might have had. A child now in residential care might have been in foster care first since entry into care or may indeed have been in another residential home. There is hidden discontinuity and disruption here which would be regarded as the most damaging aspect of care. The need for provision of stability of placement is emphasised in other studies elsewhere.

To complete the study the author discussed relevant issues in the area of children and young persons in care. There is a problem for Ireland in funding

social services since having higher transfers to families than other EC countries, it has to levy higher taxes to fund those transfers. However, it has been argued that transfers to support families may cost less in the end. Where a child has to be placed in care because of family problems or breakdown, it usually costs the State more to support this child in care than if the family had been enabled to keep the child at home.

To sum up, the prevention of children entering care through lack of family resources would be one of the aims of family policy. Then if the child must be placed in care it would only be where all else had failed and a new permanence and continuity for that child would have to be found. Above all, what is needed is a coherent workable family policy. This has been called for many times in the past (notably in the *Task Force Report,* 1980), and the absence of such a policy negates or seriously undermines the ability of social workers in the field to help families and, in this case, to support them so that their children will not have to be placed in care.

INTRODUCTION

Setting

This study is set within a framework of an evolving concern for children and their rights. De Mauze (1974, p.42) asserts that "the history of childhood is a nightmare from which we have only begun to waken". "The further back in history one goes" he continues "the lower the level of child care and the more likely children were to be killed, abandoned, beaten, terrorised and sexually abused". Within this evolution of concern for children in general, a study of children who have been placed in the care of the State is particularly relevant. In Ireland, the concept of the child in the care of the State developed from the efforts of private groups at the end of the eighteenth century to help orphan and other destitute children in need of care. We will look more closely into subsequent developments in the next chapter.

Any expression of concern about children being removed from their family of origin and placed in State care implies that the family is the proper setting for the socialisation of children. The basic assumption is that the nuclear family forms the best environment in which the socialisation of children may be carried out and empirical evidence shows that people put a positive value on the family as such, and on certain of its characteristics. (See, for instance, Farmer, 1979, p. 208.)

The *Task Force Report on Children's Services in Ireland* (1980, p. 2) states that if a democratic society such as ours is to fulfil its obligations to children it must *protect the rights of all children; it must also support the family, and provide services and facilities* for children to meet those needs which the family is unable to meet. "If the norm and the ideal is that a child should grow up within a caring family, then efforts will be directed towards enabling this to take place or, failing that towards enabling the closest approximation to a caring family to be provided" (p.8). Kornitzer (1968, p. 11) notes that there are no real criteria for success or failure in family life, some families do fail either permanently or temporarily in one of their primary functions — that of rearing children, and it is with some of these children that this study is concerned.

In a study such as this, types of family other than the nuclear family have to be considered. While the Constitution does not define "family", the Supreme Court has ruled that the term relates only to a family founded on marriage (see *Task Force Report,* p.213). An unmarried mother and her child, for instance, are not a family within the meaning of the Constitution. This concept of the family has been questioned and calls have been made to have one-parent families, whether a lone mother or a lone father, unmarried to the person with whom

they are cohabiting, or unmarried people living with their child or children alone, recognised as "valid" family types. For the purposes of this study, a mother or father and her or his illegitimate child or children are considered as a family, and placement in care of any of these children is included as one type of family failure.

When children are taken into care, it may be on one or other of two legal 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 received 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's Act (1908) Section 58. A child may be placed in care in the following situations:

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

The situation 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. This particular study is concerned with children at present in the care of the State, because they have no family or their family cannot or will not look after them, either permanently or temporarily i.e., those children in category (iii) above. Therefore, the definition used in this study for a "child in care" is of a child in the care of a Health Board, whether placed in a setting outside of 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 all in care, which *may* include young persons up to 21 years of age[1]. Children in need of care and protection are generally those who lack proper care or guardianship, and against whom offences, such as neglect, ill-treatment, assault or abandonment have been committed. Such offences would be likely to cause unnecessary suffering or injury to health.

Purpose and rationale for the study

Let us now look at the purpose of the study and the rationale for undertaking such a study. The research questions which arise will first be stated briefly and will then be extended and hypotheses formulated based on the literature.

The main purpose of the study is to identify from the data available: (i) What

1. Under the *Children (Care and Protection) Bill*, 1987 "for the purposes of the Act 'child' means a person under the age of 18 years other than a person who is or has been married". Some persons over the age of 18 appear to be in care – most likely they are in full-time education – therefore they are included in this study.

factors combine to culminate in the placement, discharge or retention of a child in care? (ii) What are the socio-demographic characteristics of children in care, and do they differ from the general child population? Do Health Boards differ significantly in their propensity to place children in care, and if they do, why? (iii) What types of care are available and what criteria are used for the placement of a child in a particular type of care?

The rationale for undertaking a study such as this 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 statement on the importance of a stable family setting for children has already been noted. Added to that, Farmer (1979, p.197) points out that before Bowlby's researches 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 on the acquisition of social maturity and skills, both of which could give rise to problem behaviour, a matter of concern for the whole society. Later Ayres (1985) was to contend that 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 the findings of Rowe and Lambert (1973), Packman *et al* (1986) and others. Another aspect of "care" is as Packman *et al* (1986, p.197) describe it — the "last resort" stance. Those authors feel that this defensive reaction to care actually contrives to reinforce the obvious faults in the child-care system itself, ensuring that public care is indeed something to be avoided. They add "A 'rule of pessimism' operated about the care system which meant that admission was sometimes almost unthinkable, until it became too late to think at all. 'Last resorts' are, after all, seldom desirable or constructive places to be." It is important to add of course, that in certain limited circumstances, care may be positive experience for a child (see, for instance, Berridge, 1985) but in general, it is accepted that taking a child into care is seriously disruptive and possibly damaging.

Little is known of the children in the care of the Health Boards who have been deprived of a normal home life, and who are seldom problematic; this is a group that excites less political interest, than say, children involved in crime. It is felt therefore, that an analysis of reasons why children are placed in care; of their socio-demographic characteristics; of the higher propensity of certain

areas to place children in care (perhaps explainable by the socio-demographic character of the area); and of the types of care available; along with an examination of the situation of children in long-term care, will enable us to come to an understanding of the constellations of circumstances which make certain children more vulnerable than others to placement in care. With that understanding strategic support services for families "at risk" may be suggested in order that in future only in particular cases where the family environment is never likely to be satisfactory will care be necessary.

Before looking in detail at the three groups of critical questions it is important to state the data sources available for this study and indicate the limitations of the data. The reader can then see the particular restrictions placed here on the responses to the research questions arising in a study of children in care.

The data available were from the 1980, 1981, 1982, and certain figures from the 1983 Child Care Surveys of the Department of Health. These data are based on a questionnaire completed by social workers in the eight Health Board areas. (Copy of the 1982 questionnaire is in Appendix F.) The questionnaire had Censal dates; 30 September in 1980 and 1981 and 31 December in 1982. They were not necessarily completed on these dates, however, so the information contained on them is correct at the time of completion, rather than the Census date. Certain information, i.e., date of admission will, of course, remain the same, but information on type of care could change, since a child might be placed in what is expected to be short-term foster care due to family crisis. The crisis might become a long-term problem, with the result that, for instance, the child might continue in foster care for a considerable length of time or indeed be subsequently changed to residential care.

The questionnaires have data on each admission to care during the year in question, and on admission from other years which continued into the relevant year. Therefore, if 1982 is taken as an example, the 3,675 figure, which is presented as the total in the Department of Health's report "Children in Care, 1982" represents all admissions which began prior to or during 1982, the ones prior to January, 1982 continuing into some part, or all, of 1982. Each child has an individual number so is never double or triple counted. It was decided, however, to base most of the analysis on the 1982 Census figures, that is, the children in care on 31st December 1982. These were the latest figures available at the time of commencing the study. The Census figure on 31 December 1982 is 2,446 children. This figure was arrived at by eliminating all children who had been discharged from care up to that date. It was assumed that this group was relatively representative of the group which might have been discovered to be in care on any particular date in 1982. The end of December is probably

not the best time to take a Census, since there may be pressure particularly on the residential institutions to return the children to their families for the Christmas period. The number in care may thus be understated, and may be biased towards the most problematic children. The 3,675 figure is used where appropriate.

Within the range of analysis offered by the data base, the Department of Health questionnaire findings, four independent variables are identified:

- age of child (including age at admission);
- sex of child;
- birth status of child;
- area – Health Board and Community Care.

Where appropriate, variables such as type of care, basis for admission, length in care, and family size were included in the analysis. Such variables as socio-economic status, family living conditions, parental age and health and many others, are of great relevance in respect of children in care. Concentration on the former variables does not deny the significance of the latter but is indicated by the child-centred orientation of the data. No details of any background factors are included on the questionnaire. However, much can be learned using the child-centred variables available to us.

Research Questions

The three groups of critical questions will now be stated in more detail. The first group is concerned with the socio-demographic characteristics of children in care.

(i) Here it is asked, when placement in care is deemed essential, what are the socio-demographic characteristics of the children who come into care as compared with similar characteristics in the total child population? What are the differences in terms of the children's age, sex, birth status, family size or area? By ascertaining the relative proportions of certain categories of children in care, and by comparing these to the corresponding relative proportions in the overall population, identification is possible of the socio-demographic characteristics of those who have a higher than average probability of being taken into care. Health Boards and Community Care areas may differ in their tendencies to take children into care, as well as in the care assigned to each child. If such differences exist, what accounts for them? How much of the decision to place a child in care is dictated by the underlying approaches which structure the programme managers' or senior social workers' decisions and his/her vision of "in need of care and protection"? Are there specific guidelines for social workers?

To answer the above questions data are available on such socio-demographic characteristics as: age (at admission and present age), sex, birth status, and area. In addition there are some data on family size. These data will enable an enquiry on: (a) At what age children are most likely to enter care? (b) Is any age group over represented in their proportion in care in comparison to their proportion in the population? (c) Is either sex more prone to placement in care than the other? (d) How important is birth status in probability of placement in care? (e) Are some areas more likely to place children in care than others? and (f) What size are the families of the children in care compared with the general population?

When considering the age of children in care and their age at admission, as Packman (1968), Crellin, *et al.*, (1971), and Hyman (1978) note a large proportion of the mothers of the children in care are very young. These studies found that this was particularly true of illegitimate children, so it is very likely that more children would be admitted to care in the younger age groups generally, with illegitimate children being particularly vulnerable in their earlier years. This is based on the assumption that if their mothers are young, the children are likely to be young also, even though there are no data here to confirm or deny this.

Sex is not mentioned as being a significant variable in any of the studies of children in care noted here.

Birth status was regarded as being a strong indicator of vulnerability to placement in care in a number of studies, some of which have already been mentioned (i.e., Packman, 1968; Crellin, *et al.*, 1971; Graham, 1980; Richardson, 1985; and Berridge, 1985).

Information on area differences is accessible through the reasons why children enter care in each Health Board, and on the socio-demographic characteristics of the children. The probability of a child coming into care in any Health Board can be calculated; and whether or not the differences between Health Boards are significant. Data are not available which would allow positive identification of what accounts for any differences occurring at a significant level, but some possible explanations can be suggested.

The variation between areas in the probability of a child entering or being in care is a problem which has arisen elsewhere and will be examined in the light of the findings of studies in Britain on this theme – studies such as Packman's 1968 and 1986 studies and that of Davies, Barton and McMillan carried out in 1972.

Deprivation and consequent vulnerability to placement in care is not limited to one birth status group, such as one parent families and illegitimate children. As Wedge and Prosser (1973, p.11) state, 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. McQuaid (1971) stresses that: "One does not have to convince sociologists or educationalists of how depriving an experience it is to be born into a large social class 5 family, underprivileged, badly housed, poorly provided for educationally and located in a sub-cultural delinquent area" (p. 164). Children from large and/or one-parent families, can be identified but no data are available on the other variables.

On this question of family size, Parker (1966, p. 61) found in his study that most of the children placed in care came from what might be regarded as "large families" and Packman (1968, p. 46) states "The large family is clearly heavily over represented [among children in care]..." Apart from the child being part of a large family, there is also the question of whether or not the child has siblings in care. Studies of children in care and child care statistics frequently give the misleading impression that only individual children come into care. Berridge (1985, p.32) found in his study that this was not so, for whole families are affected by the same problems and it was common for groups of brothers and sisters to enter care together.

It will be hypothesised here (i) that birth status will prove to be the most important socio-demographic variable in probability of placement in care; and (ii) that given the findings of other studies, areas are likely to differ significantly from one another in their propensity to admit and retain children in care. They will also vary on the age, birth status and other relevant variables such as basis for admission and length in care. Lastly, it is hypothesised that children in care will have come from larger than average families.

The second group of questions relates to the reasons why children are in care.

(ii) What factors combine to culminate in the placement, and then either the discharge or retention of a child in care? Further to this the question may be asked, what are the characteristics of each child by reason for admission, who is discharged and who is retained?; Does the reason for placement in care dictate the type of care in which any particular child is placed — are particular types of children more likely to be placed in one type of care rather than another? Then it must be asked, will this placement in care result in a better situation for the child than existed and will the child eventually be returned to a home better able to provide a stable background? Are the reasons for placement of the child in care due to adverse structural factors in the family's environment, i.e., poor housing, or due to inadequacies in the personality of the parent or parents or both? How long do children spend in care? Why

> are some children retained in care for long periods? Who are these children in long-term care (a) in terms of their reasons for being in care; (b) in terms of the available socio-demographic characteristics, age, sex, birth status, area and family size; and (c) in terms of the reason for retention in care? Is the reason the child is not returned home because the environment in the home has not changed since the reason for placement in care has not changed?

The available data, details of which are noted above, provide answers to only some of these questions. Information is available on one precipitating reason for admission to care, one reason for leaving and one reason for retention. Obvious constraints will be felt by this limited information. For instance, admission to care is seldom precipitated by one reason alone. Richardson (1985, p. 176) in Ireland and Berridge (1986, p. 35) in Britain evidenced this in their studies of children admitted to residential care, and no doubt, it would be equally applicable to admission to any type of care. In the absence of better data, however, one can only proceed with what is available. Further study would be required to include all the factors involved.

Some relevant studies will now be examined and some hypotheses suggested on reasons for placement discharge or retention in care.

While no recent or comprehensive study of the socio- demographic backgrounds of children in care has been undertaken, certain empirical indicators point to there being structured, patterned deprivation and vulnerability to coming into care – this vulnerability is generally agreed to follow social class differences. As far back as 1971, McQuaid showed 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. There has not been much change over time. Richardson (1984) reviewed certain indicators of the socio-economic backgrounds of a sample of children in residential care. Her findings suggest an over-representation of the lower socio-economic groups among her sample. Both of these studies are of children in residential care only, and no information is available on other types of care in Ireland. In the British experience, Berridge (1985, p. 104) for instance states: "Most children admitted to care today are victims of poverty and physical neglect..." but Packman (1968, p. 51) writing on the social class of the children in her study *(Child Care, Needs and Numbers)* stated 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. What it does suggest, Packman goes on to say, is that they 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, p. 4).

The class specific vulnerability to entering care, therefore, may not be explaining very much, but may be merely an artefact of limited options for the parents. However, since only a minority of all children are placed in care, any straightforward argument in terms of class background influencing 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. For the purposes of this study, the fact remains that evidence from other studies indicates that children in care appear to be overwhelmingly from deprived backgrounds, and it is with these children in care that we are concerned here.

This class specific vulnerability to entering care would result then in the high numbers of children from single or one-parent families, or broken homes entering care (e.g., see Richardson, 1984, p. 140), since O'Cinneide (1972) identified widows, and wives with absent husbands, as one of the groups which were particularly vulnerable to poverty. Sheehan (1975) showed that of those in her sample who were on the Home Assistance Register or receiving help from the St. Vincent de Paul Society, two-thirds were women. She further pointed out that widowed, separated and deserted women accounted for one-third of her sample and were a particularly vulnerable group in need of support, and thereby likely to be over represented among parents with children in care.

A woman may become a single parent through one of three circumstances, (a) bearing children out of wedlock, (b) being separated, divorced or deserted, and (c) being widowed. In the case of single mothers Nic Ghiolla Phadraig (1974, p.79) gives evidence to show that the climate of opinion has softened greatly towards unmarried mothers and their children and cites the introduction of the Unmarried Mothers' Allowance in the early 1970s as an indication of this. Nevertheless, Darling (1984) suggests that a comprehensive study of unmarried mothers would show that they are over represented among the poverty figures and that a higher proportion live in unsatisfactory or unsuitable housing. In her own study (although it must be remembered it is not representative), over 85 per cent of her sample of unmarried mothers had problems relating to housing or finance or both (Darling, 1984, p. 147).

Illegitimate births are relatively more important in the younger age groups of the fertile span; they are heavily concentrated among single women aged between 15 and 24 years and, in fact, account for about one-third of all births to women in this age group (Sexton and Dillon, 1984, p. 26). The Central Statistics Office shows that of the 2,958 births registered to teenagers in 1983,

54 per cent were illegitimate. The over representation of illegitimate births to women under 20 years is further highlighted by the fact that 2 per cent of all legitimate births in 1983 were to teenagers in contrast to 35 per cent of all illegitimate births being to teenagers. Children of all these young mothers are not necessarily children subsequently placed in care, but immaturity is more likely to lead to inability to cope both financially and emotionally and, therefrom, placement in care for some of these children. In a study in Britain (see Crellin, *et.al.*, 1971) the proportion of children with very young mothers was five times greater among illegitimate than the legitimate. Other findings of the study of Crellin, *et al.*, confirm those of different authors that illegitimate children who remain with their own mothers are likely to grow up in a poorer social environment than is the case for the population as a whole. Crellin, *et al.*, (op. cit., p.99) go on to say that, in addition, a high proportion were not only living in an atypical family situation, but in many cases a stable or constant father figure was not available. Again, previous studies have shown that children in atypical homes are at greater risk of deviant behaviour, learning, and other difficulties, because family relationships in such homes are more likely to be disrupted, disturbed or otherwise unsatisfactory.

One-parent families, then, especially those headed by single mothers, have been shown to have a higher than average number of problems in regard to finance, housing and support networks. Accruing from these problems, Richardson (1985) in the Republic and Graham (1980) in Northern Ireland both found that the children of one-parent families, generally, were vastly over represented among those in residential 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. 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 'illegitimate'. This simultaneous rise in the fertility of the unmarried is evident from Sexton and Dillon (1984, p. 26). In 1961 illegitimate births represented just 1.6 per cent of all births, while in 1982 (the year on which this study is based) that percentage had risen to 6 per cent. At the moment, the term illegitimacy refers to just less than 1 in every 16 of all births.

Furthermore, if one analyses illegitimacy rates in terms of age-specific fertility rates per 1,000 single and widowed women, 1955-1981, it is clear that "for all

age groups under 40 years, the rate of increase was approximately threefold over the 26 year period" (Clancy, 1984, Table 12, p. 28).

In this time of falling overall fertility rates, and rising illegitimacy rates, an increasing number of unmarried mothers are choosing to keep and raise their own children as indicated by the falling adoption rate and increase in Unmarried Mothers' Allowance Claims, (see Abramson, 1984, and Department of Social Welfare records). Therefore, the single mother headed household will become a much more substantial group than before.

National statistics in Ireland provide no information on the social class, as measured by occupational status, of the mothers (or putative fathers for that matter) of illegitimate children. This is also true of Britain where Gill (1977, p. 11) notes age, marital status, parity, social class and area of residence are given only for legitimate births. For illegitimate births marital status and parity are omitted and social class is provided only in Scotland. Omission of these important details, says Gill (p. 11) reflects and at the same time reinforces, the tendency to treat illegitimacy as a unitary phenomenon — first births to unmarried girls. In fact the population of illegitimate births is composed of a number of sub-categories. This is evidenced by the table on family size in this study (Table 3.16, Ch.3) where although the highest proportion of illegitimate children are single children (68 per cent), yet the remaining one-third have 1 or more siblings, and in fact a small proportion (12 per cent) have 3 or more siblings.

Based on all of the findings above, it could be hypothesised that the reason for placement in care of a disproportionate number of children would be traceable to their being members of one-parent families. Data are available to confirm or deny this. However, further data which would allow identification of the particular problem or problems encountered by the one-parent family or even the age of the mother whose child is placed in care, are not available.

As noted earlier, deprivation, and consequent vulnerability to placement in care is not limited to one-parent families and illegitimate children. For instance, unemployment was a reality for the families of the majority of children in care in the Richardson (1985) study. It is not possible to check whether unemployment was a contributory factor to any of the children being placed in care in this study, but other factors can be examined.

Richardson (1985, p. 200), continuing the discussion on the reasons for the children in her study entering residential care, talks of the most striking finding being the unsatisfactory or broken home as a major cause of children being admitted to care. Her study clearly showed that marital breakdown in 28 per cent of cases was the major reason, and in 36.4 per cent it was a contributory

factor to the child being taken into care. Richardson (op. cit., p.276) also found that 41 per cent of the mothers and 18 per cent of the fathers of children in residential care (where information was available) were considered to suffer from some psychiatric problems.

So, another hypothesis which can be formulated on the data available for legitimate children is that a proportion of those in care will have come from broken homes or homes with unsatisfactory marital relationships. Again there are no details of the type of problem or problems causing the actual break-up or disharmony. We do not know if it was caused by structural problems, i.e., poor accommodation, or by personality problems or both.

Children in need of care and protection may be subject to abuse and Hyman (1978) studied some of the characteristics of abusing families, resulting in a high probability of the children being taken into care. She found that early parenthood, with the likelihood of larger than average families by the time the family was completed, appeared to be a characteristic of families where there was child abuse. Maternal ill-health, especially psychological ill-health, was one of her confirmed findings. Generally family violence rather than the scapegoating of a single child was frequent. Family disruption was high with separation, housing and employment changes, and previous criminality occurring in a disproportionate number of families. There are a number of factors here, but the data are limited to identifying children who came into care because of abuse or neglect, and some data on family size are available also. If one had figures over an acceptable number of years it would be possible to trace whether or not levels of abuse and neglect were rising. It may be known also that a child comes from an abusive family background, but usually the dimensions of the problem are not known. However, increased public awareness and willingness to report possible abuse would also have to be taken into consideration. Increasing concern about child sexual abuse has led to the present Minister for Health (Dr O'Hanlon) issuing revised detailed guidelines on 29 July 1987 (the first were issued in 1978) to help professionals identify, investigate and treat child abuse, i.e., non-accidental injury (battery/abuse and neglect) plus sexual abuse.

Research has shown that children who remain in long-term substitute care are particularly vulnerable and show a higher incidence of both emotional disturbance and of educational backwardness than those coming from similar socio-economic backgrounds but living in their own homes (see, for instance, McQuaid, 1971 and Ayres, 1985). This finding cannot be tested here in this study, but it is possible to look at the reason why these children have been placed in care and compare it with the reason for placement of children in short-term care, to identify any significant differences. Rowe and Lambert's (1973) study

of children in need of substitute care found that children in care for longer than six months were likely to remain there for a considerably longer time. Millham *et al.*, stated from their study that those who stay long in care are usually older children, have well-forged links with family and others on entry, and the provision of stable, substitute parenting is difficult to ensure. As we will see, a large proportion of children in this study spent more than one year in care, so children in long-term care will be defined as those in care for one year or more.

It is also intended to see if the type of care in which a child is placed relates to the reason for admission. Here a question was specifically asked on reason for placement in residential care. Presumably since foster care would be the first option, a valid reason for placement in residential care instead, would be required.

To sum up, the hypotheses for this group of questions on available data, would be

(a) that illegitimate children, and children of one-parent families will be over represented in the group of children in care;
(b) that legitimate children will come mainly from homes where there are unsatisfactory marital relationships.

Finally, I would reiterate here that information on numerous vital variables is missing from the data. No details are available on variables such as type of housing, employment situation, support networks, age of mother, and how the circumstances in the home had changed to facilitate the child's return there. What efforts, if any, had been made to speed up the return of children in long-term care? This information would be necessary to build a complete picture of the reasons why children are placed in care, returned home, or retained in care.

The third group of questions concerns what happens after a decision has been made to place a child in care.

> (iii) Once in care, a child may be looked after in a number of ways which are not determined by any legal considerations. The two main types of care will be noted — foster care and residential care and also the main distinctions between those children placed in foster care and those in residential care. What are the likely social consequences of this differentiation? Foster care most closely resembles the family setting and whether or not this type of care is on the increase, as one would expect it to be given the stress on the importance of the family setting to a child, will be examined. Are children in long-term care more likely to be in foster or residential care? Does either type of care appear to facilitate early discharge? We will also note children placed in private foster care and those under supervision at home, but the numbers here may be too small for any satisfactory information to be gleaned.

For the purposes of responding to these questions there are data (a) on the type of care chosen for each child, and (b) on the 5 socio-demographic

characteristics of the children in each type of care, which will help to distinguish between those placed in foster care and those in residential care. There are no data on whether there are social consequences for the children in each type of care. A number of authors who feel care of any type is damaging to a child have already been mentioned and, further, Farmer (1979, p. 146) for instance, notes in her section on an alternative milieux to the family that fostering has been for a number of years the preferred way of caring for children deprived of home life. This is in order to give the child a substitute family which will provide him or her with stable loving relationships as alike those of a good family as possible. Farmer adds that children with a care experience, particularly residential care, have been assumed to be at a disadvantage in that it is difficult to create bonds of affection where there is turnover, sometimes rapid turnover, of care-taking staff. Another serious problem for children in residential care is the dichotomy between the transmission by the staff of individualistic values and goals appropriate to a wider society, and the expected collectivist behaviour needed to facilitate communal living. However, one must not totally denigrate residential care, as in some instances it may be the best option for some children – Berridge (1985) in particular stresses this, but one must remain aware of the possible difficulties also. On the other hand if a child must go into care foster care should not be seen as a panacea. Breakdown of the relationships between the foster parents and the children can and does occur, which breaks the continuity for a child as much as changes of staff in a residential home, and change from one residential home to another, possibly because of lack of appropriate placements for very rejected or disturbed children. The child can suffer from feelings of rejection when breakdown of any type of care occurs. As Goldstein *et al.*, (1979, p. 26) for instance note, the emotional bonds of the adults to the foster child will sometimes be loose enough to be broken whenever external circumstances make the presence of the foster child in the home inconvenient and irksome. Disruption can sometimes be linked to inadequate assessment as the Irish Foster Care Association (1984, p. 52) points out. This can happen if some inadequacy on the part of the foster parents or family, to successfully foster a particular child, is not spotted by the social workers or if the foster parents themselves do not fully perceive what is expected of them in relation to this child in the course of their assessment as foster parents. Other factors would be the ability or not of the child to attach, preparation of the child for fostering, and the previous care career of the child. In this context it is important not to underestimate the effects of a fostering breakdown on a child. Williams (1961) concluded that the experience is frequently shattering and often leads to personality damage of such seriousness that it may be impossible for the child

to be refostered in an ordinary home. Berridge (1985, p. 96) notes that the majority of breakdowns appear to be due primarily not to the children's behaviour, but to placement-related factors, such as marital tension of foster parents or inappropriate selections. And also fostering breakdowns generally propel children into residential care. Thus, the necessity for the continuity of relationships, surroundings and environment, essential for the child's normal development, are not always supplied in foster care either and it may often be a temporary and unsatisfactory type of care.

A dimension of continuity in care, namely that *between services,* is not often remembered. Residential and foster care, as Berridge (1985, p.117) particularly records, are generally treated as two distinct services. An administrative distinction, however, does not reflect a social reality. Berridge's study repeatedly highlighted the interrelationship between residence and fostering. For instance, he questioned the assumption that children, once in the care system, are channelled into *either* residential or foster care. Evidence from the "family links" study of Millham *et al.,* (1984) suggest that in Britain 1 in 3 of all children who stay in care more than six months experience both a residential and a foster placement. Data are not available here to enquire into this aspect of care, but it is an important point to be borne in mind, as continuity of care has been regarded as vital to the psychological well-being of a child.

Disruption is a complicated issue and the social worker needs to know the child. In a personal memorandum Mary O'Hagan, Senior Social Worker, Fostering Resource Group, pointed this out and added that sometimes children show no feelings when leaving a family. This can upset the family a great deal.

Having detailed the research questions and the available data, how the study will be organised to respond in so far as possible to the questions posed will now be examined.

Chapter 1 will give some socio-historical background to the question of children in care of the State, and the evolution from the social risk model to the "developmental" model in child care.

Demographic data are the topics covered in Chapter 2. Within the framework of demographic description and comparison, the demographic characteristics of the children in care on 31 December 1982 will be considered and related to the more general Irish demography. This should facilitate the identification, from the data available, of what demographic characteristics, if any, are peculiar to children entering care. This information in turn provides part of a limited picture, presently to be constructed of the "child in care".

Chapter 3 will deal with the reasons for children being placed in care, discharged or retained in long-term care. Since all children are or have been

part of some type of family structure, one cannot treat the child in isolation, so even the limited data here give a small but necessary insight into the backgrounds of the children. The child has been removed from its family for some reason or reasons; has been returned to that family; or has been retained in care because of some continuing problem or problems in the family. These data here should provide important information in order that strategies or interventions may be suggested which would modify the vulnerability of the families to their children being taken into care. Only brief comments will be made on the data at this stage – detailed comment and recommendations will be reserved for the final discussion chapter.

Chapter 4 observes the types of care available and the merits or demerits of each. It examines the importance of contact between the family and the child in care, since the level of contact has been found to be an important indicator as to the length of time a child will spend in care. Chapter 4 also observes which type of children go into which type of care. Distinctions in terms of the 4 independent variables will be made between foster and residential care. Other relevant variables will also be examined in terms of type of care, in order to provide as complete a picture as possible of the likelihood of a particular child being placed in a particular type of care.

Chapter 5 summarises the findings from this study and draws conclusions from the available data. The problem of area differences in propensity to admit, discharge or retain children in care will be examined here also.

In the final chapter the whole area of children in care in Ireland will be discussed and recommendations for necessary changes will be proposed.

As mentioned earlier, this particular study of children in care, is confined within the parameters of the body of data available (i.e., the Department of Health questionnaire). A certain amount of insight will be gained from a thorough analysis of these data. However, it is fully acknowledged that background data on children in care (e.g., socio-economic status, housing conditions, etc.) is of vital importance in knowing the full picture. These data are not available since, up to the present, they have not been collected.

Chapter 1

SOCIO-HISTORICAL BACKGROUND

It would seem appropriate in a study such as this to explore briefly the historical dimension in order to appreciate the present situation of child care in Ireland, and to chart the evolution from the 'social risk' model of children in care to the present-day 'developmental' model. In Ireland the evolution of the State control of child care in general, Robins (1980, p.9) writes, starts after 1838 when

> ... the workhouse 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. The introduction of a system of boarding-out in 1862 was one of the first and most notable steps away from the stern principles of the early poor law.

"As the nineteenth century progressed", says Robins, (ibid.) "the contribution of private charity grew and the religious-controlled institutions came to care for many of the children in need of help". The establishment of reformatories and industrial schools was a response, towards the end of the nineteenth century, to the increasing awareness of the need to provide for delinquent children or those exposed to vicious influences. However, on the introduction of the Industrial School System to Ireland in 1868, Local Authorities were unwilling to contribute towards the maintenance of the children. As a result, various religious orders were requested to undertake the work. Where the Order was willing to do so, where it provided suitable premises, these premises were certified as fit for the reception of children in care.

Robins (ibid., p.9) notes that the awareness which had been increasing in the nineteenth century led to the growth of a body of law aimed at protecting children generally from cruelty and exploitation, and as he sees it, the callousness and indifference of the eighteenth century towards charity children had given way to a relatively remarkable concern for their welfare.

O'Sullivan (1979) would see the changing philosophical or ideological background to alternative child care as changing from the 'social risk' model of the child in care where a child was regarded as a danger to society to the

"deprived model". O'Sullivan would say that the Industrial School System when first introduced into Ireland in 1868, under the Department of Justice, emphasised almost entirely the "social risk" model of the child in which society's interests were preeminent. He traces the fortunes of that model and the transition to the deprived model, where the predicament of the child is seen as an affront to tenets of social justice (O'Sullivan, 1979, p.210). Quoting Davies (1976), he points out that child care was seen originally as a means of social control (and containment) rather than an opportunity for children to develop or to have individual fulfilment.

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) literary and manual instruction, and (iii) moral formation (Cussen Report, 1936).

The image of the Industrial School child as a delinquent began to change with the transfer of responsibility for Industrial Schools from the Minister for Justice to the Minister for Education in 1928. Gradually, the link was broken with the prison system which had previously given rise to the notion of Industrial Schools as being just milder forms of reformatories. This, O'Sullivan (op.cit.) would argue, was evidence of a changing view of the child. Although, as Robins (op.cit.) noted, the movement away from the principle of the poor law had begun as early as 1862, probably the first really fundamental change in emphasis with regard to orphans, neglected and illegitimate children is to be found in the Cussen Report of 1936. However, as O'Sullivan argues, even this report did not go far enough. It was not until the late 1950s that institutionalisation was formally and finally regarded as undesirable, and alternatives such as adoption (although only conceived of for infants at that time) and fostering were much more widely considered for children who had not committed crimes but were in need of care and protection.

The Report on Industrial Schools and Reformatories, 1970 (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's Act limited, but also that the Act was not suitable to an era of changing conditions. While in 1908 the Children's Act was a new charter for children as the Kennedy Report (1970) stated, the many advances over the years in the field of child care and in the attitudes of the public, made it imperative that the whole concept of child care be examined afresh.

With the Kennedy Report of 1970, the "developmental" model had finally arrived. Psychological and emotional needs were now to be taken into consideration. However, as O'Sullivan so rightly points out, 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", says O'Sullivan (op. cit., p.213). In addition, the move had to be made from a situation which was Victorian in philosophy and practice. Some worthwhile changes have been in the transformation in residential care from the large institution to small units; the setting up of the first training courses for child-care workers in Kilkenny. Although the latter has now closed, six other courses are in operation with the emphasis on working with family sized groups in residential settings. The foster-care system has also been modernised. The training needs of child care workers with families have not been identified either at Department of Health or Health Board level to date (NESC Report, No. 84, p.70). The absolute numbers in any type of residential care have declined dramatically over the years, so proportionately foster care has become more important.

In 1974 the Government assigned to the Minister for Health the main responsibilities in relation to child-care services. 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 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 Chidren's 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 the legal responsibilities of the Minister for Health in relation to child care were somewhat limited (1980, p.52). However, the National Plan, *Building on Reality* (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 out-dated 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 emphasised keeping the child in a family setting rather than in residential care; (ii) *Adoption Bill, 1986,* which aimed to extend the categories of children who may be legally adopted, and (iii) a Bill, the subject of which was juvenile justice. With the change of government in February, 1987, the *Children (Care and Protection) Bill, 1985* was first redrafted by Deputy Brendan Howlin of the Labour Party in June 1987 as a Private Member's Bill in response to the criticism of the original. A further redraft of this Bill is now in progress by the Government party and publication of this is expected shortly. The *Adoption Bill (1986)* was redrafted twice, the first presented by Deputy Shatter in 1987 as the *Adoption Bill (1987)* and the second was presented by Senator Lanigan in June 1987, as *Adoption (No 2) Bill, 1987.* While the two amended Bills responded to some of the reaction to the original Bills, the objectives remained unchanged.

Another recent piece of legislation is 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.

This account so far has been limited to focusing mainly on formal legislative development. In practice some changes have taken place in terms of provision of social workers, limited initiation of community based projects and so on. The services provided for children as part of the Community Care Programme fall into two broad categories: Child Health Services and Personal Social Services. In this study the more relevant are the Personal Social Services. The sub-division of the personal social services 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/playgroups
    – Day fostering
  (c) Community Projects

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

The NESC Report No. 84 (October 1987) records the major review of personal social services for children undertaken by the Task Force on Child Care Services (1980). No notable action relating to the recommendations in the final report has been taken at a Health Board level to date, says the NESC report. The Task Force recommendations have major administrative implications for Health Boards (see: p. 69 NESC Report No. 84).

The NESC Report No. 84 also sums up the situation at present by stating that the development of the services is uneven and no community care area has a comprehensive range of services for children. "In general", the Report adds "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).

As regards the development of services, the Report concludes it is clear that until the present administrative structures are reviewed and the issues resolved, the development of services will be impeded.

While there is still no written agenda of the rights of children, and indeed no absolute consensus as to the exact definitions of children's rights, some efforts have been made to improve children's services and provide supportive services to families who find themselves in difficulties. On the whole, attitudes, if not much legislation and provision, have become more sensitive to children, more tolerant of different family life styles and more aware of their disadvantaged position *vis-a-vis* the State.

This then is a short record of the principal changes which have occurred in Ireland in the area of State care for children. It indicates an increasing emphasis on the rights of the child and a changed climate of care and protection rather than containment, and it is in this changed climate that this study is set.

Chapter 2

DEMOGRAPHIC DATA

This chapter is concerned with the first group of questions which relate to the socio-demographic characteristics of children in care. The objective here is to compare the characteristics of children in care on which data are available with those of children in the general population. For instance, what are the characteristics in terms of the children's age, sex, birth status and area? By ascertaining the relative proportions of certain categories of children in care, and then by comparing these with the corresponding relative proportions in the overall populations, the socio-demographic characteristics of those children who have a higher than average probability of being taken into care may be identified. It should then be possible to see if, as hypothesised, certain groups, i.e., illegitimate children, are disproportionately represented among those in care.

First, however, for information, this chapter will focus very briefly on the inflows and outflows to care, showing the numbers of admissions and discharges. Figures from 1980 onwards are the only ones recorded as being revised in *Statistical Information*, 1983, 1984, 1985 and 1986. Earlier figures could not be regarded as being reliable, and 1983 are the latest available.

Admissions to Care

Year	*Frequency*	*Percentage of all in care in that year*	
1980	1,249	36.0	(3,465)*
1981	1,381	37.6	(3,674)
1982	1,282	34.9	(3,675)
1983	1,335	37.1	(3,595)

Discharges from Care

Year	*Frequency*	*Percentage of all in care in that year*	
1980	1,143	33.0	(3,465)*
1981	1,276	34.7	(3,674)
1982	1,229	33.4	(3,675)
1983	1,061	29.5	(3,595)

* Total in care that year.

The number and proportion of admissions to care has not varied very much in the four years for which there are data. A similar situation occurs with regard to discharges, although the proportion discharged in 1983 has decreased. However, further information on later years would be needed to enable comment to be made on whether or not this indicates a trend or is just a once-off occurrence.

Concentrating for a moment on the 1982 figures on which this study is based, the 3,675 figure of children in care represents the number of admissions which began prior to 1982 and which continued into some part of that year, as well as admissions which began in 1982 itself. Also, as already stated, each child is given a unique number on first admission, so cannot be double or triple counted (see Introduction). In all, four groups are distinguishable among the 3,675 children who have been in care at any time during 1982 (see Diagram 1).

(a) admissions beginning during 1982, and not ending during 1982 (N = 522);
(b) admissions beginning during 1982 and ending during 1982 (N = 760);
(c) admissions beginning prior to 1982 and not ending during 1982 (N = 1,924);
(d) admissions beginning prior to 1982 and ending during 1982 (N = 469).

I turn now to the four independent variables, age, sex, birth status and area, to identify the socio-demographic characteristics of children in care on 31 December, 1982.

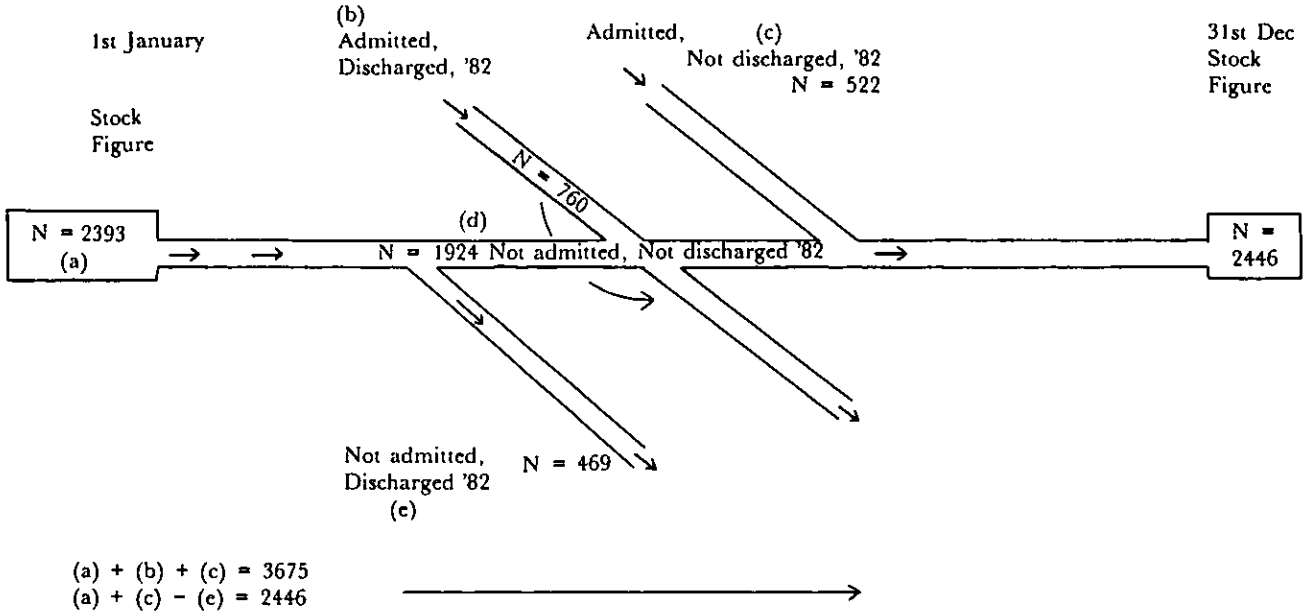
Age

There are two ways in which the age of children in care is relevant. First, it is necessary to know the age of children at the time of admission to care to determine the average age at admission. Are younger children more vulnerable to admission to care than older children? Secondly, the age structure of the in-care population at the date of questionnaire completion must be examined and compared with that of the overall child population. This will give some idea of a child's age specific chances of actually being in care. It must be noted that age specific probabilities of admission are not necessarily the same as age specific probabilities of being in care in a particular year, since trends of both admissions and length of stay are likely to have varied over the years. They are, however, likely to be similar.

Age at Admission

Table 2.1 shows the distribution of children in care on 31 December 1982, by the age at which they came into care, compared to the age of children in the total population. It is clear that children are most likely to be admitted to care in their infant years, with much higher proportions in the under 2 year

Diag. 1: *Inflows and Outflows to Care, 1982*



olds than any other group. Seventy-two per cent of those admitted are less than 7 years old, compared with 33 per cent under seven in the overall population.

Table 2.1: *Age at Admission: Children in Care at 31 December 1982 (2,446)*

Age at Admission	*Frequency*		*Percentage*		*Percentage in General Population*	
Years						
< 2	919		37.6		9.9	
2-3	382	1773	15.6	72.5	9.3	33.0
4-6	472		19.3		13.8	
7-11	480		19.6		23.6	
12-14	155		6.3		13.6	
15 -21	38		1.6		29.8	
N =	2,446		100.0		100.0	

Looking at age of admission by sex, there are few differences between females and males by age at admission. Table 2.2 shows the numbers and percentages involved. Boys and girls are both more likely to be admitted to care in their infant years.

Table 2.2: *Age at Admission by Sex in Care at 31 December 1982*

	Sex		
Age at Admission	*Female per cent*	*Male per cent*	*Total per cent*
Years			
< 2	37.7	37.4	37.6
2-3	17.4	14.0	15.6
4-6	18.3	20.2	19.3
7-11	18.5	20.7	19.6
12fi	8.1	7.7	7.9
N =	1,164	1,282	2,446

χ^2 = fl 7.48278 with 4 df. $p < 0.1125$.

Table 2.3 shows that the birth status of the child dictates the age at admission to care. Illegitimate children are more likely to be admitted to care at a younger age than are legitimate children. Explanations in terms of reasons for coming into care will be noted when that question is examined and no doubt will be found to be particularly in terms of one-parent families being less able to cope. As recorded in the Introduction, single mothers are more likely to be poor and deprived and, therefore, less likely to be able to cope in a crisis or with a young child. (Appendix Table A gives a more detailed breakdown of age at admission by status.)

Children awaiting adoption are almost always illegitimate and most likely to be infants at the time. However, the number actually awaiting adoption on 31 December 1982 was very small (56 children) and although 86 per cent of these were less than six months old, that number is too small to influence the younger age groups, so that over-representation still remains and is not an artefact of awaiting adoption. Therefore, age at admission and birth status are significantly related.

Table 2.3: *Age at Admission by Status in Care at 31 December 1982**

Admission	*Legitimate per cent*	*Illegitimate per cent*	*Total*
Years			
< 2	22.0	58.9	36.3
2-3	14.4	17.4	15.6
4-6	24.6	12.3	19.8
7-11	28.0	8.0	20.2
12fi	11.0	3.4	8.1
N =	1,448	918	2,366

* Excludes the 80 extramarital children in care on that date. $\chi^2 = 409.86475$ with 4 df. $p < 0.0$.

Table 2.4 gives an idea of variations in children's age at admission across the Health Boards. The North Eastern Health Board shows the highest proportion of admissions in the under-two year age group (47.6 per cent of admissions in that area). Four Health Boards have above the average proportion for the youngest age group – North Eastern, North Western, Southern and Western. It is difficult without further data to explain these differences but we will endeavour to do so later by discussion of possible reasons, such as services available and take-up of available services. However, the differences are only significant at the 0.0022 level.

Table 2.4: *Age at Admission by Health Board*

Age at Admission	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
Years					*Years*				
<2	35.8	32.4	33.6	47.6	44.5	36.8	40.5	42.5	37.6
2-3	14.3	20.1	11.9	17.1	16.4	19.2	17.6	13.1	15.6
4-6	20.3	14.5	21.8	12.4	17.3	19.8	20.1	20.6	19.3
7-11	20.9	20.1	22.9	17.1	14.5	20.1	16.5	15.6	19.6
12+	8.8	12.9	9.7	5.9	7.3	4.1	5.4	8.2	7.9
N =	903	179	327	170	110	318	279	160	2,446

χ^2 = 54.09508 with 28 df. $p < 0.0022$.

A more detailed breakdown of age at admission is given in Appendix Table B, which gives age at admission by Community Care area, of those in care on 31 December 1982 and at any time during 1982. Large variations occur in the percentage of admissions in each age group within Health Board regions. For instance, in the Western Health Board, Roscommon had nearly 52 per cent of its admissions to care aged 0-6 months, while Galway had only 23 per cent. The very small numbers involved must be taken into account here. We will look into possible reasons for the differences later on in Chapter 5, Summary and Conclusions.

Clear significant differences are apparent between the age at which a child is admitted to care and its birth status, but the area differences are not so clear. Thus it may be stated that illegitimate children are admitted to care at a significantly younger age than legitimate children, and although Health Board regions did not differ greatly in the age at which the children in their care were admitted, community care areas appear to do so.

Age Structure

Considering now the age structure of the Census population (2,446), Table 2.5 compares the age structure of the overall child population with the age structure of the group of children who were in care on 31 December, 1982. In Column 1 of the table, the number and proportion of children under 21 years in each of the age groups in the overall child population are presented. Column 2 looks at age specific numbers and proportions of the in-care population on

Table 2.5: *Population by Age Group up to 21 Years and Numbers in Care at 31st December, 1982**

Age Group	*General Population Up To 21 years (%)* *1*	*Nos. in Care on 31 Dec. 1982 and Percentages* *2*	*Probability of Being in Care 31 Dec. 1982* *3*	*Nos. in Care on 31 Dec.1982 and Percentages, Children Not Awaiting Adoption* *4*	*Probability of Being in Care at 31 Dec.1982 and Not Awaiting Adoption* *5*
Years					
Under 1	73,379 (4.9)	137 (5.6)	.0019	91 (3.8)	.0012
1	73,864 (5.0)	119 (4.9)	.0016	111 (4.6)	.0015
2-3	137,658 (9.3)	252 (10.3)	.0018	250 (10.5)	.0018
4-6	205,654 (13.8)	407 (16.6)	.0020	407 (17.0)	.0020
7-11	351,193 (23.6)	681 (27.8)	.0019	681 (28.5)	.0019
12-14	201,981 (13.6)	463 (18.9)	.0023	463 (19.4)	.0023
15-21	444,096 (29.8)	387 (15.8)	.0009	387 (16.2)	.0009
Totals	1,487,825 (100.0)	2,446 (100.0)	.0016	2,390 (100.0)	.0016

*Sources: Ireland: Census of Population, 1981, Vol.2, Table 10, and Department of Health Child Care Survey 1982.

31 December 1982. Column 3 looks at the age specific probabilities of a child being in care on that date. Column 4 abstracts those not awaiting adoption, and presents the age structure of that group in care. Column 5 presents the probabilities of children being in care, other than awaiting adoption, at that date.

Comparing Column 1 and Column 2 of the table, it is evident that in general the age structure of the in-care group is fairly similar to that of the whole child population. The only remarkable difference is the very clear under-representation of the 15-21 year old age group in the in-care population, explainable by the legal provisions and (a) the lack of provision for adolescents, (b) the practical difficulty of holding reluctant adolescents. The cutoff point for children entering care is 16 years. (A small number of children have been recorded as entering care after age 16 and an explanation for this is being sought.)

Column 3 summarises the relationship between the first and second columns. It is again shown that the probability of being in care is not age specific in general except for the previously mentioned marked lower probability of being in care after age 15.

Column 5 demonstrates that the absence of children awaiting adoption lowers the probability figures for very young children being in care — a fact borne out by the youthful bias of the "awaiting adoption" group.

In assessing this table it must also be remembered that there is a growth in the probability of being in care over time from 1 to 14 years old.

Table 2.6 shows the age structure of children in care by sex, both in the general child population and in the in-care population at 31 December 1982. The male:female ratio in the overall child population stood at 51.2 per cent: 48.8 per cent in 1981. This ratio holds relatively constant across our age groups. For the "in care" groups (at December 31, 1982), the total ratio figure is quite similar to that of the overall population (52.2 per cent: 47.6 per cent). This figure changes only slightly from one age group to another. Girls are somewhat over-represented amongst the infant (< 2 years) group, and amongst the over 15 group. In the middle age groups, the ratio conforms to that of the general population. The over-representation of girls among the younger group is somewhat explicable in terms of there being a higher proportion of girls among the (very young) awaiting adoption group. At the other extreme, the explanation must be in terms of boys leaving care at a younger age than girls, creating an over-representation of girls among older children in care. The differences between the ages of boys and girls in care are not significant.

As regards the age structure by birth status, illegitimate children have higher proportions in the younger age groups. For instance, if the groups 3 years old or less are taken, 11.7 per cent of the legitimate children are in those age groups,

Table 2.6: *Population up to 21 Years by Sex 1981 and Numbers in Care in Each Age Group by Sex, at 31 December 1982*

Age Groups	*Population*		*Numbers in Care*	
	Males	*Females*	*Males*	*Females*
Years				
< 2	75,749 (51.4)	71,494 (48.6)	122 (47.7)	134 (52.3)
2-3	70,293 (51.1)	67,365 (48.9)	137 (54.4)	115 (45.6)
4-6	105,701 (51.4)	99,953 (48.6)	215 (52.8)	192 (47.2)
7-11	179,757 (51.2)	171,436 (48.8)	363 (53.3)	318 (46.7)
12-14	103,909 (51.4)	98,072 (48.6)	259 (55.9)	204 (44.1)
15-21	226,761 (51.1)	217,335 (49.9)	186 (48.1)	201 (51.9)
Total	762,170 (51.2)	725,655 (48.8)	1,282 (52.4)	1,164 (47.6)

Sources: *Census of Population*, Vol. II, Table 10, 1981 and Department of Health: *Children in Care Survey*, 1982

$\chi^2 = 8.19784$ with 5 df. $p < .1457$

and almost 33 per cent of the illegitimate children. In the general population, 19 per cent of the children under 21 years are under three years old. The probability of a child who is illegitimate being in care at an early age appears to be much higher than for a legitimate child. Birth status is, therefore, significantly correlated with age of children in care (Table 2.7).

Table 2.7: *Age Structure by Birth Status – Children in Care 31 December 1982*

Age	*Status**		*Total*
Years	*Legitimate*	*Illegitimate*	*Per Cent*
<2	5.0	18.1	10.1
2-3	6.7	14.8	9.8
4-6	14.4	19.3	16.3
7-11	32.3	21.4	28.0
12-14	24.0	12.4	19.5
15+	17.7	14.1	16.3
N =	1,448	918	2,366

*Excluding 80 extramarital children.

$\chi^2 = 209.10278$ with 5 df. $p < 0.0$.

The age structure of children in care by Health Board is set out in Table 2.8. It may be necessary to mention that the classification by Health Board region here refers to the region in which the child is placed in care. This may not necessarily correspond to the area of residence of the child. There is some small trans-regional mobility of children, and Table 4.2 records this by type of care.

Table 2.8: *Age Structure by Health Board*

Present Age	*Health Board*								
	Eastern	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
Years									
<2	8.6	12.8	10.7	13.5	12.7	6.0	13.2	16.9	10.5
2-3	9.6	9.5	8.9	18.2	4.5	12.3	9.7	10.6	10.3
4-6	18.4	18.4	12.5	18.2	18.2	13.8	17.6	14.4	16.6
7-11	28.7	25.1	30.0	23.5	27.3	28.3	29.0	23.8	27.8
12-14	18.3	17.3	22.9	14.7	19.1	22.3	16.5	18.1	18.9
15+	16.4	16.8	15.0	11.8	18.2	17.3	14.0	16.3	15.8
N =	903	179	327	170	110	318	279	160	2,446

$\chi^2 = 59.51776$ with 35 df. $p < 0.0060$.

Comment will be made on this trans-regional mobility in Chapter 4 — Types of Care. Some differences occur between Health Board areas in the age structures of the children in their care. The Western Health Board, for instance, has almost three times the proportion of children in care under two years old than the South-Eastern has. (Appendix Tables C and D give more detailed information on age in care by area.)

Why these differences occur is difficult to say, but some possible explanations will be posited, in terms of area policy or social worker density in Chapter. 5

From the variable "age" it may be seen that (a) there are significant differences between the age of children in care by birth status — younger children in care are more likely to be illegitimate; and (b) Health Board regions differ somewhat in the age of the children they have in care.

Sex

Coming to a sex breakdown, is either sex more likely to be in care than the other? There were 1,164 females and 1,282 males in care at 31 December 1982, so, as already noted, the ratio of females to males in care — 47.6 per cent females to 52.4 per cent males — is well in line with the ratios in the overall child population (48.8 per cent: 51.2 per cent). Also the probability of being in care is .0017 for females and .0018 for males, so no great differences appear (see Appendix Table E). When the male/female breakdown by status is examined it will be noted that the ratios here are: legitimate 48:52; illegitimate 47;53; and extramarital 50:50. Thus the ratios remain comparable with the general population. Table 2.9 gives the details.

No significant relationship appeared between the sex of the child and his/her birth status.

Table 2.9: *Sex of Children in Care on 31 December 1982 by Birth Status**

Sex	*Status*		*Total*
	Legitimate	*Illegitimate*	
	%	%	
Female	695 (48.0)	429 (46.7)	1,124
Male	753 (52.0)	489 (53.3)	1,242
Total	1,448	918	2,366

*Excludes 80 extramarital children.
$\chi^2 = 0.31168$ with 1 df. $p < 0.5767$.

The male/female ratio varies from one Health Board region to another (see Table 2.10). In the Western Health Board, for instance, the ratio stands at 58.8 per cent girls to 41.3 per cent boys and 45.3 per cent girls to 54.7 per cent boys in the Eastern Health Board (compared with the national child population ratio of 48.8 per cent girls to 51.2 per cent boys). These sex variations between the Health Board areas do not appear to be significant however.

Birth Status

In the Children in Care Survey, 1982 — children are classified by their birth status in one of three ways:

- legitimate
- illegitimate
- extramarital

A legitimate child is a child born of married parents. A child of a married woman is assumed to be that of her husband (and therefore legitimate) unless definite proof to the contrary is produced. There are various ways by which a child who is not of married parents may gain the legal status of "legitimacy". It is the legal presumption that a child born out of wedlock can be "legitimated"

Table 2.10: *Sex of Children in Care at 31 December 1982 by Health Board (Responsible)*

Sex	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
					Per cent				
Female	45.3	52.0	46.2	47.1	53.6	46.2	47.0	58.8	47.6
Male	54.7	48.0	53.8	52.9	46.4	53.8	53.0	41.3	52.4
N =	903	179	327	170	110	318	279	160	2446

$\chi^2 = 13.44209$ with 7 df. $p < 0.0620$

Appendix Table E details the differences in probability of coming into care in all Community Care areas by sex.

by the subsequent marriage of its parents (provided both the father and mother were legally free to marry at the time of birth or at some time during the ten months preceding the child's birth), or a child may be "legitimated" by an adoption order being made in respect of her/him. Apart from legitimation by marriage or adoption, a declaration of legitimacy may be obtained from the courts under the Legitimacy Declaration (Ireland) Act, 1868.

Conversely then, an illegitimate child is one whose parents were not married at either its conception or birth or, at any intervening time, or whose parents did not subsequently marry (with the above provisos) and who did not have an adoption order or Legitimacy Declaration made in respect of her/him. Furthermore, a child whose parents' marriage is legally annulled is an illegitimate child.

An extramarital child is one whose mother was known to be married to a man other than its father, at the time of its birth. (See Shatter, 1981, Chapter 11, pp. 168-174 for a discussion of "Legitimacy and Legitimation".)

To put birth status in context, Table 2.11 looks in general at birth rates by sex, changes in fertility by birth rate, numbers and proportions of illegitimate children and the marriage rate for the years 1979-1985 in Ireland. It will be noted that while both the marriage rate and the overall birth rate declined in these six years, the number and proportion of illegitimate births increased. Comment has already been made on this in the Introduction. Table 2.12 shows the rates of illegitimacy in 11 EEC countries. The figures for Denmark show very clearly that a falling marriage rate, with the reported rise in cohabitation, is reflected in the rising numbers of illegitimate children.

It would be almost impossible to estimate the proportion of the child population which stood as "illegitimate" in Ireland in 1982, since accurate information on a number of key questions is not available. To assess the size of the illegitimate child population one would have to take account of:

(a) the inflow of illegitimate children to the population in the previous 15 years, i.e., the actual number of illegitimate born in each year;
(b) the lessening of this illegitimate inflow in terms of:
    (i) adoption, either by own family or other couples,
    (ii) subsequent legitimation by parental marriage[2],
    (iii) mortality rates of illegitimate children.

2. The Registrar General's figures for those parents who apply for re-registration of their children after their marriage are not inconsiderable, i.e., 849 in 1982. Not all children are re-registered in their parents' marriage, so this is probably an under-estimation of the figure of children legitimated by their parents' subsequent marriage.

Table 2.11: *Births: Males and Females; Birth Rate, Changes, Nos. of Illegitimate Children Born; Illegitimate as Proportion of Population; Marriages: Total; Rate per '000 and Changes**

Year	*Births*							*Marriages*		
	Total	*Males*	*Females*	*Per '000 population*	*Change from Previous Year*	*No. of Illegit.*	*Illeg. as % of All Births Registered*	*Total*	*Rate per '000*	*Change from Previous Year*
1979	72,352	37,222	35,130	21.5	0.2 below	3,331	4.6	20,864	6.2	0.1 below
1980	74,388	38,488	35,900	21.9	0.4 below	3,691	5.0	21,723	6.4	0.2 above
1981	72,355	37,119	35,236	21.0	0.9 below	3,911	5.4	20,550	6.0	0.4 below
1982	70,933	36,328	34,605	20.4	0.6 below	4,351	6.1	20,441	5.9	0.1 below
1983	66,815	34,474	32,341	19.0	1.4 below	4,715	6.8	19,181	5.5	0.4 below
1984	64,237	33,082	31,155	18.2	0.8 below	5,030	7.8	18,355	5.2	0.3 below
1985	62,250	32,059	30,191	17.5	0.7 below	5,268	8.5	18,552	5.2	–

*Sources: *Reports on Vital Statistics* for relevant years.
Statistical Information, Department of Health, 1985.
Health Statistics, Department of Health, 1986.

Table 2.12: *Percentage Illegitimate in Certain Selected Countries in Certain Years*

Year	*IRL*	*DEN*	*UK*	*FRG*	*FR*	*IT*	*NETH*	*BEL*	*GR*	*SP*	*PORT*
1975	3.7	21.7	9.1	6.1	8.5	2.9	2.1	3.1	1.3	2.0	7.2
1976	3.8	24.0	9.2	6.3	8.5	3.1	2.5	3.1	1.3	2.2	–
1977	4.1	25.9	9.7	6.5	8.8	3.5	2.7	3.1	1.3	–	–
1978	4.2	27.9	10.2	7.0	9.4	3.9	3.1	3.4	1.4	–	–
1979	4.6	30.7	10.9	7.1	10.3	–	3.4	–	1.4	2.8	–
1980	5.0	33.2	–	7.6	11.4	–	–	–	–	–	–
1984	7.8	41.9	17.0	8.1 (1983)	15.9 (prov)	5.0	7.0 (1982)	5.2	1.7	–	11.5

Sources: *United Nations Demographic Year Book, 1981.* (Special topic: Natality Statistics)
Reports on Vital Statistics, relevant years
Health Statistics, Department of Health. 1986.

The latter point, (iii), in particular would be difficult to ascertain with accuracy. It may stated with little doubt, however, that the number of illegitimate children, as a proportion of the overall child population, is unlikely to exceed the 1.6 to 6.1 percentage ranges of the 1960-1982 period, and indeed is likely to be significantly less, given adoption and subsequent legitimation.

As regards illegitimate children in care, the proportion at 31 December 1982 is 37.5 per cent (918:2,446), a much higher proportion than that within the general population. The ratio of 59:38 legitimate to illegitimate children in care on 31 December 1982 is in contrast to an over-estimate of 94:6 in the general population.

Three per cent of the 2,446 children in care on 31 December 1982 were extramarital children, but a total lack of information hinders us estimating the proportion of children in the general population who might be regarded as "extra marital".

Area

Table 2.13 gives details of the birth status of children in care at 31 December 1982 by Health Board area. It has been noted previously that the overall legitimate:illegitimate ratio for children in care on 31 December 1982 stands at 59:38. Looking at the Health Boards it will be noted that this ranges from a ratio of 73:27 in the Southern Health Board to 53:46 in the North Eastern Health Board. It appears then that the Southern Health Board has the lowest proportion of illegitimate children in care while the North Eastern Health Board has the highest proportion of illegitimate children in care. The difference between the Health Boards is significant in the birth status of the children in their care.

It is interesting to compare the proportion overall of children who are registered as illegitimate in each Health Board area with the proportions of children in care in each area who were illegitimate. Table 2.14 gives the comparisons over

Table 2.13: *Birth Status by Health Board*

Status	*Health Board*								
	Eastern	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
Legitimate	61.0	54.7	64.8	53.5	54.6	61.1	73.1	54.4	61.2
Illegitimate	39.0	45.3	35.2	46.5	45.4	38.9	26.9	45.6	38.8
N =	882	170	315	157	108	303	271	160	2,366*

*Excludes 80 extramarital children

$\chi^2 = 29.70056$ with 7 df. $p < 0.0001$.

Table 2.14: *Comparisons of Percentages of Children Registered as Illegitimate and Percentage of Children in Care Who are Illegitimate by Health Board and Year**

Area	*Percentage of Annual Births Registered as Illegitimate*				*Percentage of Children in Care Who Are Illegitimate*			
	1980	1981	1982	1983	1980	1981	1982	1983
Eastern	7.1	7.8	9.0	10.2	37.0	38.0	38.1	36.3
Midland	3.8	4.1	4.2	3.9	40.0	35.0	43.0	36.6
Mid Western	3.6	4.6	5.7	5.5	28.0	32.0	33.9	36.0
North Eastern	3.3	3.6	4.1	3.8	48.0	46.0	42.9	47.7
North Western	3.3	4.2	3.7	4.7	32.0	44.0	44.5	47.2
South Eastern	4.8	4.9	5.6	5.7	32.0	31.0	37.1	35.6
Southern	4.7	4.7	4.6	6.2	15.0	15.0	26.2	26.1
Western	3.0	3.1	3.4	3.8	51.0	50.0	45.6	56.1
Mean	5.0	5.5	6.1	6.8	35.0	36.0	40.2	37.6

*Sources: Statistical Information relevant to Health Services, Various Years

the years 1980, 1981, 1982 and 1983. Consistently over the four-year period the Western Health Board had the lowest proportion of children registered as illegitimate, but one of the highest proportions of illegitimate children in care. No other Health Board was quite as consistent in showing that the less acceptable illegitimacy is, the higher the proportion in care, although the North Eastern Health Board has a fairly similar pattern to the Western. Overall, the Western, North Eastern, Midland and North Western had the lowest levels of children registered as illegitimate in their areas, and it seemed to follow, particularly in 1982 and 1983 that these Health Boards had the highest proportions of illegitimate children in care. One can only speculate on reasons for these differences. They may occur in terms of (a) Health Board area policy of dealing with single mothers and their illegitimate children, (b) existence of voluntary agencies in an area, e.g., adoption societies, or lack of such agencies, or (c) the more mobile/able mothers moving to, say, Dublin, and having the child's birth registered there (see O'Hare and Dromey, 1988). Possible reasons will be examined later in Chapter 5.

Family Size

It has already been suggested that children who are placed in care are likely to come from larger than average families, so family size is examined here. Table 2.15 shows (a) the number of siblings children in care had, and (b) the number of siblings who were also in care.

Table 2.15: *Siblings and Siblings in Care*

Number	*Siblings per cent*	*Siblings in Care per cent*
None	33.2	45.0
1	15.0	18.0
2	11.6	11.4
3	12.0	10.2
4-5	15.6	10.4
6+	12.6	4.9
N =	2,446	2,446

In the 1981 Census the average number of children under 15 years per family unit, including lone parents was given as 2.2, and if lone parents are excluded the average was 2.6. For lone parents, the average number of children was 2.0. The average number of children per family in this study was 3.3, so it would appear that the group in care came from larger families than the population in general. This would confirm the hypothesis that among the factors contributing to the probability of entering care, children in large families are more at risk than are other children.

Looking at the second column in Table 2.15 it may be noted that 55 per cent of the children in care had siblings in care as well, and over a quarter had 3 or more of their siblings in care.

The question was asked — were there any differences between the numbers of siblings each status had, and it is clear that significant differences occurred.

Table 2.16: *Siblings and Siblings in Care by Birth Status*

*Number of Siblings**	*Siblings*		*Siblings in Care*	
	Legitimate	*Illegitimate*	*Legitimate*	*Illegitimate*
None	11.7	68.1	24.0	77.1
1	15.1	14.6	20.6	13.6
2	15.1	5.4	16.6	3.6
3	17.1	4.1	16.0	2.0
4-5	22.8	4.9	15.9	2.5
6+	18.2	2.8	6.8	1.2
N =	1,448	918	1,448	918

$\chi^2 = 879.17725$ with 5 df $p < 0.0$. $\chi^2 = 689.90625$ with 5 df $p < 0.0$.

*We have collapsed the categories — originally there were up to 15 siblings for 3 legitimate children and up to 11 siblings for 3 illegitimate children. For those with siblings in care, there were up to 11 siblings in care for 9 legitimate children, and up to 7 siblings in care for 5 illegitimate children.

As might be expected legitimate children had significantly more siblings than illegitimate children (Table 2.16). When average family size for both groups was examined it was found that legitimate children in care came from families averaging 4.4 children, while illegitimate children came from families averaging 1.8 children. The problems associated with large families leading to their placement in care could only occur in families of legitimate children. Family size, defined as a large family, did not appear to account for illegitimate children being placed in care, whereas it would seem to be a factor in the placement of legitimate children.

Summary

This chapter did not set out to explain anything but to describe the available demographic characteristics of the children who were in care on 31 December 1982, in comparison with the general population. Four variables were originally chosen and to those family size was added.

The main findings in this chapter were:

(i) the majority of young admissions were illegitimate children
(ii) the probability of being in care is neither age nor sex specific
(iii) Health Board regions differ significantly in the ages of children in their care
(iv) the very large proportion of illegitimate children in care relative to their proportion in the population was the most striking finding
(v) the lower the incidence of illegitimacy in an area, the higher the likelihood of an illegitimate child being placed in care
(vi) legitimate children in care came from larger than average families

Chapter 3

REASON GIVEN FOR ADMISSION, DISCHARGE AND RETENTION IN CARE

The objectives of this chapter are to deal with the second group of questions asked in stating the purpose of the study – what factors combine to culminate in the placement, and then either the discharge or retention of a child in care? Three separate sets of "reason" were identified (a) reason for admission; (b) reason for discharge; and (c) reason for retention in care. These will be examined and then cross-tabulated with the socio-demographic characteristics of each group of children, along with the type of care each group received. Children in long-term care will be considered separately. The restriction placed on the information by the limitations of the data is discussed first.

To avoid, if possible, the separation of a child from its family, one needs to know the true reasons why a separation is thought advisable. Identification of the problems which lead to children in some families being taken into care could suggest what particular interventions might be attempted to either reduce or negate the problems. Accurate information on reasons for admission, reasons for discharge and reasons for retention in care are, therefore, vital in a study of children placed in care. Unfortunately, the limitations of these data become particularly acute and obvious when the three groups of "reason" in the available data are examined. As mentioned in the Introduction, the 1982 children in care survey permitted only a single response among a range of given options in answer to the questions regarding (a) "Precipitating reason for current admission", (b) "Primary reason child is not reunited with family", and (c) "Reason for leaving care". It will be appreciated, therefore, that a number of difficulties arise as a result of this answer format. First of all, analysis of any secondary reasons for admission, retention or discharge will be impossible. Thus, information on the overall accumulation and constellation of circumstances which results in a child coming into care, being retained there, or discharged, is lost.

Berridge (1985, p.35) in his study of children in residential care, found that statistics imply that categories are mutually exclusive and that, consequently, cases are relatively straightforward.

> In fact, [Berridge writes] there is considerable overlap between the groups and most children come into care because of several inter-related factors which emerge when senior staff at the homes are interviewed, case records scrutinised, and social workers asked to identify problems responsible for precipitating children into care.

The reasons given on the 1982 questionnaire which provided the data for this study are not mutually exclusive either, i.e., "neglect" is a blanket term which could include abuse, among other things. A child could be neglected because the parent/parents were unable to cope with, for instance, its physical needs, or a parent might not be able to cope emotionally with a child out of control. Some of the given reasons tell very little about the full reasons why the child had to be placed in care. For instance, what does "unable to cope" as stated on the questionnaire, mean? Is it financially, physically or perhaps psychologically unable to cope?

Furthermore, what is considered to be the "major" or precipitating reason is, in many cases, at the discretion of the social worker involved in filling out the questionnaire which may occur some considerable time after the admission. A danger exists here also that social workers may differentially interpret the meanings of categories. This causes fewer problems if the variations in choice of category are randomised but we have no assurance that this is in fact the case. It is possible that choice of response is structurally biased. For example, a child of a one-parent family who is neglected or physically abused may be placed in one of three categories:

(a) Physical abuse of child
(b) Neglect of child
(c) One-parent family unable to cope.

Mindful of these problems, it is still evident that some useful information can be gained from looking at the reasons for admission, discharge and retention of children in care.

First, a comparison will be made between the years for which reliable data are available and any differences noted. Then an examination of the proportions in each reason for admission, discharge and retention in care will be undertaken, leaving comment and discussion on the findings until the conclusions chapter.

Admissions to Care

Table 3.1 has details on the reasons for admission for the available three years.

From this table it appears that the proportions entering care change from year to year in all the categories of reasons. The only large category where a decrease has occurred over the years is Category 1 and the explanation for this is most likely to be the drop in the number of adoptions in recent years (see Adoption Board Reports for relevant years). The increase in the numbers in Category 2 may possibly be explained by an increase in the level of active parental abuse, or that the level of reporting of neglect or abuse had increased in the years noted.

Table 3.1: *Reason for Admission to Care by Year**

Reason	*1980 per cent*	*1981 per cent*	*1982 per cent*
1. One-Parent Incapacity (Including Adoption)	48.0	49.8	39.6
2. Active Parental Abuse**	13.9(173)	12.6(174)	18.5(236)
3. Temporary Parental Incapacity	19.4	22.5	25.6
4. Parental Disharmony	7.0	4.7	6.7
5. Parental Absence/Abrogation	6.7	6.9	2.9
6. Parental Inability to Control	5.0	3.4	6.7
N =	1,249	1,381	1,282

$\chi^2 = 87.45$ with 10df $p < .01$

*The reasons for admission have been collapsed into fewer categories to make for more coherence. A copy of the questionnaire giving all the reasons is in Appendix F.

**Figures in parentheses are the numbers of children involved.

From a practitioner point of view, of course, it would be an increase, whatever the explanation for it.

That the reason for placement in care of a disproportionate number of children would be traceable to their being members of one-parent families had been hypothesised, and this appears to be borne out consistently for each year for which there are data. However, as noted earlier, this tells little about the full circumstances of why the child was placed in care. Was it purely because of being a one-parent family and in what way was the parent unable to cope? Much more detailed information would be required to enable accurate identification to be made of the family problems behind the precipitating or presenting problem.

Around one-fifth, and in the case of 1982, one-quarter, of the children in care were there due to temporary parental incapacity. It is to be hoped that these children will be returned home quickly, the parent(s) being given whatever assistance is required to overcome their problems, although there is no evidence that the social workers are given the means to provide this assistance.

Around 15 per cent on average, of the children in care in any of the years noted, had been subject to active parental abuse. This must give cause for grave concern about these children. As recorded, this reason for placement may well be on the increase, although three years is hardly long enough to indicate a trend, and, as already mentioned, other factors may be involved. It is, however, something on which attention should be focused in future.

Discharges from Care

Reason for discharge is presented in Table 3.2 (and data for 1983 have been included here).

Looking at Table 3.2, it seems heartening that in each year over 85 per cent of children discharged were (re)introduced into a family setting. There are no details of the families concerned, but it is to be hoped that the situations which created the necessity for the placement in care had resolved themselves. No data are available on whether or not the return home was planned, and if it had been planned, what involvement parents had in the planning.

In the cases of the children in care in 1982, the data on which the study is based, those who were (re)introduced to families had mainly come into care because of parental incapacity — either temporary two-parent incapacity; one-parent incapacity — or had been placed in care to await adoption, and were now adopted (total 78 per cent — Table 3.3). Nine per cent of those returned to their families had come into care because of active parental abuse and, in these cases, again it is to be hoped that the situations to which these children returned had been fully investigated and the problems resolved before their return home.

Packman (1968, p. 196) comments on the arguments between the children's officers[3] in her study about discharges from care. On the one hand, some

Table 3.2: *Reason for Discharge from Care by Year*

Reason	*1980* per cent	*1981* per cent	*1982* per cent	*1983* per cent
(Re)introduced to (own) Family Situation	86.7	89.8	86.8	88.9
Reached legal age limit	5.7	4.9	8.8	5.4
In After-care/Self-sufficient	3.0	1.8	1.8	3.0
Admitted to Specialised Unit* / Absconded / Died* / Other	3.6	3.4	2.6	2.8
N =	1,143	1,234	1,228	1,061

*Categories introduced in 1982

χ^2 39.60 with 9 df $p < .01$ (Last four categories grouped for χ^2).

3 The former title in the UK for social workers assigned duties in relation to the care and protection of deprived children.

officers, with few children in care, argued that their colleagues were over-possessive about their children and did not rehabilitate them to their families often enough or quickly enough. Their colleagues argued in return that children *elsewhere* were often discharged precipitately and ill-advisedly, before their home circumstances had improved sufficiently to make genuine rehabilitation feasible. The result in their view was further family breakdowns and a greater measure of insecurity and deprivation for the children concerned.

Table 3.3: *Reason for Admission by Reason for Leaving Care, 1982*

Reason	*Reached legal age limit*	*Reunited with family rels./adopted*	*In After-care/self sufficient*	*Absconded Admitted to Spec. Unit/ Death/Other*	*Total*
One-Parent Family, Including Adoption	54.6	46.7	31.8	13.0	46.5
Active Parental Abuse	16.7	9.3	9.1	39.1	10.5
Temporary Parental Incapacity	1.9	30.7	4.5	–	27.1
Parental Disharmony	12.0	7.6	22.7	–	8.1
Parental Absence, Abrogation	10.2	2.8	13.6	–	3.6
Parental Inability to Control	4.6	2.9	18.2	47.8	4.1
N =	108	1,076	22	23	1,229

χ^2 = 224.82336 with 15 df. $p < 0.0$.

Retentions in Care

The next table lists the third group of "reasons" – reasons for retention in care over the four years for which there are reliable data. These are children in care for over three months and not awaiting adoption. Later characteristics of children in long-term care – i.e. more than one year in care will be considered in some detail.

In each year the largest proportion of children retained in care were retained there because there were no parents or relatives available to claim them. Nearly as large a proportion had parents who were still unable to cope with them. These two reasons accounted for about two-thirds of all retentions in each year. Where no parents or relatives were available, very little could now be done to fund them. The extent to which professional omissions had allowed a sense of attachment to wither is not known. However, the provision of whatever type of family support service was required could have reduced the proportion of children whose parents were unable to cope with them.

Table 3.4: *Reason for Retention in Care by Year*

Reason	*1980*	*1981*	*1982*	*1983*
Parents' Continuing Inability to Cope	28.8	28.3	29.0	31.0
No Parents or Relatives	37.7	37.8	36.0	33.5
Illness of Parents Mental/Physical	9.3	9.7	8.9	9.2
Marital Disharmony	6.2	5.4	5.9	5.5
Abusive Family Environment*	9.9(229)	11.1(265)	11.1(305)	13.4(324)
Parental Incapacity to Adequately Control	8.2	7.7	7.6	7.3
N =	2,319	2,392	2,420	2,415

χ^2 = 21.6778 with 15 df. $p < .20$

*Figures in parentheses are the numbers of children involved.

The proportion and number of children retained in care because of an abusive family environment appears to be increasing slightly. Hopefully this is because of more vigilant work with the families, and reluctance to return a child to its family until the situation is suitable for such a move, rather than an indication of an increase in the prevalence of abuse and neglect of children. It may well be that supports to help the child and its family are few, so the child must remain in care.

It is interesting to contrast the reasons for the children's entry into care with those constraints that kept them there. Table 3.5 notes the reason for admission by reason for retention in 1982. In the case of a child's parent's present inability to cope, that child was most likely to have been placed in care because of coming from a one-parent family unable to cope (46 per cent) or from a family where there was active parental abuse (33 per cent). Where the parents were either physically or mentally too ill for the child to return home, 80 per cent of the children had come into care for the same two reasons above. Nearly 70 per cent of the children who could not return home because of an abusive family environment had entered care originally for the same reason.

The high proportions of children from one-parent families unable to cope being retained in care would beg the question again of what is the definition of inability to cope and what efforts are being made to help these parent(s) to 'cope' effectively, and avoid the placement of their child in care. Where no parent(s) or relative(s) are available, some success may now be achieved in finding adoptive parents for these particular children in the future with the introduction of the previously mentioned changes in the Adoption Act, if adoptive parents willing to take older

Table 3.5: *Reason for Admission by Reason for Retention: Children in Care, 1982.*

Reason	*Parents' Continuing Inability to Cope*	*No parents/ Relatives Available*	*Illness of Parents, Mental, Physical*	*Marital Disharmony*	*Abusive Family Environment*	*Parental Incapacity to Adequately Control*	*No Reason Given*	*Total*
One-Parent Family, Including Adoption	46.3	44.3	37.6	11.2	15.8	33.8	64.6	1,037
Active Parental Abuse	33.8	15.5	46.1	23.3	68.7	29.1	9.8	690
Temporary Parental Incapacity	4.6	6.9	7.9	0.9	3.5	5.4	8.8	146
Parental Disharmony	5.2	11.4	5.1	55.2	8.5	2.7	4.0	231
Parental Absence, Abrogation	3.6	19.0	1.7	7.8	2.7	14.9	7.8	234
Parental Inability to Control	6.5	2.9	1.7	1.7	0.8	14.2	4.8	108
N =	613	736	178	116	259	148	396	2,446

χ^2 = 879.80273 with 30 df. $p < 0.0$.

difficult children can be found. It is unclear from the data whether or not parents who cannot or will not accommodate are in contact at all.

Where marital disharmony was concerned, 55 per cent of the children retained in care for this reason had been placed in care for the same reason. Had anything been done for these marriages? Did counselling services exist in the area and if so, could counselling have helped? What were the particular difficulties encountered by the partners? Were they financial, psychological, emotional? Was any help available in their area? The answers to these questions are not known, but they seem to be the most relevant ones to ask in the circumstances of children being placed in care because of marital disharmony.

So in looking at the three groups of reasons overall, it was found that the largest proportion of children entering care come from one-parent families unable to cope and the second largest because of temporary parental incapacity. When children are discharged, the majority are discharged to family situations, and when the children are retained in care it is mainly because there are no relatives to claim them, or their parents continue to be unable to cope with them. The data here may hide a lot of possible options for children to return to a family setting, e.g., if moneys/supports were available to relatives, they might take the child or apply to be foster parents, if that option were open.

Reason for Admission by Independent Variables

Concentration will now be on reason for admission in 1982, correlated with the independent variables, age, sex, birth status and area, followed by some other relevant variables, i.e., basis for admission, type of care and family size.

Table 3.6 gives reason for admission by age at admission and it seems that the younger a child is at admission the more likely he/she is to be from a one-parent family unable to cope. This holds even if the number of children awaiting adoption is deleted and would seem to indicate that one-parent families find problems with very young children, and find them early on, if they are to find them at all. The low level of supports and resources expose the weaknesses earlier.

Berridge (1985, p. 33) pointed out that adolescents come into care for different reasons than do younger children, and this study found that children who were victims of active parental abuse appear to be older at admission — in the age groups 2 years and over the proportions are similar (Table 3.6). As might be expected, a notable proportion of the children in the 12 years plus category have come into care because of being out of control (30.4 per cent). In the case of these children the question must be asked, what, if anything, is being planned to cater for this group? Adolescent placement schemes with appropriate funding/training need to be in place to focus on helping the adolescent and the family work through their difficulties.

Table 3.6: *Reason for Admission by Age at Admission During 1982*

Reason	*<2 years*	*2-3*	*4-6*	*7-11*	*12+*
One-Parent Family Incl. Adoption	63.7	37.4	31.5	27.9	18.7
Active Parental Abuse	13.6	26.0	31.0	29.8	24.2
Temporary Parental Incapacity	10.3	17.4	14.9	14.7	11.7
Parental Disharmony	6.7	10.7	12.7	10.1	7.7
Parental Absence, Abrogation	5.6	8.0	8.9	10.5	7.4
Parental Inability to Control	0.3	0.6	1.0	7.0	30.4
N =	1,511	535	629	674	326

χ^2 = 1016.16040 with 20 df. $p < 0.0$.

Where actual age is concerned (Table 3.7), the largest proportion in each age group is from one-parent families and children awaiting adoption. With the exception of the < 2 year age group, a considerable proportion of children in each age group is in care because of active parental abuse.

Table 3.7: *Reason for Admission by Actual Age*

Reason	*<2 years*	*2-3*	*4-6*	*7-11*	*12-14*	*15+*
One-Parent Family Incl. Adoption	69.1	42.0	39.2	36.0	33.2	41.1
Active Parental Abuse	8.4	22.1	27.9	29.1	26.4	19.4
Temporary Parental Incapacity	15.0	20.9	16.1	13.7	7.3	7.3
Parental Disharmony	4.3	7.2	10.6	10.6	10.9	10.1
Parental Absence, Abrogation	3.2	7.2	5.7	8.3	9.3	12.2
Parental Inability to Control	0.0	0.7	0.5	2.3	12.9	10.8
N =	693	417	577	867	549	572

χ^2 = 569.74316 with 25 df. $p < 0.0$.

The difference between the reason for entering care and age, actual and at admission is significant at the 0.0 level.

In the sex breakdown by reasons for admission, the only reason where any discrepancy occurs between boys and girls is where children are out of control. Nearly twice as many boys as girls are in care because of being out of control. Girls are only slightly more likely to be in care because of abuse and neglect and boys because of being from one-parent families. Otherwise the proportions are very similar in each reason for admission (Table 3.8, $p < 0.0103$).

Where birth status is concerned, Table 3.9 shows that in all categories the proportions of legitimate and illegitimate children are quite different, indicating that legitimate and illegitimate children enter care for significantly different reasons ($p<0.0$). Legitimate children come into care for a greater variety of reasons than illegitimate children, 75 per cent of whom are from one-parent families unable to cope and for adoption, in comparison to 21 per cent of legitimate children. Legitimate children are more likely to enter care because of active parental abuse (32 per cent), than for any other reason. These differences may well be only artefacts of the designation of most illegitimate children as coming from "one-parent families unable to cope". An illegitimate child could be abused or neglected because his/her single mother could not cope financially and/or emotionally with him/her, but he/she would have been categorised as being from a one-parent family unable to cope. A legitimate child in a similar situation would be recorded as being abused or neglected. Here again the difficulty with the reason is evident.

Table 3.8: *Reason for Admission by Sex*

Reason	*Male*	*Female*	*Total*
One-Parent Family Incl. Adoption	44.1	43.5	43.8
Active Parental Abuse	20.8	23.9	22.3
Temporary Parental Incapacity	13.0	13.1	13.0
Parental Disharmony	9.1	9.0	9.0
Parental Absence, Abrogation	7.6	7.5	7.6
Parental Inability to Control	5.4	3.1	4.3
N =	1,922	1,753	3,675

χ^2 = 15.00644 with 5 df. $p < 0.0103$

There are significant differences also between the Health Boards and the reasons for admission ($p<0.0000$). Where the reason for admission is one-parent family unable to cope, all but the Southern Health Board have over 40 per cent of children in care for this reason, indeed the Western Health Board has 54 per cent. Looking more closely at this reason, however, it may be noted that the proportion of children awaiting adoption is 20 per cent in the case of Western Health Board and 16 per cent in the case of the North Western. These proportions are very much higher than for the other Health Boards, and explanations for the high numbers of admissions for adoption in these Health Boards will be sought in Chapter 5.

Table 3.9: *Reason for Admission by Birth Status**

Reason	*Legitimate*	*Illegitimate*	*Total*
One-Parent Family Including Adoption	21.2	75.5	43.7
Active Parental Malevolence	31.8	9.5	22.6
Temporary Parental Incapacity	18.7	5.4	13.2
Parental Disharmony	13.8	1.6	8.8
Parental Absence, Abrogation	8.0	6.4	7.4
Parental Inability to Control	6.5	1.5	4.5
N =	2,096	1,477	3,573

*Excluding 102 Extra-Marital Children.

χ^2 = 1087.86255 with 5 df. $p < 0.0.R$

Table 3.10: Reason for Admission by Health Board

Reason	Eastern	Midland	Mid-Western	North-Eastern	North-Western	South-Eastern	Southern	Western	Total
One-Parent Family Including Adoption	41.9	45.2	47.6	45.7	49.7	45.7	32.7	53.5	43.8
(Adoption Only)	(6.5)	(2.3)	(2.0)	(3.2)	(16.2)	(5.3)	(2.1)	(20.1)	
Active Parental Abuse	23.6	23.2	19.1	19.5	22.0	19.2	27.9	19.4	22.3
Temporary Parental Incapacity	14.7	10.4	11.5	15.8	13.1	8.8	17.9	7.0	13.0
Parental Disharmony	7.9	6.9	10.2	9.5	10.5	12.6	7.4	9.2	9.0
Parental Absence, Abrogation	5.8	13.1	5.9	7.2	2.6	11.2	9.3	8.8	7.6
Parental Inability to Control	6.0	1.2	5.7	2.3	2.1	2.5	4.8	2.2	4.3
N =	1,377	259	460	221	191	475	419	273	3,675

χ^2 = 138.92451 with 35 df. $p < 0.0000$.

Reason for Admission by Other Relevant Variables

Turning now to other relevant variables, had basis for admission an effect on reason for admission? Table 3.11 indicates that there are significant differences between the reasons why children enter care and their basis for admission, particularly where one-parent families and active parental abuse are concerned. In the case of children placed in care through being from a one-parent family, 96 per cent were in care voluntarily in contrast with 52 per cent of children from an abusive family environment. This meant that 48 per cent of these latter children had to be taken into care by Court Order.

The question of what kind of care is provided for each kind of case is detailed in Table 3.12.

Here there are significant differences between the type of care a child receives and the reason for its admission to care. One-parent family children are most

Table 3.11: *Basis for Admission by Reason for Admission*

	One-Parent Family Unable to Cope, Incl. Adoption	*Active Parental Abuse*	*Temporary Parental Incapacity*	*Parental Disharmony*	*Parental Absence or Abrogation*	*Parental Inability to Control*	*N*
Voluntary	95.9	51.8	94.4	86.4	84.5	89.9	3083
Court Order	4.1	48.2	5.6	13.6	15.5	10.1	592
N =	1,609	819	479	331	278	159	3,675

χ^2 = 841.72705 with 5 df. $p < 0.9$.

Table 3.12: *Type of Care by Reason for Admission*

Reason	*One-Parent Family Incl. Adoption*	*Active Parental Abuse*	*Temporary Parental Incapacity*	*Parental Disharmony*	*Parental Absence, Abrogation*	*Parental Inability to Control*	*Total*
Foster Care	66.5	39.9	40.3	50.5	68.0	7.5	1,958
Residential Care	33.3	58.5	59.3	49.6	31.6	92.4	1,699
Short-Term Foster	18.3	7.3	28.6	13.0	4.0	0.6	547
Long-Term Foster	39.9	31.9	10.9	36.9	64.0	6.9	1,266
Short-Term Residential	11.1	9.5	38.6	10.0	4.3	18.2	516
Long-Term Residential	22.2	49.0	20.7	39.6	27.3	74.2	1,183
Private Foster Care / Supervision at Home	8.4	2.3	1.3	0.6	0.4	–	163
N =	1,609	819	479	331	278	159	3,675

χ^2 = 941.02173 with 20 df. $p < 0.0$.

likely to be in foster care, while children from a background where there is active abuse and neglect are more likely to be in residential care. In these cases, the first group are more likely to be young and illegitimate, whereas the second group are more likely to be older and legitimate. As noted, these latter children may be disturbed and foster homes difficult to find for them. Berridge (1985, p.39) feels that there will always be a significant group of children for whom fostering is difficult to organise. However, long-term foster homes have obviously been found for some, since 20 per cent of those in long-term foster care are in care for this reason.[4] Where children are out of control they are almost always placed in residential care which also confirms the statement that residential care is more likely to cater for difficult or disturbed children than foster care, although it is also difficult to find residential places for very disturbed difficult children. Berridge (op. cit., p.8) for instance, found that residents of children's homes in Britain are more likely to be older adolescents who can be extremely awkward and anti-social.

Turning to family size, did the reason for entering care differ by the number of siblings a child had? The first part of Table 3.13 shows that there were significant differences in the reasons by number of siblings. The fewer siblings a child had the more likely they were to be from a one-parent family unable to cope (72 per cent of only children). Where active parental abuse or neglect was concerned, it appeared that the larger the family the greater the likelihood that the child had this type of parents — almost 50 per cent of those with 6 siblings or more came into care for this reason.

4 In a private communication a social worker from the Eastern Health Board noted that the Board had some success in placing a number of very disturbed and difficult children in foster care.

Similarly, there were significant differences in the reasons for entering care by the number of siblings in care. Clearly, in the case where there was active parental abuse, the larger the number of siblings in care, the higher the proportion in care for this reason, indicating that children in care from large families are more prone to abuse and neglect than children in care from smaller families. There is an implication here that whole families are in care, since in over 50 per cent of the cases the child had 1 or more siblings in care.

Table 3.13: *Reason for Admission by Number of Siblings*

	No. of Siblings						*No. of Siblings in Care*					
Reason	*0*	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*
One-Parent Family Including Adoption	72.2	43.7	26.7	21.8	20.4	18.6	62.4	34.5	22.2	26.4	16.4	21.4
Active Parental Abuse	8.7	19.8	23.5	26.1	36.0	49.7	12.3	24.6	29.2	27.0	43.5	55.7
Temporary Parental Incapacity	6.6	13.2	21.2	20.9	17.8	11.3	9.1	15.6	21.5	17.3	15.8	9.3
Parental Disharmony	2.3	12.2	13.8	14.3	15.7	7.9	3.3	14.0	11.6	17.9	17.6	8.6
Parental Absence, Abrogation	6.9	8.5	10.8	10.6	5.6	8.4	6.9	8.1	12.1	8.8	4.5	5.0
Parental Inability to Control	3.3	2.6	3.9	6.3	4.5	4.2	6.0	3.3	3.4	2.6	2.4	0.0
N =	1,368	531	434	426	534	382	1,790	643	414	352	336	140

χ^2 = 1012.07788 with 25 df.p< 0.002 χ^2 = 770.65820 with 25 df.p < 0.0002

Discharges by Independent Variables

Reasons for discharge from care in 1982 are first correlated with the four independent variables, age, sex, birth status and area, and then followed on with other relevant variables, i.e., basis for admission, type of care and family size.

Tables 3.14 and 3.15 indicate that the younger a child is at admission, and the younger in actual age the more likely he/she is to be reunited with family and relatives, and the older a child is at admission, and in actual age the more likely he/she is to leave when they reach legal age limit. Berridge (1985) found in relation to residential care that those who linger in care are mostly adolescents, irrespective of the build-up of years in care.

Sex proved to be the only variable where there was no significant difference apparent in the reasons for discharge ($p<0.3074$), (table not included) although in the case of birth status the differences were not highly significant ($p<0.0818$) – children, irrespective of status, were most likely to be reunited with family, relatives or to be adopted. When adoptions were excluded, illegitimate children

Table 3.14: *Reason for Discharge by Age at Admission*

Reason	*<2 years*	*2-3 years*	*4-6 years*	*7-11 years*	*12+*	*Total*
Reunited with Family/ Relative Adopted	92.9	90.2	89.8	80.9	61.7	86.8
Reached Legal Age Limit	6.1	7.8	7.0	12.9	18.0	8.8
In After-Care/Self-Sufficient	0.7	1.3	0.6	2.1	8.3	1.8
Admitted to Specialised Unit / Absconded / Death of Child / Other	0.4	0.7	2.5	4.1	12.0	2.6
N =	592	153	157	194	133	1,229

χ^2 = 172.75241 with 12 df. $p < 0.002$.

Table 3.15: *Reason for Discharge by Actual Age*

Reason	*<2 years*	*2-3 years*	*4-6 years*	*7-11 years*	*12-14 years*	*15+ years*	*Total*
Reunited with Family/ Relatives Adopted	98.4	95.8	91.8	92.5	76.7	46.5	86.8
Reached Legal Age Limit	0.9	4.2	5.3	5.9	4.7	39.5	8.8
In After-Care/Self-Sufficient	0.2	0.0	0.0	0.0	0.0	11.4	1.8
Admitted to Specialised Unit / Absconded / Death of Child / Other	0.4	0.0	2.9	1.6	18.6	2.7	2.6
N =	437	165	170	186	86	185	1,229

χ^2 = 577.03613 with 15df. $p < 0.002$.

were still most likely to be reunited with their families or relatives, although less likely than legitimate children. One-fifth of illegitimate children were discharged only when they reached the legal age limit (Table 3.16), in contrast with 8 per cent of legitimate children, indicating that more illegitimate children remained in care until they were adults.

Where area is concerned, there were significant differences between the Health Boards and the reasons for discharge. In the Mid-Western and Western Health Boards, for instance, well over 90 per cent of the children in their care were reunited with families/relatives or adopted, in comparison to, say, 76 per cent of children discharged in the North-Eastern Health Board. However, as noted earlier, 20 per cent of children admitted to care in the Western Health Board

Table 3.16: *Reason for Discharge by Birth Status*

Reason	*Legitimate*	*Illegitimate*		*Extra Marital*	*Total*
		Excl. Adoption	Incl. Adoption		
Reunited with Family/Relatives	86.1	74.3	36.5	95.5	63.5
Adopted		–	51.0		23.3
Reached Legal Age Limit	7.9	20.6	10.0	4.5	8.8
In After-Care/Self-Sufficient	2.0	3.3	1.6	0.0	1.8
Admitted to Specialised Unit Absconded Death of Child Other	3.9	1.8	1.0	0.0	1.6
N =	648	272	559	22	1,229

χ^2 = 19.28748 with 6df. p<0.0818.

were for adoption, so that may account for the high proportion in the category – reunited with family/relatives/adopted in that Health Board. This was not the case in the Mid-Western Health Board area, however, where only 2 per cent of the children were admitted to await adoption, so some other explanation must be sought (see Table 3.10). The Mid-Western Health Board appears to be able to return almost all its children to their families or relatives on discharge, and have few adoptions.

Table 3.17: *Reason for Discharge by Health Board*

Reason	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North Western*	*South-Eastern*	*Southern*	*Western*	*Total*
Reunited with Family/Relatives Adopted	85.4	87.5	95.5	76.5	88.9	86.0	87.1	93.8	87.6
Reached Legal Age Limit	12.2	5.0	3.8	11.8	11.1	8.9	6.4	2.7	8.8
In After-Care/Self-Sufficient	1.3	3.8	0.8	5.9	0.0	3.2	0.0	3.5	1.8
Admitted to Specialised Unit Absconded Death of Child Other	1.1	3.8	–	5.9	–	1.9	6.4	–	1.9
N =	474	80	133	51	81	157	140	113	1,229

χ^2 = 65.61589 with 21 df.p < 0.00.

In what type of care were the discharged children during their stay in care? Of those reunited with their families, just over 70 per cent had been in short-term care, and, as might be expected, for those who left care having reached the legal age limit, 80 per cent had been in long-term care. The differences here were significant ($p<0.0$, Table 3.18). The numbers in the other categories are too small for comment.

Did the number of siblings a child had affect the reason for discharge? There were significant differences here and children with 6 or more siblings were least likely to be reunited with their families (Table 3.19, $p<0.0000$), and although the number of children who absconded was low, the majority of them were from families of 6 or more.

Where children had siblings also in care similarly significant differences occurred and again those with 6 or more siblings in care were least likely to be reunited with their families, a higher proportion of these latter than any other group left having reached the legal age limit. It seems possible then that some of the whole families placed in care are never reunited with their parent(s). A proportion had come into care because of active parental abuse or neglect. Particular concern must be expressed for these children, for while the numbers are small they have had a very disturbing experience in their lives and were now discharged from care having no home base.

Table 3.18: *Type of Care by Reason for Discharge*

Type of Care	*Reunited with Family Relatives Adopted*	*Reached Legal Age Limit*	*In After-Care/Self Sufficient*	*Admitted to Special Unit/ Absconded/ Other*	*Total*
Short-Term (Foster and Residential)	71.5	2.8	9.0	77.4	64.6
Long-Term (Foster and Residential)	24.9	80.5	90.9	22.6	30.5
Short-Term Foster	37.5	0.9	4.5	6.4	33.0
Long-Term Foster	7.9	37.0	54.5	–	11.1
Short-Term Residential	34.0	1.9	4.5	71.0	31.6
Long-Term Residential	16.6	43.5	36.4	22.6	19.4
Private Foster Supervision at Home	4.0	6.7	0.0	0.0	4.9
N =	1,068	108	22	31	1,229

$\chi^2 = 317.02466$ with 15 df. $p < 0.0$.

Table 3.19: *Reason for Discharge by Number of Siblings*

Reason	*Number of siblings*						*Number of siblings in care*					
	0	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*
Reunited with Family/Relatives	86.5	87.7	92.7	95.5	84.2	77.3	86.6	90.6	86.7	92.2	87.7	68.4
Adopted	11.0	9.8	6.0	3.0	7.9	8.0	10.0	7.9	8.1	5.9	3.7	15.8
Reached Legal Age Limit	1.6	1.8	1.3	0.8	1.3	6.7	2.3	1.0	0.7	2.0	1.2	0.0
In After-Care/Self Sufficient												
Admitted to Specialised Unit												
Absconded												
Death of Child	0.9	0.6	–	0.8	6.6	8.0	1.0	0.5	4.4	0.0	7.4	15.8
Other												
N =	556	163	150	133	152	75	689	203	135	102	81	19

χ^2 = 64.50897 with 15 df.p < 0.0000 χ^2 = 54.71762 with 15 df.p < 0.0000

Length of Time in Care

Length of time in care has been noted as an important factor in a child's subsequent adjustment (see, for instance, Rowe and Lambert, 1973; Richardson, 1985; Millham *et al.*, 1986 and Packman *et al.*, 1986). Here are shown the lengths of time spent in care by those children discharged in 1982, as the exact length of their stay in care can be measured. Decisions about length of stay are a vital ingredient in child-care planning. A special study, initiated and funded by the DHSS in Britain, was undertaken by the National Children's Bureau there to examine the factors contributing to the differing lengths of time children stay in care. Some detailed comment will be made on the findings at a relevant stage in this study. Here, concentration will be on those discharges from care in 1982 by length in care, as it seems the most appropriate place to include this information.

When length in care by reason for admission is examined, significant differences are apparent. Table 3.20 shows that children who came into care because of abuse or neglect or because their parents were dead or had abandoned them, were on the whole more likely to spend longer in care than children entering for other reasons. No doubt the reaction of social workers to discharging these two particular groups of children was different to that of discharging others, in that orphaned or abandoned children had no families to return to and alternative families had to be found. In the case of children from an abusive

family background, although their families may have been available to take them, social workers would be reluctant to return the children until they were satisfied that the situation in the home was suitable.

When children were discharged from care, 95 per cent of those in care for less than one year were reunited with their families and were significantly more likely to be reunited with their families than those longer in care. The longer in care the less likely to be reunited with family. This would confirm other studies' findings that children who leave care within a short time are those whose families have kept in close contact with them, and vice versa. See, for instance, Rowe and Lambert's 1973 study.

Table 3.20: *Length in Care by Reason for Admission*

Length in Care	*One Parent Family Incl. Adoption*	*Active Parental Abuse*	*Temporary Parental Incapacity*	*Parental Disharmony*	*Parental Absence, Abrogation*	*Parental Inability to Control*	*Total*
<6 Months	61.4	46.5	92.8	61.0	34.1	52.9	823
7-11 Months	5.9	8.5	2.1	8.0	4.5	5.9	65
1 Year	4.9	16.3	1.2	4.0	22.7	17.6	76
2-3 Years	9.4	12.4	1.8	10.0	11.4	13.7	98
4-6 Years	5.4	6.2	0.3	3.0	6.8	7.8	50
7 Years+	12.9	10.1	1.8	14.0	20.5	2.0	117
N =	572	129	333	99	44	51	1,228

χ^2 = 212.17021 with 25 df $p < 0.0$.

Table 3.21: *Reason for Discharge by Length in Care Reason for Discharge*

	<6 Months	*7-11 Months*	*1 Year*	*2-3 Years*	*4-6 Years*	*7 Years+*	*Total*
Reunited with Family/Relatives							
Adopted	96.1	92.3	84.2	81.6	60.0	43.6	1076
Reached Legal Age Limit	1.0	6.2	11.8	14.3	34.0	47.9	108
In After-Care/Self Sufficient	0.2	1.5	3.9	4.1	4.0	8.5	22
Admitted to Specialised Unit/ Absconded/ Death of Child/ Other	2.7	–	–	–	2.0	–	31
N =	823	65	76	98	50	117	1229

χ^2 = 395.64233 with 15 df. $p < 0.002$

Taking length in care by the independent variables, age, sex, birth status and area, first age at admission will be considered.

Table 3.22 shows that length of time in care is significantly related to age at admission. Children coming into care at an older age may expect to spend longer in care.

Table 3.22: *Length in Care by Age at Admission, for All Discharged in 1982*

	Age at Admission					
Length of Stay	*<2 Years*	*2-3 Years*	*4-6 Years*	*7-11 Years*	*12+ Years*	*Total*
<6 Months	74.2	69.9	68.8	55.7	45.9	823
7-11 Months	5.1	3.3	2.5	7.2	9.0	65
1 Year	4.1	3.9	8.3	7.7	13.5	76
2-3 Years	6.4	4.6	5.1	6.7	24.1	98
4-6 Years	3.5	2.6	2.5	8.2	3.8	50
7 Years+	6.8	15.7	12.7	14.4	3.8	117
N =	592	153	157	194	133	1,229

χ^2 = 126.58087 with 20 df. $p < 0.0000$

The length a child spends in care is not sex specific, nor are there highly significant differences in length in care by birth status. However, significant differences do occur between length of time in care and Health Board areas, as Table 3.23 clearly demonstrates. For instance, just 86 per cent of children in the Mid-Western Health Board had spent less than one year in care, compared with 58 per cent of children in care in the South-Eastern Health Board. There is no way of knowing exactly why the Health Boards differ in this way, but, as previously mentioned, this whole question of divergences between areas on aspects of children's care will be examined in some detail in the Summary and Conclusions.

Table 3.23: *Length in Care by Health Board*

	Health Board								
Length in Care	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
<6 Months	63.3	66.3	80.5	58.8	74.1	53.5	75.0	74.3	67.0
7-11 Months	6.8	2.5	5.3	5.9	1.2	4.5	4.3	6.2	5.3
1 Year	5.3	3.8	4.5	5.9	3.7	10.8	7.1	8.0	6.2
2-3 Years	9.7	7.5	3.8	15.7	8.6	10.2	2.9	5.3	8.0
4-6 Years	5.1	7.5	0.7	0.0	4.9	7.6	0.7	1.8	4.1
7 Years+	9.9	12.5	5.3	13.7	7.4	13.4	10.0	4.4	9.5
N =	473	80	133	51	81	157	140	113	1,228

χ^2 = 72.57118 with 35 df. $p < 0.0002$

On the question of discharges by basis for admission — were children placed in care under a court order more likely to be retained longer in care than others placed voluntarily in care? Table 3.24 shows that overall there is a significant difference between the length of time either group spend in care — voluntary admissions spending a significantly shorter time in care than court order admissions.

Children Retained in Long-Term Care

It has been noted that long-term care is regarded as being detrimental to the well-being of the child in most cases (see, for instance, Packman *et al.*, 1986; Rutter, 1981; Adcock, 1980; and Bowlby, 1953). In this section those children

Table 3.24: *Length in Care by Basis for Admission*

Length in Care	*Voluntary Admission*	*Court Order Admission*	*Total*
<6 Months	68.2	49.4	67.0
7-11 Months	5.1	8.4	5.3
1 Year	5.2	19.3	6.2
2-3 Years	7.5	14.5	8.0
4-6 Years	4.0	4.8	4.1
7 Years+	9.9	3.6	9.5
N =	1,145	83	1,228

χ^2 = 38.51981 with 5 df. $p < 0.0000$

who have been retained in care for over one year are being selected out for examination of their characteristics. These children have been identified as having been in care on 1 January 1982 and still in care on 31 December 1982. The reasons why they were placed in care and retained for such a long time will first be considered.

A large proportion — 80.4 per cent of the 2,393 children in care at the beginning of 1982 were still in care at December 31st of that year. Table 3.25 gives the reason for admission to care of the 1,924 children in long-term care.

The main reasons why these children came into care were "one-parent family unable to cope" and "active parental abuse". Notable here is the difference in the proportions of children who came from homes where there was active parental abuse or neglect and the length of time in care. Over a quarter of the children

Table 3.25: *Reason for Admission – Children Unadmitted/Undischarged in 1982, and Children in Short-Term Care*

Reason for Admission	*Percentage*	*Children in Short-Term Care Percentage*
One-Parent Incapacity (Including Adoption)	43.7	40.8
Active Parental Abuse	26.9	8.4
Temporary Parental Incapacity	5.5	37.8
Parental Disharmony	10.5	7.9
Parental Absence/Abrogation	11.0	1.7
Parental Inability to Control	2.5	3.4
N =	1,924	760

Significant differences occurred between the reason for admission of short- and long-term care children.
$\chi^2 = 537.7710$ with 5 df. $p < 0.0$

in long-term care (27 per cent) came from this type of background in comparison with only 8 per cent of those in short-term care.

Why had children in long-term care not been returned to their families? Table 3.25A gives the details. Almost one-third had no parents or relatives willing to accommodate them. As noted earlier, with the introduction of new legislation, allowing legitimate and abandoned children to be adopted, it is to be hoped that some of the children in long-term care because of no parents or relatives willing or able to claim them will now be adopted.

If it is argued that the new legislation will assist some of these long-term in care children to find new families, then it must be enquired what proportion of these children are legitimate, since illegitimate children would already have been potentially adoptable. Sixty-one per cent of the children in long-term care for whatever reason are legitimate. The hope that some of these children may be adopted in the future is somewhat chastened by the knowledge that in 1982, 46 per cent were admitted to care at four years old and upwards and 70 per cent were seven years old or more on 31 December 1982. Older children are, of course, less likely to be adopted. Overall, however, the effect of the new legislation should be positive for some children in the future who might otherwise be likely to spend a long time in care. It is appreciated, of course, that there may be special difficulties attendant on placing older children for adoption, e.g., the child needs preparation.

Table 3.25A: *Primary Reason Why Child is Not Reunited with Family — Children Unadmitted/Undischarged in 1982*

Reason	*Frequency*	*Percentage*
Parents' Continuing Inability to Cope	472	24.5
Abusive Family Environment	199	10.4
No Parents or Relative Willing to Accommodate	631	32.8
Illness of Parents, Mental or Physical	151	7.8
Marital Disharmony	99	5.1
Parental Incapacity to Adequately Control	121	6.3
No Reason Given	251	13.0
N =	1,924	100.0

Table 3.26 details the reason for retention by reason for admission to care and shows that there are significant differences between the categories.

Almost two-thirds of the 840 children who entered care because of coming from a one-parent family unable to cope, and spent more than a year in care, were still being retained because either their parents were unable or unwilling to accommodate them or they continued to be unable to cope, which may be the same thing. Children who had been placed in care because of active parental abuse or neglect were unable to return home because this was still the situation in one quarter of the cases. It is noted also that 105 of these children in long-term care had originally entered care because of a temporary or short-term parental incapacity, which apparently became long term.

When considering the reason for retention in care by sex of children in long-term care, it is clear that there are no significant differences between the reasons for retention in care and the sex of the child (χ^2 / 14.73537 with 10df.$p<0.1420$) (table not included).

Reason for Retention by Birth Status

Significant differences occurred between birth status and reason for retention. For instance, over 14 per cent of legitimate children were retained in care because their family environment was abusive, in contrast with 4 per cent of illegitimate children (Table 3.27). There was a relatively large proportion of "No reason given" (just 22 per cent) where illegitimate children were concerned and the distribution of these reasons for retention may have made a difference to the other proportions. However, there is no way of obtaining that information, so Table 3.27 must be accepted as it stands.

Table 3.26: *Reason for Retention in Care by Reason for Admission*

Reason for Retention	*Active Parental Abuse*	*One-Parent Family Unable to Cope*	*Parental Marital Disharmony*	*Parental Inability to Control*	*Temporary Absence/ Abrogation*	*Parental Incapacity*	*N*
Parents or Relatives Unwilling to Accommodate	17.8	34.8	37.1	6.3	61.1	38.1	631
Illness of Parents, Mental/Physical	12.4	7.4	3.5	4.2	1.4	12.4	151
Parents' Inability to Cope	28.2	26.9	15.3	50.0	10.0	22.9	472
Abusive Family Environment	25.4	3.7	10.9	2.1	1.9	8.6	199
Marital Disharmony	5.0	1.5	24.8	0.0	4.3	1.0	99
Parental Incapacity to Adequately Control	6.3	5.5	2.0	22.9	9.0	7.7	121
No Reason Given	4.8	20.2	6.4	14.6	12.3	9.5	251
Total	518	840	202	48	211	105	1,924

χ^2 = 622.86035 with 30df. $p < 0.0$

Table 3.27: *Reason for Retention by Birth Status — Children Unadmitted/Undischarged in 1982.*

Reason	*Legitimate*	*Illegitimate*
Parents' Continuing Inability to Cope	28.5	18.7
Abusive Family Environment	14.3	4.4
No Parents or Relatives Willing to Accommodate	29.3	38.7
Illness of Parents Mental or Physical	7.8	8.5
Marital Disharmony	6.9	1.2
Parental Incapacity to Adequately Control	5.8	6.6
No Reason Given	7.5	21.7
N =	1,137	728

χ^2 = 183.96893 with 6df. $p<0.0$.
(Full list of reasons on questionnaire Appendix F).

Since the proportion of legitimate children coming from an abusive environment was more than three times that for illegitimate children, this must beg the question — is the greater likelihood of a father's presence a contributory factor in abuse and neglect of children. This is assuming, of course, the greater likelihood of the presence of the father where legitimate children are concerned.

Reason for Retention by Area

Where area is concerned, there are significant differences between Health Boards and the reasons why children are retained in care. For instance, just half of the children in long-term care in the North-Western Health Board are retained because they have no parents or relatives to accommodate them, while only one-fifth of the children in long-term care in the Midland Health Board are in the same position (Table 3.28). The North Western Health Board has also the highest proportion of children from abusive family environments (20 per cent); while the Midland Health Board has a relatively low proportion (5.2 per cent). The explanation for the differences may simply be in terms of differences in interpretation of the categories. This is another aspect of this situation to be examined more fully in the chapter *Summary and Conclusions.*

A number of children who had been in care before January 1st 1982 and who were still in care on 31st December 1982 had been recorded on the questionnaires as being in short-term care, but they have been included in the figures on Table 3.29 which gives the details of the reason for retention by the type of care. No doubt they had originally been thought of as 'short-term' cases, but developed into long-term.

Significant differences occur between the reason for retention and the type of care a child is in. Where there are no parents willing to accommodate — parents unable to control their children or where there is marital disharmony, the majority of children have been placed in foster care. On the other hand, where the family environment is abusive, parents are ill or continue to be unable to cope, the majority were in residential care. It is not known at this point what the reasons are for these differences, perhaps they are again based on age, sex, status and area? These variables, correlated with type of care will be examined in the chapter on *Types of Care* and whether or not these variables are influential in deciding type of care will be checked.

Comparing children in long-term care with children in short-term care, children in long-term care were more likely to have been from an abusive family environment or to have had absent parents than children in short-term care (Table 3.25). All of the tables have not been included here, but the data have been checked and children in long-term care were older at admission and, of course, older on 31 December, 1982. No differences appeared between boys and girls in short and long-term care — the proportions were each in line with the Census proportions. As regards birth status, legitimate children appeared to be slightly more likely to be in long-term than short-term care — 59 per cent in long-term care were legitimate and 54 per cent in short-term, while illegitimate children were slightly more likely to be in short-term care, 38 per cent in long-term were

Table 3.28: *Reason for Retention by Health Board — Children Unadmitted/Undischarged in 1982*

Reason	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
Parents' Continuing Inability to Cope	24.9	26.1	26.6	23.9	10.5	23.1	30.9	19.3	24.5
Abusive Family Environment	10.7	5.2	10.3	9.6	20.0	9.3	14.3	1.6	10.4
No Parents or Relatives Willing to Accommodate	31.4	21.6	21.9	48.5	49.5	34.0	34.3	38.7	32.8
Illness of Parents, Mental or Physical	6.0	6.7	15.5	4.5	9.5	7.1	7.0	10.9	7.8
Marital Disharmony	5.2	11.2	10.3	1.5	3.2	3.4	3.9	0.0	5.1
Parental Incapacity to Adequately Control	6.2	23.1	5.6	0.0	5.3	5.2	3.9	4.2	6.3
No Reason Given	15.6	6.0	9.9	11.9	2.1	17.9	5.7	25.2	13.0
N =	711	134	233	134	95	268	230	119	1,924
χ^2 = 250.36981 with 42 df. p< 0.0000									
Children in long-term care (%)	37.0	7.0	12.1	7.0	4.9	13.9	12.0	6.2	1,924
Children in short-term care (%)	37.5	6.7	12.8	3.3	7.0	9.3	13.7	9.7	760

See Chapter 2 – groups (b) and (c)

Table 3.29: *Type of Care by Reason for Retention*

Type of Care	*Parents' Continuing Inability to Cope*	*Abusive Family Environment*	*Parents/ Relatives Unwilling to Accommodate*	*Illness of Parents Mental/ Physical*	*Marital Disharmony*	*Parental Incapacity to Adequately Control*	*No Reason Given*	*Total*
Foster Care	43.3	41.6	66.7	47.7	53.1	59.2	84.0	58.0
Residential Care	56.7	58.4	33.3	52.3	46.9	40.8	16.0	42.0
N =	471	197	631	150	98	120	250	1,918*

χ^2 = 141.26964 with 6df. p < 0.000

*Excludes 6 children under supervision at home.

illegitimate, 43 per cent in short. Those awaiting adoption may account for a higher proportion of these latter children being in short-term care and deleting them would bring the proportions closer to each other. Where Health Boards were concerned, differences are shown at the bottom of Table 3.28. For the most part the proportions in each Health Board are fairly similar, both to each other and to their proportions in the Census population.

Finally, more children in long-term care were admitted by Court Order than children in short-term care (19 per cent, 6 per cent); and children in long-term care had somewhat more siblings, and particularly more siblings in care than children in short-term care (Table 3.30).

Table 3.30: *Number of Siblings of Children in Long- and Short-Term Care*

	Number of Siblings						*Number of Siblings in Care*						
Type of Care	*0*	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*	*N*
Children in Long-Term Care (%)	33.7	15.0	11.5	10.9	16.2	12.6	43.8	18.7	11.4	10.0	10.6	5.6	1924
Children in Short-Term Care (%)	42.6	12.8	13.8	13.2	11.9	5.6	52.1	16.4	13.7	9.3	7.1	1.3	760

Summary

The objectives set out for this chapter were to deal with the second group of critical questions posed in the Introduction — briefly, what factors combine to culminate in the placement, discharge or retention of a child in care, and what of children in long-term care?

Reason for placement, reason for discharge and reason for retention were the three sets of reasons observed.

The restrictions of the data were commented on together with the constraints imposed by the lack of information on secondary or contributory reasons for placement in, discharge from, or retention in care. Attention was drawn to the non-mutual exclusivity of the sets of reasons on the questionnaire.

The main findings in this chapter were:

(a) *Reason for Admission*

(i) Fairly similar proportions were recorded on reasons for admission over the years for which data were available, although a slight increase in the proportion and numbers placed in care for abuse and neglect was recorded;

(ii) the need for vigilance in respect of child abuse was stressed, and a hope expressed that the increase is rather in the level of discovery of, and reporting on abused children, than that the actual level of abuse is increasing;
(iii) one-parent families were over-represented in the proportion of families with children in care;
(iv) different age groups are placed in care for different reasons;
(v) legitimate children are placed in care for different reasons than illegitimate;
(vi) Health Board regions differ significantly in the reasons why they take children into care;
(vii) foster care is more often chosen for younger children. Older children are more often placed in residential care;
(viii) where the reason for admission was parental abuse or neglect, the family was more likely to be a large one, and legitimate.

(b) *Reason for discharge*
In general, the characteristics of the discharged group were:
(i) they were most likely to be reunited with their families, particularly younger children, irrespective of birth status;
(ii) there were no significant sex differences or status differences in reasons for discharge;
(iii) significant differences did occur between the Health Board regions;
(iv) significant differences were apparent in the type of care, basis for admission and family size. Short-term care and voluntary admission were most likely to lead to discharge to relatives. Those children from the largest families were least likely to be reunited with them.

(c) *Children retained in care*
(i) children of one-parent families were over-represented;
(ii) almost three-quarters of these children came from one-parent and abusing families;
(iii) over two-thirds of parents of these children were regarded as still being "unable to cope", the reason their child was placed in care originally;
(iv) they were older at admission, consequently older now than children in short-term care. More were admitted by Court Order and more came from larger families than children in short-term care, and they had more siblings in care also.

These findings along with those from the other chapters will be discussed more fully in the Summary and Conclusions chapter. At this point, however, it seems clear that overall, most children who enter care do so not because of behavioural problems, i.e., being out of control, but because of situational difficulties that affect their families from temporary illness to homelessness.

Chapter 4

TYPES OF CARE

As stated in the Introduction it is widely believed in this society that the best type of care for a child is a stable family setting. Love and security have been acknowledged as a basic need for children (see, for instance, Bowlby, 1953; Kellmer-Pringle, 1975 and Rutter, 1981). If a child is deprived of a stable family setting to such an extent as to be in need of care and protection, what is then available to that child? Here, the various types of available care will be examined, then the supply/demand for care will be considered, and the importance of placement near a child's family for ease of contact will be discussed.

Also it will be asked when a child is placed in care, 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 the four independent variables, age, sex, birth status and area. It will be ascertained whether or not significant differences occur between the children in either of the main types of care — foster and residential. What are the likely consequences of any differentiations?

Other aspects to be examined in this chapter are the type of care by family size — does the number of siblings affect the type of care a child is placed in; and given that residential care is regarded as being, in most cases, detrimental to the child's well-being, what are the reasons for a child being in residential care? Finally, the type of care by basis for admission is examined, to ascertain if children entering care on foot of a Court Order are placed in different type of care to other children, and possible reasons if that is so.

As noted in the Introduction there are 4 types of care relevant to this study and each of these will be examined before dealing with the stated questions. (Foster care, short-term and long-term; Residential care, short-term and long-term; Private Foster Care and Supervision at home.)

Foster Care

Foster care is defined in the *Task Force Report* (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.[5] 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 1, Robins (1980) spoke of the beginnings of a boarding-out system in Ireland as early as 1862, and the 1954 Boarding-Out Regulations contained a proviso that foster care should be the first option considered.

Foster care has advanced a great deal in some areas since its introduction in the 1950s. When the Health Board teams began to develop 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.

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 parents are chosen.

It may be noted here that the *Children (Care and Protection) Bill, 1987,* in Section 55, updates the law in relation to foster care. A new provision will enable a Health Board to place any child in its care in foster care, whereas at present only children who are orphaned or deserted, or whose parents are destitute may be placed in foster care by Health Boards. Another change to be introduced by this Bill is that whereas at present the Courts can commit deprived children directly into residential homes, in future a child coming into care through a Court Order will be placed in the care of a Health Board. That Board will decide what type of care is most suitable, — the first option being foster care. A Health Board can apply for a Care Order and the Health Board will have the same authority in respect of the child as if it was his or her parent. The text of the new Bill in preparation is not yet available, so it can only be assumed there will not be a great deal of difference in this section.

Private Foster Care

The *Task Force Report* (1980, p. 173) notes that the Children's Act (1908), as amended by the subsequent Children's Acts of 1934 and 1957 and Section 10

5. Boarding Out of Children Regulations, 1983, p. 5.

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. These are the children referred to in the legislation as children "at nurse". Children can 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.

The duties imposed on Health Boards relating to nursed-out children require 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).

In general, foster 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 a foster family, although, as Berridge concludes (p. 120), it would be naive to assume that foster care is suitable for all. A similar situation exists in Ireland. It goes without saying that it is impossible to quantify the availability of foster homes at any given time.

Residential Care

Residential or Children's Homes are for the sole purpose of providing necessary care for children who need care 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 available.

The majority of Children's Homes are run by Religious Orders, but some are administered by Protestant and non-denominational committees, and the balance are State administered. The proportions here are 87 per cent Roman Catholic, 6.4 per cent Protestant and 4.1 per cent non-denominational, 2.5 State Homes. (See Gilligan, Kearney and Lorenz, 1987). From 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 ages of sixteen.

The transfer in 1983 of functions relating to a number of Residential Homes

run by Religious Orders from the Minister for Education to the Minister for Health has placed statutory and administrative responsibility for all Children's Homes in one department (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).*

Like foster care, residential care can be short term or long term. The proportion and number of children in residential care appears to be more or less stable, according to the Department of Health reports. From time to time, certain homes could have a social worker on secondment from the Health Board, but it is by no means the general rule or practice. Ideally, child care workers should link up with social workers in the Health Boards. It was hoped that each child being placed in a residential home would have a named social worker, and if that social worker resigned, his/her caseload would be given to the person taking over. This liaison with residential homes is still very much in a state of transition. If operated successfully, no child would be in care without some connection between the residential home and the child's family.

The basis on which Children's Homes have been financed since January 1984 is a budgetary one. Prior to that date, the basis was *per capita.* This latter method of financing may have encouraged the admission of more children into residential care than necessary as it was important to have sufficient numbers to keep the income of the school at an acceptable level. Table 4.1 shows the number of residential places by community care and Health Board area and the proportion of places per head of population in each Health Board. It is clear from this table that wide variation exists across the Health Board and community care areas in availability of residential places.

Supply/Demand and Contact

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. However, certain information on the number of residential places available in each Health Board and community care area has been shown on Table 4.1. The emphasis on the availability of places in a child's own Health Board or community care area is guided by the research findings of the importance for a child of maintaining contact with its parents while in care.

In this context, Richardson (1985) notes in her study of children in long-term residential care in Ireland, that a consistent finding of research studies has been

Table 4.1: *Number of Places Available in Residential Homes in each Health Board and Community Area*

Health Board	*Community Care Area*	*No. of Places**	*Prop. of Places per Population (Health Board) (per cent)*
1	*2*	*3*	*4*
Eastern	1 Dun Laoghaire	147	0.13
	2 Dublin South-East	51	
	3 Dublin South-Central	24	
	4 Dublin South-West	–	
	5 Dublin West	58	
	6 Dublin North-West	18	
	7 Dublin North-Central	111	
	8 Dublin North	–	
	9 Kildare	–	
	10 Wicklow	81	
South-Eastern	11 Carlow/Kilkenny	90	0.17
	12 Tipperary (S.R.)	37	
	13 Waterford	79	
	14 Wexford	8	
Southern	15 Cork North Lee	120	0.11
	16 Cork South Lee		
	17 North Cork		
	18 West Cork		
	19 Kerry	64	
Midwestern	20 Limerick	87	0.09
	21 Tipperary (N.R.)	–	
	22 Clare	–	
Western	23 Galway	58	0.05
	24 Mayo	–	
	25 Roscommon	–	
North-Western	26 Donegal	24	0.13
	27 Sligo/Leitrim	61	
North Eastern	28 Cavan/Monaghan	–	0.06
	29 Louth	38	
	30 Meath	20	
Midland	31 Laois/Offaly	–	0.09
	32 Longford/Westmeath	60	
		1,236	0.08

**Source: Dáil Debates* – 10 April 1984, pp. 1545/1546 – Places for all types of institutions and children.

the importance of the maintenance of contact between natural parents and their children in care, both for its value in facilitating rehabilitation and for its

contribution to the overall mental and physical well-being of the children. 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. Millham *et al* (1986) also stressed the importance of links with family. 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. For a minority of children, Richardson (1985, p. 151) and Millham *et al* (1986) for instance, argue, that where parental relationships are of little or no significance, it may be better that there be legal severance of parental contacts. Incidentally, in the case of legitimate children this would allow their placement for adoption under the new Adoption Bill. Further comment will be made on this particular point later. Richardson's argument is only one side of the debate on the value of natural parents who may not be very caring *vis-a-vis* say caring adopting parents, and she also raised the question of how far should contact between parents and children 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? In addition, she asks how important is a sporadic, on-off relationship with his/her 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. Nevertheless, it would be accepted that frequency of contact by parents would be a major factor in the decision to send a child home.

Follow-up studies of children when they leave Children's Homes and return to live with their families are rare. One exception is that of Rutter (1981), which demonstrates that adults who, as infants, had experienced prolonged periods of institutional care subsequently encountered considerable social problems and frequently went on to make poor parents. Presumably these children had low levels of contact with parents given their prolonged periods in institutional care, before returning to their parents.

Obviously the placement of a child in care within its own community care area depends on there being at all times a supply of both foster homes and residential "places" to meet the demand. This is not always the case for residential care anyway, as Table 4.1 has shown. In some areas no places are available,

i.e., Mayo and Roscommon, and children must then be placed outside their own community care areas.

Table 4.2 shows that children who are placed outside their responsible Health Board region are placed mainly in long-term (both foster and residential) care (7.7 per cent). The final column on this table presents the level of transfer of children to other Health Board regions by each of the Health Boards. There are four Health Boards with proportionately high transfers in long-term residential care. If Table 4.1 is examined it may be seen that in the cases of three of these four, the numbers of places in residential homes are not distributed through the community care areas. For instance the highest level of transfers is in the Mid-Western Health Board and Limerick is the only community care area with residential places. Tipperary (NR) and Clare have no residential places. Similarly, in the North Eastern Health Board, Cavan/Monaghan have no places and overall there is a low proportion of places available in that Health Board. The Western Health Board has also a very low proportion of places available and these are all in Galway. The fourth Health Board with a high transfer in residential places is the North Western. If is difficult to find an explanation for the situation in that region as there is a higher than average proportion of places available and the community care areas all have places. There is no way of knowing whether or not a child might benefit from placement outside his/her own area. A possible positive reason for placing a child outside his/her own area, even if a place were available, is that a higher level of proximity to the child's original home may be ensured. This could occur if the foster/residential home and the original home were near the borders of the two community care or Health Board areas. For instance, the responsible Health Board for a child in East Roscommon is the Western Health Board. Therefore, a child would have to go to Galway for placement if he/she were placed in a home in their own Health Board area, since as Table 4.1 shows, Galway is the only place with residential facilities in the Western Health Board area. To facilitate contact, therefore, this child might be placed somewhere in the Longford/Westmeath community care area and Midland Health Board area.

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 his/her home, and his/her parent(s) are poor, it may only be possible for one visit per month to be made.

There are few means of discovering the level of frequency with which the criterion of placing a child near his/her family is used. Where this criterion is not used, further study would be required to identify the rationale for the

Table 4.2: *Responsible Health Board by Type of Care for all Children being Cared for Outside their Responsible Health Board Region, 31 December, 1982*

Responsible Health Board	*Short-Term Foster Care*	*Long-Term Foster Care*	*Short-Term Residential Care*	*Long-Term Residential Care*	*TOTAL*	*Proportion of Children in Care Who are Placed Outside Responsible HB Regions*
			Per Cent			
Eastern	–	4.5	3.9	5.9	40	4.4
Midland	4.3	14.3	–	11.1	23	12.8
Mid-Western	–	0.5	–	35.5	40	12.2
North-Eastern	–	13.6	7.1	22.5	25	14.7
North-Western	–	13.1	–	21.2	15	13.6
South-Eastern	–	6.9	–	4.3	17	5.3
Southern	–	2.4	–	6.4	11	3.9
Western	–	6.8	–	29.7	17	10.6
Totals placed in each type of care	1	73	3	111	188	7.7

placement of children in residential or foster homes many miles from their families if closer ones were available, even though in other local authority areas.

Berridge (1985, p. 95) adds to this question of contact between parents and their children in care, the parents' own problems in contact. He feels that it is clear that for many of the parents, visiting residential homes is 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.

To sum up these points of supply/demand and contact no information is available here on whether or not the first priority is to find a place for a child in its own area, or whether distance from home is considered at all. The problems the families encounter in trying to keep in contact with the child are not measurable here either. I can only speculate on the reasons for the placement of a child in care in any particular area. There are at least two possibilities — first, a genuine desire to place a child near his/her home, and, second, a matter of expediency, with little or no planning involved, brought on primarily by lack of available resources.

Assessment and Criteria for Placement in Care

Prior to reception into any type of care, an assessment is usually carried out by the social worker in charge of the case, in consultation with a senior social worker. No social worker decides alone. In some cases, where it is felt necessary, a case conference on plans for the child will be held. Parents can, of course, effectively dictate the type of care for their child by, for instance, refusing to consent to the placement of the child in foster care. Where the child is committed through a Court Order, a case conference is usually held. A summary of the guidelines for Health Board field workers in the case of non-accidental injury is in Appendix G. These guidelines are used in the case of non-accidental injury but can be used in all cases where a child is to be placed in care, with the appropriate changes in each circumstance.

Number and Characteristics of Children in Each Type of Care

Turning now to the data on type of care, Table 4.3 shows the numbers of children in each type of care on Census days 1980, 1981, 1982 and 1983. Over 80 per cent of children in care in December 1982 and 1983 are in long-term care of one sort or another – either foster or residential care. The highest single proportion of children in care in 1982 were in long-term foster care (46.2 per cent) with nearly 39 per cent in long-term residential care. In 1983, a similar situation obtained, although the proportions were slightly smaller (43 per cent and 36 per cent) – more children being in short-term care. The proportion in foster care has grown over the four years, both short-term and long-term care, which is to be expected given the emphasis on that type of care. In 1983, however, the proportion in short-term residential care doubled over that of 1982. No explanation can be found for this, and as figures are only available for two years, it is impossible to know which figure is the one most likely to be representative.

Type of Care by Independent Variables

The kind of children in each type of care in terms of their age, birth status, sex and area, will now be examined.

Age at Admission

Children who had come into care at under 2 years were more likely to be in foster care while children who were older on coming into care tended to go into residential care, (Table 4.4). In examining Table 4.4 in more detail (rows 3, 4, 5 and 6) separating long- and short-term care, it may be seen that *long-term* foster care is the most likely place of admission for a child under 2 years – nearly 58 per cent of children under 2 years were admitted there. From age

Table 4.3: *Number of Children in Each Type of Care on Census Days in 1980, 1981, 1982 and 1983**

Type of Care	*1980*	*1981*	*1982*		*1983*	
			Per cent			
Long-term foster care	41.7	44.5	46.2		43.0	
Short-term foster care	3.8	5.4	5.8		7.1	
Long-term residential care	46.9	43.7	38.6	43.8	36.0	46.8
Short-term residential care			5.2		10.8	
Private foster care	7.7	6.4	3.8		2.8	
Supervision at home			0.4		0.4	
N =	2455	2486	2446		2534	

**Source:* Department of Health Children in Care Surveys.

four on, *long-term* residential care takes over as the most likely type of care at any age at admission. No great differences occur in the proportion in *short-term* care, the highest being 10 per cent of those under 2 years in short-term foster care. This is not surprising as children awaiting adoption are most likely to be admitted to care at under 2 years.

Table 4.4: *Type of Care by Age at Admission*

		Age at Admission					
Type of Care		*<2 years*	*2-3 years*	*4-6 years*	*7-11 years*	*12-14 years*	*Total*
				Per cent			
Foster care	1	76.2	54.9	49.0	34.6	30.0	55.84
Residential Care	2	23.9	44.8	50.4	64.6	69.5	43.84
STFC	3	10.0	5.2	2.3	2.7	3.1	5.8
LTFC	4	57.6	47.9	45.6	31.7	26.4	46.2
STRC	5	5.9	5.5	3.2	4.8	7.8	5.2
LTRC	6	18.0	39.3	47.2	59.8	61.7	38.6
Private FC/ Supervision at Home	7	8.6	2.1	1.7	1.0	1.0	4.2
N =		919	382	472	480	193	2,446

χ^2 = 382.76123 with 16df $p<0.0$

The explanation for the high proportion of younger children in foster care may be that the public image is of foster care being more appropriate for babies and young children than for older children. (A more detailed table on type of care by age at admission is at Appendix H).

Did birth status have an effect on type of care by age at admission? In controlling for birth status it was found that the older a legitimate child is at admission the more likely he/she is to be admitted to long-term residential care and, consequently, the less likely to be admitted to long-term foster care (Table 4.5). In the case of illegitimate children, the picture is somewhat less clear, since the number of illegitimate children entering care at all in the age groups 7 years and over is very small. As Table 4.5 shows, however, illegitimate children are mainly in long-term foster care at any age. Looking at Table 4.5 for illegitimate children up to 7 years old, it does show that the proportion in long-term residential care increases with each age group. Nevertheless, it still remains the smaller proportion in contrast to the larger proportion of legitimate children being in long-term residential care from age 2 on.

To sum up, the older a legitimate child is on admission, he/she is significantly more likely to be admitted to long-term residential care and the less likely to be admitted to long-term foster care. For illegitimate children, there are also significant differences between the age at admission and the type of care ($p<0.0000$) – the older a child is at admission, the more likely to be placed in residential care, even though as has been noted, at no time does the proportion in residential care exceed that in foster care, as is the case with legitimate children. (Appendix Table J gives the breakdown in more detail).

Table 4.5: *Type of Care by Age at Admission Controlling for Status**

Type of Care	*Age at Admission*										*Total***	
	<2 years		*2-3 years*		*4-6 years*		*7-11 years*		*12+ years*			
	Leg.	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*
	Per cent											
Foster care	59.5	84.2	39.8	73.8	43.4	67.6	29.1	64.4	23.9	58.1	40.3	78.0
Residential care	40.5	15.7	60.1	26.3	56.7	32.4	70.8	35.6	76.1	41.9	59.7	22.0
STFC	8.2	11.6	4.8	5.0	3.1	–	2.7	2.7	3.8	–	4.4	8.0
LTFC	49.7	59.1	33.6	66.3	38.9	67.6	26.4	60.3	19.5	58.1	34.9	61.5
STRC	5.0	6.5	5.3	4.4	3.4	2.7	5.0	4.1	8.8	3.2	5.1	5.3
LTRC	35.5	9.2	54.8	21.9	53.3	29.7	65.8	31.5	67.3	38.7	54.6	16.7
Private FC	1.6	13.5	1.4	2.5	1.4	–	–	1.4	0.6	–	1.0	8.5
N =	318	541	208	160	355	111	401	73	159	31	1441	916

$\chi^2 = 175.51118$ with 16df. $p<0.0$.

$\chi^2 = 247.13564$ with 16df. $p<0.0$.

*For a detailed account of age at admission by status, see Appendix Table F.

**Excludes extra-marital children and children under supervision at home.

Table 4.6: *Type of Care by Present Age*

Type of Care		*Present age*						*Total*
		<2 years	*2-3 years*	*4-6 years*	*7-11 years*	*12-14 years*	*15+ years*	
				Per cent				
Foster care	1	73.0	73.4	67.3	49.7	41.4	48.5	55.8
Residential Care	2	27.0	26.6	32.2	49.5	58.1	51.5	43.8
STFC	3	27.2	11.1	4.2	2.3	1.5	0.8	5.8
LTFC	4	36.7	58.3	57.2	45.1	38.0	44.7	46.2
STRC	5	18.0	7.5	5.4	3.8	1.9	1.6	5.2
LTRC	6	9.0	19.0	26.8	45.7	56.2	49.9	38.6
Private FC / supervision at home	7	8.6	4.0	6.4	3.1	2.4	3.1	4.2
N =		256	252	407	681	463	387	2446

χ^2 = 586.50586 with 20df $p<0.0$

Age Group

In this section the question is posed — is there any difference in actual age between children who are in the different types of care? If Table 4.6 is examined, first from the point of view of the differences between foster and residential care by age (Rows 1 and 2), a bias in favour of foster care for the younger age groups can be seen. Looking at types of care by age and long and short-term care (Table 4.6, Rows 3, 4, 5 and 6) it becomes clear that long-term foster care is more likely for children up to 7 years old with long-term residential care taking over for the children in the 7-11 year age group on. These differences in age by type of care are significant ($p<0.0000$). Age then dictates the type of care in which a child finds him/herself. (Appendix Table K gives more detailed information).

Sex

On the basis of the analysis, no relationship existed between a child's gender and the type of care in which they were at 31 December 1982.

Birth Status

In examining the relationship between the birth status of children and the type of care they are provided with, irrespective of age (Table 4.7) it becomes clear that the disparity between children of different birth statuses exists only in relation to long-term care. There is little difference between legitimate and illegitimate children in relation to whether they are placed in short-term foster

care or short-term residential care. However, the relationship between long-term care type and status remains the same – legitimate children are more likely to be placed in long-term residential care while illegitimate children are more likely to be placed in long-term foster care. Illegitimate children are also more likely to be placed in private foster care (78 out of 93 children in private foster care) probably as a direct result of the legislation which imposes stricter controls on the care of illegitimate children (see Task Force Report, pp. 173-174). The actual numbers in private foster care are very small, so they have little influence overall.

Table 4.7: *Type of Care by Birth Status*

	Birth Status		
Type of Care	*Legitimate*	*Illegitimate*	*Total*
		Per cent	
Foster Care			
Short-term	4.4	8.0	5.8
Long-term	34.7	61.3	45.1
Private	1.0	8.5	3.9
Residential Care			
Short-term	5.0	5.3	5.2
Long-term	54.4	16.7	39.7
Supervision at home	0.5	0.2	0.4
N =	1,448	918	2,366*

χ^2 = 370.64282 with 4df. $p<0.0$.

* The 80 extra-marital children are excluded.

Responsible Health Board

There were significant differences between the responsible Health Boards in terms of type of care, although the majority of children in care in each area were in long-term foster care (see Table 4.8). There are two exceptions – the Eastern Health Board, where the largest proportion of children were in long-term residential care (47 per cent) and the Southern, where long-term care was evenly divided between residential and foster care.

The Eastern Health Board is far more likely than any of the other Health Boards to have children in private foster care (Table 4.8). Even allowing for this, the majority of children in care in the Eastern Health Board area were still in residential care.

Table 4.8: *Type of Care by Health Board: All Children in Care on 31 December 1982*

Type of Care	*Eastern*	*Midland*	*Mid-Western*	*North-Eastern*	*North-Western*	*South-Eastern*	*Southern*	*Western*	*Total*
					Per cent				
Short-term foster care	4.7	12.8	8.6	2.9	5.5	2.8	3.2	12.5	5.8
Long-term foster care	32.2	62.6	56.0	64.7	55.5	50.3	44.8	55.0	46.2
Short-term residential care	5.6	5.6	1.8	8.2	9.1	2.9	5.7	7.5	5.2
Long-term residential care	47.1	19.0	33.6	23.5	30.0	44.0	44.8	23.1	38.6
Private foster care / Supervision at home	10.4	–	–	0.6	–	–	1.4	1.9	4.2
N =	903	179	327	170	110	318	279	160	2446

χ^2 = 337.09277 with 35df. $p<0.0$.

Referring back to Table 4.1, which details the proportion of residential places in the population, the proportion of residential places in the Eastern, South Eastern and Southern Health Boards is higher than in, for instance, the Midland and Western (South-Eastern 0.17; Eastern 0.13; Southern 0.11; Midland 0.09; Western 0.05). Those latter two have the lowest proportions in residential care. The actual availability of places may possibly explain the varying proportions of children in residential care in the different Health Boards. Perhaps supply of residential places dictates the urgency with which foster homes are sought. This is assuming that demand does not dictate supply.

Taking each birth status group separately in each Health Board area (Table 4.9), it seems that in three Health Boards, namely the Eastern, South Eastern and Southern, legitimate children are most likely to be in long-term residential care (65; 63 and 55 per cent respectively) in contrast to the Midland and Western Health Boards, for instance, where 31 and 34 per cent of legitimate children are in long-term residential care. Conversely, of course, the three first mentioned Health Boards had much lower proportions of children in long-term foster care i.e., 22, 30 and 39 per cent respectively in contrast with 50 and 54 per cent for the two latter mentioned Health Boards.

Turning to illegitimate children, again the Eastern, Southern and South Eastern had higher proportions of illegitimate children in long-term residential care than the other Health Boards, although the proportions are much lower than for legitimate children. For instance, the Eastern Health Board had 22 per cent of the illegitimate children in its care in long-term residential care and 46 per cent in long-term foster care. At the other end of the scale, the North Eastern Health Board had 12 per cent of the illegitimate children in its care in long-term residential care and 78 per cent in long-term foster care. The Eastern

Health Board was the only one with less than half the illegitimate children in its care in long-term foster care. When private foster care is taken into consideration, the Eastern Health Board's proportion of illegitimate children in long-term foster care increases to 67 per cent which, although still lower than all but one of the other Health Boards (the Southern with 57 per cent of illegitimate children in long-term foster care), brings it more in line with the other Health Boards.

Table 4.9: *Type of care by Health Board and status*

Type of Care	*Eastern*		*Midland*		*Mid-Western*		*North-Eastern*		*North-Western*		*South-Eastern*		*Southern*		*Western*	
	Leg.	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*	*Leg.*	*Illeg.*
								Per cent								
Foster care	27.7	73.5	66.7	83.1	48.6	90.1	52.4	83.6	45.8	79.6	32.4	80.5	42.4	64.3	64.3	75.4
Residential care	71.0	25.9	33.3	16.9	51.4	9.9	47.6	16.4	54.2	20.4	67.6	19.5	57.5	35.6	35.6	24.6
Short-term foster	3.3	6.4	17.2	7.8	6.4	12.6	2.4	4.1	1.7	10.2	1.6	4.2	2.0	6.8	8.0	17.8
Long-term foster	22.5	45.6	49.5	75.3	42.2	77.5	50.0	78.1	44.1	69.4	30.8	76.3	39.4	54.8	54.0	56.2
Short-term residential	5.9	4.4	2.2	10.4	2.9	·	10.7	4.1	13.6	4.1	4.9	–	3.0	13.7	1.1	15.1
Long-term residential	65.1	21.5	31.2	6.5	48.5	9.9	36.9	12.3	40.7	16.3	62.7	19.5	54.5	21.9	34.5	9.6
Private foster care/ Supervision at home	3.2	22.1	–	–	1.4	–	–	1.4	–	–	–	–	1.0	2.7	2.3	1.4
N =	538	344	93	77	204	111	84	73	59	49	185	118	198	73	87	73

For legitimate children χ^2 = 178.63139 with 28df. $p<0.0$
For illegitimate children χ^2 = 217.25481 with 28df. $p<0.0$

Concerning private foster care, in all there were 78 illegitimate children in this type of care. Sixty-four of them were in care because they came from one-parent families unable to cope, 13 were children awaiting adoption and one was said to be in care because of marital disharmony, but since these are all illegitimate children, some error in completion of this questionnaire must have occurred. Seventy-four of the 78 illegitimate children in private foster care were in the Eastern Health Board area. Does this mean that the Eastern Health Board Region there is much greater use made of this type of care or that there are few or no agencies of this type available in the other Health Boards? Comment will be made on this question at a later stage.

To sum up, it is difficult to know whether the supply of places is dictating the higher proportions of children in residential care in those areas where more places are available, or whether a genuine effort to find foster homes for both birth statuses has been unsuccessful.

Children in Residential Care

As earlier noted, care, particularly residential care, is regarded as being detrimental to the well-being of a child in most cases. There are some data on the criterion used to place a child in residential care, and this information will now be examined (Table 4.10).

Table 4.10: *Reason for Child Being in Residential Care*

Reason	*Frequency*	
	Number	*Per cent*
1. No suitable short-term foster home available	24	1.8
2. No suitable long-term foster home available	144	11.0
3. Breakdown in foster placement	25	1.9
4. Child placed with siblings	388	29.6
5. Child awaiting adoption	55	4.2
6. Parents refuse to allow child to be fostered	51	3.9
7. Residential care most suited to child's needs	578	44.1
8. Other	46	3.5
	1,131	100.0

It is noted from the above that the most often mentioned reason for a child being in residential care is the catch-all one which explains very little "Residential care most suited to the child's needs" (44 per cent). This reason would need to be explained to allow any conclusion on the real reason why children find themselves in residential care. Berridge (1985, p. 6) remarks on the paucity of information about children in residential care — on their backgrounds, how they arrive there 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.

A further 30 per cent of the children in the present study were said to be in residential care to be with siblings. There are opposing views as to the merits of placing siblings together in care. Goldstein *et al* (1979), George (1970) and Parker (1966) contended that the placement of siblings together may not be as important as is often presumed. On the other hand, Berridge (1985, p. 124) argues that a particular strength of Children's Homes is to keep siblings together or to reunite them when they have been split up. He argues 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.

In only 12.8 per cent of the cases were no suitable short-term or long-term foster homes available. There is no way of knowing if social workers tried to obtain foster homes for the older children, as only a very low proportion of parents (just 4 per cent) refused to allow their children to be fostered, and in only 2 per cent of cases was there a breakdown in the foster placement. This leaves just over 80 per cent of the children in residential care (being 29 per cent of all children in care), where there is no evidence that an effort was made, for whatever reason, to find foster homes. Given that fostering is alleged to be the first priority for children entering care, the proportion in residential care where apparently no effort was made to find foster homes, seems rather high.

Family Size

Table 4.11 shows the number of *siblings* each child in care has, by the type of care. It also shows the number of siblings in care each child has, by the type of care. In both cases, it is evident that children who come from smaller families, and children who are alone, or with a small number of siblings in care are more likely to be placed in long-term foster care.

Table 4.11: *Number of Siblings by Type of Care: All Children in Care on 31 December 1982*

Type of Care	*Number of Siblings*						*Number of Siblings in Care*					
	0	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*
Short-term foster care	7.4	7.1	5.3	3.4	6.0	2.6	8.4	6.1	2.2	1.2	4.7	0.8
Long-term foster care	61.5	51.9	41.9	36.2	32.2	30.0	57.8	48.4	33.7	31.6	27.1	32.2
Short-term residential care	5.4	4.3	4.9	6.1	4.2	6.5	5.2	5.0	6.5	4.8	4.7	5.8
Long-term residential	15.4	35.3	46.1	53.9	56.0	60.6	20.6	39.3	56.3	62.4	61.6	61.2
Private foster care/ supervision at home	10.3	1.4	1.8	0.3	1.6	0.3	8.0	1.1	1.3	0.0	2.0	0.0
N =	812	368	284	293	382	307	1101	440	279	250	255	121

χ^2 = 417.92529 with 20df. $p<0.0$ χ^2 = 388.51367 with 20df. $p<0.0$

It has been said earlier that legitimate children will have a greater number of siblings than will illegitimate children, thus the relationship between size of family and care type may, in fact, be a spurious one, reflecting birth status differences rather than family size. To see if this was true, birth status was controlled for and the results are presented in Table 4.12. Whereas legitimate children without siblings have 54 per cent in foster care and 41 per cent in residential care, as the number of siblings increases the proportions decreases in foster care and increase in residential care. In the case of illegitimate children the proportions in foster care stay fairly similar, irrespective of family size (but then after 4-5 siblings the numbers involved are too small for comparison). The

Table 4.12: *Number of Siblings by Type of Care, Controlling for Birth Status. All Children in Care on 31 December 1982*

Type of Care	*Number of Siblings*												*Number of Siblings in Care*											
	Legitimate						*Illegitimate*						*Legitimate*						*Illegitimate*					
	0	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*	*0*	*1*	*2*	*3*	*4-5*	*6+*
Short-term foster care	4.1	5.9	4.1	3.6	6.4	1.9	8.3	9.7	10.0	2.6	2.2	3.8	7.5	6.4	2.1	0.9	5.2	0.0	9.0	5.6	3.0	5.6	0.0	0.0
Long-term foster care	50.3	48.4	34.9	31.0	27.3	26.1	63.7	54.5	62.0	57.9	60.0	46.2	44.5	45.5	30.3	28.9	21.4	23.2	63.1	50.4	48.5	66.7	73.9	72.7
Short-term residential care	6.5	4.1	4.6	6.5	3.9	5.3	5.3	3.7	6.0	5.3	6.7	11.5	5.7	4.7	5.0	4.7	4.8	5.1	4.7	6.4	18.2	5.6	4.4	0.0
Long-term residential care	34.9	40.2	54.1	58.9	60.9	66.3	10.6	30.6	22.0	31.6	28.9	38.5	39.9	42.1	61.0	65.5	66.4	71.7	12.0	36.8	30.3	22.2	21.7	27.3
Private foster care	4.1	0.0	0.5	0.0	1.5	0.4	12.2	0.7	0.0	0.0	2.2	0.0	2.3	0.0	0.4	0.0	2.2	0.0	11.0	0.0	0.0	0.0	0.0	0.0
Supervision at home	0.0	1.4	1.8	0.0	0.0	0.0	0.0	0.7	0.0	2.6	0.0	0.0	0.0	1.3	1.2	0.0	0.0	0.0	0.1	0.8	0.0	0.0	0.0	0.0
N =	169	219	218	248	330	264	625	134	50	38	45	26	348	299	241	232	229	99	708	125	33	18	23	11
	χ^2=92.15063 with 20df. p<0.002						χ^2=83.91765 with 20df. p<0.002						χ^2=111.29263 with 20df. p<0.002						χ^2=88.05913 with 20df. p<0.002					

same is true for illegitimate children in residential care with the exception of children without siblings. The more siblings illegitimate children have, they are only slightly more likely to be in long-term residential care. From this it may be concluded that overall family size is a factor in care type placement, but birth status has a greater effect in that, for instance, illegitimate children from larger families are far more likely to be in long-term foster care than legitimate children with the same size families. This also applies when one considers children with siblings in care – the association between birth status and care type is much stronger than family size and care type.

Basis for Admission

A significant difference was found in the type of care allocated to a child placed in care on foot of a Court Order and a child placed in care voluntarily. The latter was more likely to be in foster care; the former in residential care. One explanation for this may be that children who are placed in care on foot of a Court Order have problems which foster parents would find difficult to handle. It was noted in Chapter 3, Reason for Admission, that 74 per cent of children placed in care on foot of a Court Order, came into care because of abuse, abandonment, or neglect. A proportion of these children may have been disturbed, thus explaining their placement in residential and not foster care. Another possible explanation for placement in residential care is that the proportion of Court Order cases increases with the age at admission. It has been demonstrated that younger children are more likely to go into foster care – older children into residential care, so it follows that those entering care on foot of a Court Order, being older, are more likely to be placed in residential care.

Table 4.13: *Type of Care by Basis for Admission*

Type of Care	*Basis*		*Totals*
	Voluntary	*Court Order*	
		Per cent	
Short-term foster care	6.0	5.1	5.8
Long-term foster care	48.6	37.1	46.2
Short-term residential care	4.9	6.5	5.2
Long-term residential care	36.0	48.5	38.6
Private foster care	4.5	1.0	3.8
Supervision at home	–	1.8	0.4
N =	1,937	509	2,446

χ^2 = 78.01736 with 5df. $p<0.0$

Summary

To sum up on this chapter, first there was a description of what each type of care entailed. Then followed a discussion on the supply of places, mainly residential places, being the only ones possible to quantify. Emphasis was placed on the importance of ease of contact for parents. The rationale for this emphasis came from available evidence that problems arose where contact is concerned (a) for the social workers in finding a suitable placement, and (b) for the parents of the children placed in care. Berridge's study of children in residential care (1985) details some problems for parents which are not usually taken into account, and which can arise in foster care also. For instance — something that might be regarded as minor in another context can arouse considerable anxiety in the parent — can the child be kissed and hugged, and should the parent correct him/her if he/she misbehaves or leave it to the residential staff? These and other tacit factors often discourage contact. This is unfortunate since Lasson (1980) and others have shown that visited children are more settled in their placements and better adjusted, socially and psychologically, on a wide range of criteria.

Assessment and placement criteria were noted. The questions asked here were (a) what significant differences occur between children in foster and residential care and (b) what are the likely consequences of any differentiation? First in (a) it was found

(i) that children in foster care are significantly younger at admission and significantly younger generally than children in residential care;
(ii) that illegitimate children are significantly more likely to be in foster care;
(iii) that Health Boards differ significantly in the proportions in each type of care, particularly by birth status;
(iv) that family size was not so important to type of care as age and birth status;
(v) that children who were admitted on foot of a Court Order were most likely to go into residential care, but that age had some part to play there also.

In (b) it is difficult to assess the consequences for the children of the differentiations in care type. However, studies have continually found that care in general, but residential care in particular, can be psychologically and emotionally damaging to a child. Therefore, it may be accepted that if care is necessary, then foster care should be the first priority. This has been the case even though some Health Boards appear to have had less success than others in seeking foster homes for the children in their care. Now that the provision allowing a Health Board to place any child in its care in foster care is included in the new 1987 *Children (Care and Protection) Bill,* an improvement in the number

of placements may be seen. One group particularly vulnerable to placement in residential care appear to be older, legitimate children, who, almost always, are placed in residential homes. More detail on the reason why this is happening would be useful to enable suggestions to be made on how it might be avoided.

Finally, there was no information available on the different placements a child might have had. A child now in residential care might have been in foster care first since entry into care or may indeed have been in another residential home. There may be hidden discontinuity and disruption here which would be regarded as the most damaging aspect of care. The need for provision of stability of placement is emphasised by Berridge (1985) among others.

Chapter 5

SUMMARY AND CONCLUSIONS

This study set out to analyse the available data on children in the care of the Health Boards in Ireland. These data were provided to the Department of Health by the social workers involved in the placement of children in care. The questionnaire is sent to them annually by the Department for completion. The findings will now be examined in detail and conclusions drawn.

It was noted earlier that at the moment the vital issue is not the actual number of children in care, and how to make it shrink, but the nature and purpose of care and its appropriateness as a means of meeting the present social needs that give rise to it. The second group of questions asked centred on the data which would help identify the social needs that gave rise to the children who were in care in 1982; to their initial admission, and their discharge or retention. The questionnaire data were not very helpful here as they provided limited information on reasons for admission, discharge and retention. However, even given the limitations, some important and significant evidence is available pointing to specific groups of children as being vulnerable to placement in care.

The task of measuring areas of social need is a difficult one, but it could be asserted that children of incomplete and broken families are particularly at risk, and indeed, as regards admission to care, the most notable group in this study, as has been seen, are children of one-parent families. These children, be their parent widowed, deserted, or alone, appear to be without question represented to a far greater degree than their proportion in the population would warrant. As noted in Chapter 3, no more information was given than that the one-parent family was unable to cope, so no great detail of the particular needs of these families and the full circumstances of why these children were placed in care was available. Nevertheless, the fact remains that children of one-parent families are vastly over-represented among children admitted to care.

It was noted that nearly one-quarter of legitimate children are in care due either to their being members of one-parent families unable to cope, or where there is marital disharmony. It would be interesting to know how many of these one-parent families are those of widows or widowers. With their exclusion it would be possible to calculate the proportion of children in care either directly or indirectly as a result of marriage breakdown, through either desertion, separation or disharmony. Some counselling assistance might have aided these families before breakdown and thereby prevented their children's admission to care.

A disturbing increase appears in the numbers of children admitted to care because of active parental abuse and neglect and indeed as Table 3.9 shows just under one-third of legitimate children were admitted to care for that reason. This category includes physical, sexual, emotional, abuse and any type of neglect. It is to be hoped that this increase reflects rather a greater degree of reporting and vigilance on the part of the public and social workers than that the incidence of abuse and neglect has increased. It seems likely that a great deal of abuse, particularly sexual abuse, goes unreported. The proportion of children taken into care in 1982 as a result of sexual abuse was very small and calls have been made for mandatory reporting of all such offences.[6] 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, of course, that children who are placed in care because of abuse, either sexual or physical, can come from any stratum of society and are not necessarily victims of social need. However, there is no way of distinguishing one group from another here.

Where discharges from care were concerned, the vast majority of children were discharged into a family setting. The hope is reiterated that the situation which had caused the admission to care had resolved itself. As noted, (Chapter 3), arguments have occurred between social workers in Britain about whether or not children are discharged precipitately and ill-advisedly before their home circumstances had improved enough to make genuine rehabilitation feasible. Where this would occur, only further family breakdowns and a greater measure of insecurity and deprivation for the children concerned could result.

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 receive no social welfare benefit, this only commences at 18. 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, if 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.

6. Duncan, in his paper "The Protection of Children: Some Legal and Constitutional Controversies" (1986) called for a provision in the Children (Care and Protection) Bill which would require by law certain categories of persons such as school teachers and doctors, to report cases of suspected abuse. Echoing this call are notably, Dr Woods of the Sexual Assault Treatment Unit and Ms O'Donnell of the Rape Crisis Centre. They particularly stressed that there should be an onus on teachers who encountered victims to report the matter to the authorities (see, for instance, *The Irish Times*, 1 May, 1987).

Concern is growing about these young people. In 1987, *Streetwise* – a symposium on homelessness among the young in Ireland and abroad, in its recommendations, proposed that there should be adequate aftercare for young people who have been reared in residential care to reintegrate them back into their own families and community. The study pointed out that young people who have been in care form a significant group of the homeless population.

The Streetwise Committee, which combines all the groups working with homeless people, is undertaking a national census of youth homelessness (McCarthy, forthcoming). Preliminary investigation of an exploratory nature by the Committee points to residential care as a key factor in the biographies of homeless youth. In addition, it is suggested that the follow-on support services linking children in care into the community, e.g. hostel places, are inadequate to cope with the numbers involved.

In an internal report (Kelleher, 1988) to an Advisory Committee on Homelessness of which the Simon Community are members, Simon state that it has come to the notice of their street workers that children are being discharged from residential care without any planned support or provision. This is contributing to the youth homelessness which the workers are encountering.

In this regard also, a paper by the Programme Manager Community Care Eastern Health Board, F.J. Donohue (1987), on the role of Health Boards in providing services for the homeless and the role of hostels and institutional care in these services, considers residential care. The paper notes (option 6) that many of the existing facilities are not in a position to cater for adolescents and their problems. "Indeed", says Donohue, "regrettably they will often not accept referrals of 'difficult' boys or girls over 12 years." "It is becoming increasingly apparent", continues Donohue, "that residential care workers are facing extremely difficult and demanding situations when dealing with young people in care and these issues need to be addressed when planning services and recruiting staff."

The Department of Justice Welfare Service has been requested by the Department of Health to note anyone put on probation who had been the responsibility of a Health Board. The Welfare Service has agreed to do this, so that more accurate figures may be obtained of those from care who subsequently become involved in crime.

The prospects of leaving care can cause insecurity in young people who have reached the age limit to leave care. Berridge (1985, p.34) notes 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 (op.cit.,

p.107) notes that far from being viewed with eager anticipation and as a break from adult control, many adolescents in his study approach 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,* find that in Britain overall, the final picture for those leaving care is 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 children from residential homes were, in earlier times, 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.

In Ireland, an amount of money (£250,000) was made available in 1985 by the then Minister for Health. Part of this was to be used to increase foster-care payments (£100,000) and between £75,000 and £100,000 was to be used to help young people leaving care to set themselves up in a flat, as these young people did not have the supports other teenagers had. There are no details available on the particular way in which the money was spent, but as mentioned above, concern is growing about certain young people and the manner in which they are discharged from care.

Length in care was examined for those discharged, because of its importance to a child's future adjustment. A specific study carried out in Britain for the National Children's Bureau by Vernon and Fruin (1986), examined the factors affecting the length of time children spend in care. Their study was carried out in response to the findings in Rowe and Lambert's 1973 study *Children Who Wait* which drew attention to the large number of children who appeared to be drifting in local authority care without firm plans being made for them. Indeed, Parker (1966) had suggested that short-term admissions to care received greater social work attention than those who remained a long time in care. Returning to the present study it appeared that children who had come into care because of abuse or neglect, or because their parents were dead or had abandoned them, were on the whole more likely to spend a longer time in care than children entering for other reasons. Unfortunately, this information is not of great value without knowing whether or not the longer stays were avoidable; whether all possible means had been tried to have these children discharged earlier, or whether they

had, in fact, been "drifting in care" without any firm plans being made for them. The reason for discharge by length in care only confirmed that the longer the child remained in care, the less likely they were to be reunited with their families, but gives no reason why this is so. The most striking finding here is the significant difference in the length of time a child spends in care and the Health Board from which he/she comes. As noted earlier it is intended to deal with the differences in area on all variables in a separate section in this chapter, so no comment will be made on these differences at present.

Coming to retentions in care and the social needs which arose resulting in children being retained in care, the data show that over one-third of the children retained in care for over three months in the four years 1980-1983 had no parents or relatives available to claim them (Table 3.4). This, however, is the limit of the information available and the data do not show why or how this situation arose for these children. The reason for retention with reason for admission in 1982 have been cross-tabulated, but this does not reveal a great deal more. Almost half came from one-parent families unable to cope and only 19 per cent of these children had originally come into care because their parents had been absent or abandoned them so it seems that the balance of these parents (81 per cent) have, since the child was admitted to care, abrogated their responsibility for the child. This affects 709 children of the children in care for more than three months in 1982 and there is no further information on the reason for the subsequent abandonment of these children. It is at these children that the new Adoption Bill will, no doubt, be aimed, if they can all be placed in foster care, and fulfil the other conditions laid down in the Bill. (A point made by a social worker in private correspondence was that when adequate services were not provided by the State in staff and development of child care policy, this too was an abrogation of responsibility. Children may have been received into care for their own protection and due to pressure of work and lack of resources, no further involvement with the family followed. A system that does not provide adequate staffing and support to follow up, having intervened in a crisis, could be said to have abrogated its responsibilities.)

The proportion of children retained in care because of an abusive family environment appeared to be increasing slightly (Table 3.4). Here again it is hoped that the reason for the increase in retention in care was due to extra vigilance on the part of the social workers, and reluctance to return the child until the family environment was suitable. Table 3.5 showed that over two-thirds of children retained in care in 1982 because of an abusive family environment had been placed in care originally for that reason.

Children from families where the reason for their retention in care was marital

disharmony were admitted for this reason also. Again the question must be asked – had any assistance been given to the parents of these children? What was the nature of the disharmony? No information is available here.

Continuing on the questions about admission, discharge and retention in care and their association with particular social needs, the author endeavoured to identify these from the reason for admission, discharge or retention. The four independent variables, age, sex, birth status and area were cross tabulated with each group of reasons. Taking reason for admission by age it was found that the younger the child at admission, and the younger the age in care, the more likely it was to have been from a one-parent family, indicating that one-parent families may find young children problematic. There are no details of whether or not these are teenage mothers with a first child or, at the other end of the spectrum, deserted wives or widows with several children. Children from a background of active parental abuse appeared to be older at admission. The differences were significant between the reasons for admission and both age at admission and actual age. Where discharges are concerned the younger the child at admission, the more likely he/she is to be (re)united with family and relatives, and the older the child at admission the more likely he/she is to stay in care until he/she reaches the legal age limit (Table 3.15). It follows that the longer a child stayed in care, the less likely he/she was to be reunited with his/her family (Table 3.21), confirming the findings of other studies mentioned. Ninety-six per cent of discharges were in these two categories but, of course, the overwhelming majority were (re)united with family. Of the third group, those children who were in care at the end of 1981 and still in care at the end of 1982, a very large proportion – just 70 per cent – were over seven years old and as much as 58 per cent of them had been in care four years or more at 31 December 1982. Again, parents' inability to cope appears as the most common reason for these young people remaining in care for such long periods. It bears repetition that the longer a child remains in care, the longer he/she is likely to continue in care, so efforts at discharge are vital.

The second variable, sex, showed no clear statistically reliable relationship to any other variable. This might suggest that whatever is occurring in family interaction does not distinguish between boys and girls in its effect on their placement, discharge or retention in care.

It was found that legitimate and illegitimate children entered care for significantly different reasons ($p < 0.0$). However, when this finding is examined more closely, it may be seen that 75 per cent of illegitimate children are said to come from one-parent families unable to cope in comparison to 21 per cent of legitimate children. This finding may be due to more diverse categories into

which legitimate children can fall, while "one-parent family unable to cope" is likely to be a catch-all one for illegitimate children. A more discerning list of categories on the questionnaire could alter the results here.

Where discharges were concerned, the differences in birth status and reason for discharge were not all that significant. What may be of interest here, however, is that although it appears that a higher proportion of illegitimate children were discharged in 1982 than their proportion in the "care" population (45 per cent/38 per cent) and than the comparable proportion of legitimate children — the numbers of illegitimate children who were adopted accounts for the difference (287) (Table 3.16). In fact, if these are excluded, a lower proportion of illegitimate children are discharged from care to relatives and family than legitimate children. Seventy-four per cent of illegitimate children discharged from care were reunited with relatives and families, whereas 86 per cent of legitimate children were reunited with their relatives when discharged. If adoptees are excluded, one-fifth of the illegitimate children discharged from care left on reaching the legal age limit; while 8 per cent of legitimate children did so. It appears that illegitimate children are less likely to be reunited with their own families. However, the proportion adopted brings up the proportion of illegitimate children re-entering a family situation to 87 per cent, which is no doubt the more important factor.

Having looked at birth status by reason for admission and reason for discharge, reason for retention will now be considered. Here, children defined as being in long-term care had been retained for one year or more. Of those children it was found that just over 60 per cent were legitimate. It was noted that the hope of the new legislation assisting similar children to find new families was moderated by the fact that the children were older at admission and most were more than seven years old on 31 December 1982 and in residential care. It is unlikely that the group found in long-term care when the legislation is passed will be all that different. So, even if they are in the restricted categories of legitimate children available for adoption, their age and type of care will militate against their "adoptability". This is a matter which will have to be seriously discussed if the new *Adoption Bill* is to be of value. It will take time to establish whether or not parents are abrogating their responsibilities towards a child, and meanwhile the child is getting older and it has been shown that it is more difficult to find adoptive parents for older children. But, as has been noted, this problem may be eased if a child's foster parents are free to adopt him/her by the law and the placing agency's consent.

The proportion of illegitimate children retained in care for more than one year (39 per cent) matches their proportion in the in-care population. This constituted 728 children in 1982, most of whom had no parents or relatives willing

to accommodate them. These children were mainly in foster care, thus even at present potentially 'adoptable'. No information is available as to why adoption was not considered, or if it had been, why it was not pursued.

The fourth independent variable, area, will not be dealt with here. As previously mentioned it is planned to devote a section in this chapter to that variable.

Basis for admission, type of care, and family size were three other variables on which there was information. Significant differences occurred between reason for admission of all children in care in 1982 on all three variables. For instance, where Court Order admissions were concerned, over two-thirds were of children from abusive family environments in contrast to 14 per cent of voluntary admissions. In type of care, children from one-parent families were most likely to be in foster care, and children from abusive family backgrounds in residential care. With regard to family size, it seemed that where parental abuse was concerned, children came from larger families.

Similar variables were looked at when reason for discharge was being considered: basis for admission, type of care and family size. With basis for admission, 93 per cent of those discharged in 1982 were from voluntary admissions, which is higher than the Census percentage of 79 per cent of voluntary admissions in 1982. Although it is not an exact comparison, it suggests that, as might be expected, children admitted voluntarily were discharged more quickly than Court Order admissions. Of the children discharged in 1982, the majority of those reunited with their families or adopted had been in short-term care of one type or another, and those who left having reached the legal age limit were in long-term care, which again confirms the findings that children who spend a long time in care are less likely to be reunited with their families. On family size, children from large families were least likely to be reunited with their families.

It must be stressed once more that the categories of reason for admission, discharge and retention were very much less than ideal. Where demographic variables can be considered on their own, it is apparent from this study that children in general are more likely to be *admitted to care* in their infant years. Even allowing for the number of children awaiting adoption, this higher probability of younger children being admitted to care remains. However, probability of *being in care* is not age-specific in general – the age structure of the in-care group is quite similar to that of the population. When age-specific probability of *being in care* on a particular date is considered, it becomes clear that the number of children placed for adoption lowers the probability of very

young children actually *being in care,* but the age structure remains similar to that of the general population.

Few sex differences appear in either age at admission or age of the 'in-care' population. Birth status and age at admission do appear to be related as does age of child in care. Both illegitimate and extra-marital children are concentrated among the younger children, while the age structure for legitimate children approximates more closely to the overall age structure proportions.

Birth status does appear to be very important in the probability of coming into care. High relative proportions of illegitimate children are admitted to and are in care, even allowing for those children placed for adoption.

Regarding type of care, birth status combined with age, affects the type of care to some extent, since legitimate children are more likely to be older when admitted to care and more likely to go into residential care. For illegitimate children foster care is the more likely option, but illegitimate children are usually younger at admission anyway and it seems overall the younger the child, the more likely he/she is to be placed in foster care. For all children, where long-term care is required, foster care seems to be the most likely option for those admitted to care up to four years of age, when residential care takes over. 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 are illegitimate — they are more likely to be in long-term foster care than legitimate children.

The differences between areas will now be considered separately and the main results of the study will then be presented.

Area Differences

Variation between areas is a problem which has arisen elsewhere also and some studies have been carried out endeavouring to explain these variations, for instance, in Britain, Packman (1968), Packman *et al* (1986) and Davies, Barton and McMillan (1972).

The most relevant to this study is the work of Packman (1968) and Packman *et al* (1986) both of whose studies as noted above concern themselves with variations in the provision of care between areas. Packman's 1968 study began because of a growing awareness between some Oxfordshire county councillors and children's department officials that the number of children in care in the county was high in comparison to the national average. This meant that expenditure was also high. The County's position, however, was not unique. Oxford City was in a similar position but other neighbouring authorities did not seem to have the same problem. They had proportionately fewer deprived

children in care and expenditure was thus lower. A small research project was launched and it quickly became apparent that there was a large and complex problem to be solved; a problem of striking, persistent and puzzling variations in the proportion of children in care in the different local authority children's departments of England and Wales. This seemed to warrant a larger investigation on a country-wide basis, which Packman then undertook.

Packman (1968, p.15) defined the problem of her study as "Every county and county borough council maintains a number of children 'in care'. Not all support a similar sized burden, however, for proportions of children vary widely from authority to authority". Packman *et al's* later (1986) study focused specifically on two contrasting areas and was an intensive study of admissions to care in these two authorities.

It became clear to Packman (1968) that the problem posed by variations in proportions in care was too complex to permit any simple explanation. She found, however, that the factors examined fell into three broad categories which shaped the enquiry and helped untangle the web of contributory causes, although it was difficult to specify the influence of any one factor alone. In this sense Packman felt she had clarified the problem rather than solved it and provided a springboard for further research. The three categories were:

(i) *Need* for public care.
(ii) Voluntary and statutory services, concerned with families in difficulties, which subdivide into those which assist families to keep their children with them (preventive services) and those which offer care for the children away from their families (alternative services); and
(iii) the children's departments themselves; their resources of field staff and institutional accommodation and their policies for the admission and discharge of children.

The first of the three categories involved the question of whether *need* for public care for children was a variable factor and whether some areas were more heavily burdened with child-care problems than others. Need, noted Packman (op.cit., p.227) in these terms, is an elusive concept. Packman examined need by analysing the social and economic factors, which often give rise to need, to see how they were distributed throughout the country. It must be remembered that the British society with which Packman was dealing was a much more heterogeneous one than the Irish society from which the children in this study came. Packman was dealing with areas where newcomers and foreigners were all prominent and these same areas, or others, would to an extent be characterised by this rapid inflow of population from both outside and inside the country. On the factor of need, Packman (op.cit. p.229) concluded that the social conditions associated with

mobility may be more powerful than those related to a stagnant or depressed society, and suggested this as one explanation for the child care variations. As noted, there are no similar areas of such mobility creating need in Ireland, so this cannot apply here. It was intended, however, to examine some of the other variables quoted by Packman as also being conditions which prove most likely to produce need and as Packman noted "... would make sense to any social worker anywhere". Such features as high illegitimacy rates; high unemployment rates; the lowest social classes; poor housing; over-crowded families and high levels of mental illness and marriage breakdown were all considered by Packman. It would not be possible to include all of these in this particular study, because of lack of data. And in the end it proved impossible to find any adequate measures of probability of admission to care and its relationship to social deprivation in any area. Appendix Table W shows the attempt to do so by comparing the levels of unemployment illegitimacy and medical card usage in an area with the probability of a child being in care. The measures used for this table are crude and inadequate. For instance, the unemployment data should, by definition, refer to families affected by unemployment, and such data are not available in this study. No background details on the children was supplied. The significant differences between areas on all of the variables except sex, indicates a necessity for further data to explain these differences. More in-depth research would be required to enable a relationship between need and admission to care in an area to be established.

The second category mentioned by Packman was the voluntary and statutory services concerned with families in difficulties which endeavour to prevent family break-up, and those which offer care for children away from their families (alternative services). As Packman (1968, p.230) notes, it is clearly impossible to look at every influence which helped to bolster families in danger of breakdown. Instead, in relation to prevention, two services in particular day care and social worker provision will be considered. In relation to alternative services, adoption agencies will be considered.

Details of the numbers of social workers involved in family casework and day care services in each community care area are available from Department of Health records. There is wide variation between areas in the proportion and number of family casework social workers by the number of children under 15 in the population of each area. There appears to be no way of knowing what is the rationale for the numbers of social workers in any particular area. One possible explanation is the policy of the Regional Programme Manager of Community Care. If he/she feels that social workers perform a useful function, then presumably they will be employed in numbers proportionate with their

perceived usefulness. This point of the influence of the Regional Programme Manager's policy will be discussed later.

Differences between Health Boards and community care areas in provision of family casework social workers and day-care services will now be examined. Overall, the North Eastern Health Board has the lowest level of both social workers and day care facilities, with the community care (CC) area of Louth having the lowest in the country. When the probability of a child being in care in this Health Board area, and in its three CC areas, is examined, the probability is below the mean for the country as a whole. A similar situation occurs in the Southern Health Board which has relatively low social worker level and relatively low day-care facilities, and the probability of coming into care in any of its five community care areas is also lower than the mean and the lowest in the country is Cork South Lee.

On the other hand, in the Eastern Health Board, Dublin West has the highest probability of a child coming into care, yet this area has a relatively high number of social workers, and also a high level of day-care facilities.

It would seem, therefore, that the level of actual cover of social workers and day-care services for children in general does not affect their vulnerability to being in care. However, other factors may be operating here, since, for instance, day care would most likely be catering for children under school age, so poor day-care facilities might influence the age of children in care. Indeed, this was true for the North-Eastern Health Board, which, as noted, had the lowest level of day care in the country. The proportions of admissions to care of children aged three years and under, was the highest in this Health Board – close to 65 per cent (64.7 per cent, see Table 2.4). The other Health Board with a relatively high proportion of children being admitted to care three years old and under – North-Western (61 per cent) has also a low level of day-care facilities. Where the proportion of children aged three years and under entering care is relatively low, for instance, the Eastern Health Board (49 per cent), day-care facilities are better. It would seem then that where day-care facilities are provided, fewer of the children who would be availing of them are admitted to care.

Without further information necessary to offer a satisfactory explanation, it can only be concluded from these findings that although, overall, the level of social workers and day-care facilities does not appear necessarily to affect the probability of a child entering care – where there is a low level of social worker density and day-care facilities there is not necessarily a high probability of coming into care, and *vice versa* – the level of day-care facilities does seem to affect the probability of entering care for children aged three years and under. The incidence of low level of social workers not necessarily leading to high numbers

in care may of course be due to social workers not having the time or facilities to cover families where children need care and protection. There is no way of ascertaining this information without an intensive study of the area.

Turning now to alternative services, (e.g., adoption services) relevant to the variation between the Health Boards, provision of adoption services varied in the sense that some Health Boards dealt with all the adoptions in their areas, while in others registered adoption societies operated independently of the Health Board. The existence of these societies in an area did not appear to influence the number of adoptions. The Western Health Board, for instance, had the highest proportion of children awaiting adoption — 20 per cent of its in-care population in 1982, but had only one registered adoption society in its area. On the other hand, the Health Board with the second highest proportion awaiting adoption was the North-Western which had two other adoption societies operating independently of it. One, in Lifford, arranged 15 adoptions in 1982 and a similar one in Sligo arranged 27 adoptions. Another Health Board, the Midland, showed a different pattern again, having no voluntary registered adoption societies at all within its region, and, therefore, handled all its own adoptions but yet had well below the mean proportion of children awaiting adoption. So no definite pattern emerged. Existence or otherwise of many adoption agencies does not seem to affect the proportion awaiting adoption. Therefore, one must ask the question, do some Health Boards encourage single mothers to have their babies adopted, or conversely, assist them to keep the child? It is difficult to know what exactly is occurring, but an aspect to note is that the Western Health Board had the lowest percentage of illegitimate children born in that area (see Table 2.14), yet the highest proportion of children awaiting adoption. O'Hare *et al* (1988) note the proportions of women attending a hospital or unit within or outside their own Health Board area for the birth of their child outside marriage. In the case of the Western Health Board, for instance, 50 per cent of the mothers giving birth to children outside marriage in 1983 did so outside of their Health Board area with 32 per cent of the births being in Dublin. The authors conclude that the underlying factor is the women's desire for the anonymity afforded by attendance at a large city hospital. The area differences then regarding adoption appear to belong rather in the third area of investigation — policies for admission and discharge of children in care, since it seems that where proportions of illegitimate children registered in an area are low, proportions awaiting adoption are high. This could indicate that perhaps the policy in areas where there is a lower tolerance of illegitimacy, indicated by relatively high proportions of mothers giving birth outside of their area of residence, is to encourage the adoption of children born illegitimate in that area.

In examining differences in area policy, it is interesting that the *Commission on Social Welfare Report* (1986, p.13) found a lack of agreed interpretation within and between Health Boards on, for instance, discretionary payments and appeals procedure. The Commission Report does not seek to explain why the differences occur between the areas nor is it within its terms of reference to do so. It is mentioned here as an indication that differences also occur between areas on matters other than children in care.

Packman (1968, p.190) noted that several children's officers in her sample considered that the most important single cause of variations in the proportion of children in care was the policy pursued by each children's department. Others, she says, emphasised it less, but few failed to mention it at all. If, indeed as seems to be the case in the absence of any other strong evidence, policy variation affects the differences in proportions in care, then using it to explain the differences is not easy, for variations in policy between areas is difficult to establish precisely.

In this study it was found that significant differences between areas occurred at several levels, first in the probability of any child in that area being in care at all, then in the reasons for admission, discharge and retention; in the birth status of a child admitted to care; the type of care an area will provide for any particular child and the length of time a child spends in care. Berridge (1985, p.19) feels that: "Unfortunately the differences are often seen as a reflection, not of local tradition, children's needs and available resources, but of an ideology to which social workers adhere." However, social workers, it must be argued, are subject first to a senior social worker and also to a Regional Programme Manager.

All that can be said here is that definitions of what constitutes need and establishing what each social worker regarded as "need" would require an examination of representative areas in detail. "Need" would no doubt be based to some extent on facilities and resources, although the distribution of those facilities and resources would be at the discretion of the Programme Manager. Therefore in the absence of any other evidence at present one must return to the particular underlying approaches which structure the individual manager's decisions as being the most important factor in deciding: (a) reasons for placement in care; (b) the age and birth status of a child placed in care; (c) type of care in which a child is placed; (d) length of time in care; (e) why some areas appear to encourage adoption more than others, and finally (f) on the level of social worker and day-care provision.

In summing up, to enable one to calculate in any way accurately why areas differed from each other, in some cases so markedly, it would be necessary to explore first what "need" caused the children to be admitted to care, and determine

what exactly "need" is interpreted as, whether or not it is evenly spread over the country. However, it would be very difficult to find any definition of "need" that would be independent of the decisions made in each area by the staff. Nevertheless, as Packman (1968, p.25) points out, an independent measure is essential to see whether these decisions are themselves variable, or whether the numbers in care are an accurate reflection of the needs in each area. Second, are the preventive services, other than the community welfare services, evenly spread throughout the country and if not, is this due to variations in need or other factors?

The third line of enquiry necessary in order that the reason why areas differ could be established covers the structure, policies and work of each community care area. The resources, attitudes and activities of the staffs in each area would need to be examined. Differences in recruitment and staff-training, in the availability of institutional and foster-home accommodation, in interpretation of the law, and in the circumstances calling for the admission of children into care, may all generate important variations. (See Packman, op cit., p.26). It is obvious that these enquiries are impossible here, but without this information it is not feasible to offer a fully satisfactory explanation as to the differences between areas regarding children in care, their age, status, reason for admission, type of care, length of time in care, and likelihood of placement for adoption. The available evidence, however, points to the policy ideals and decisions of the Regional Managers as being, although one of a number, probably the most important influence on the decisions made in each area.

Having detailed the results of the analysis of the data, the main features which emerged were, first some four profiles of children vulnerable to placement in care:

(i) the young illegitimate child;

(ii) the child from a one-parent family, irrespective of age or area. These children may overlap with some of those in (i);

(iii) the older legitimate child, possibly from a large family, and very likely to be from a abusive family background;

(iv) certain children from certain areas are more vulnerable to placement in care than similar children in other areas, for instance, the North Eastern Health Board has a higher than the mean proportion of illegitimate children in its care — 47 per cent to 39 per cent, while only 27 per cent of children in care in the Southern Health Board were illegitimate.

The profiles of those children who were discharged after a short time in care were:

(i) the young illegitimate child placed for adoption;

(ii) the child of any age or status where a temporary incapacity occurred in the home;

(iii) a child from certain Health Board areas has a better chance of being discharged quickly than a child from another area, i.e., 86 per cent of discharges from the Mid-Western Health Board were within a year in comparison with 58 per cent in the South Eastern Health Board.

The profiles of children who were retained in care for more than a year were:

(i) the older legitimate child in care because of active parental abuse, and likely to belong to a large family;

(ii) the child of homeless parent(s) or parents/relatives unwilling to accommodate them;

(iii) the child whose parent(s) does not keep in contact with it once it is placed in care, sometimes where the intention is for short-term care. Just over 5 per cent (105 children) of those in long-term care were found to have been initially placed in what was to be short-term care;

(iv) a child from certain Health Board areas is more likely to be retained in care because of an abusive family background than in another area, for instance, 20 per cent of children in long-term care in the North-Western Health Board are retained for this reason, in comparison with less than 2 per cent of children in the Western Health Board area. This is in spite of the fact that there was very little difference between the proportions of children admitted to these Health Boards for that reason. Although the differences between areas in reasons for retention for these long-term in-care children are significant for all the reasons, because of the seriousness of this particular reason it has been singled out. Differences in the area policy is the most probable explanation, as has been shown as it is hardly likely that significant differences occur in the behaviour of parents in different Health Board areas.

So what are the implications of the findings of this study for future policy? These will be examined in the final chapter which follows.

Chapter 6

DISCUSSION AND RECOMMENDATIONS

Having examined the findings of this study, this final chapter will discuss some relevant issues in the area of children and young persons in care. Also some recommendations, based on the data and other related work, will be proposed. Since the children and young persons in this study are in care as a result of family breakdown of one kind or another, the importance of a coherent family policy as a means of prevention of the deprivation that leads to breakdown will be considered first (family is defined here as either a two-parent or any one-parent group).

Donnison in his *Approach to Social Policy* notes that all social services are designed to promote individual welfare, and, as most individuals live a substantial part, if not all, of their lives as members of families, it may be argued that every social service will have its repercussions on families and family life.

In their paper on *Alternative Strategies for Family Income Support,* the Council of NESC (Paper 47, p.15) recommended that additional expenditure be laid out on family income support, and that family income support was of such importance as to warrant a contribution to expenditure being met from either increased taxation, a change in the incidence of taxation, a re-deployment of expenditure or a re-arrangement in favour of families of such increases in expenditure as may be decided from time to time.

The Council further adds that Ireland's demographic and economic structure is characterised by features which further justify the need for increased transfers for dependent groups. By comparison with other EEC countries, for example, Ireland has the highest birth rate, the highest burden of dependency and the highest unemployment rate. The burden of child dependency, say the Council (p.16) is seen in proper perspective when expressed as a ratio between persons under 15 years of age and the labour force. On this basis Ireland has the highest dependency ratio,[7] and clearly requires higher transfers to families than other EEC countries. If a higher level of social services for child dependents is to be provided, then a higher level of taxation of some form will be required.

Curry (1980, p.2) also makes this point but adds (p.6) that the fact that demographic conditions may indicate the need for certain social provision does not necessarily mean that it will be made available.

7. In 1985 the ratio between persons under 15 years and the Labour Force in the then 10 Member States of the EEC was as follows: West Germany 33.2; Italy 49.3; France 49.5; The Netherlands 49.8; Belgium 47.3; Luxembourg 41.7; United Kingdom 39.9; Ireland 80.4; Denmark 34.5; Greece 53.8; EEC 43.5. *Sources: Eurostat Labour Force Survey Results 1985* (Population and Social Conditions) and *Eurostat: Demographic Statistics, 1987* (Population and Social Conditions).

The principles which informed the *Task Force Report* (1980) reflect the importance of family care for children. The Report stresses 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 states, 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 dependant allowances, the latter to be rationalised. Families where the wage earner is on low income should not be disadvantaged *vis-a-vis* social welfare families and should receive support through children's allowances and family income supplement, the latter to be modified to ensure higher take-up through a less complicated application procedure and improved level of support. Finally, on this question of Child Income Support, the Report says other families should be supported through children's allowances.

The emphasis in these Reports 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. Packman (1968, p.17) quotes 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 breakup of the home occurs." There are many services and even individuals who could preserve a threatened family unit, even if this were not their primary job. For instance, someone, e.g., a doctor, priest, or public health nurse might be able to organise some neighbourly support for a family in crisis. This type of assistance is not quantifiable but may be of enormous value to a family who might otherwise break down. Another example of a very important part of assistance to families

in a community is the self-help group. Where these have been established, for instance, Kilbarrack (Dublin 5) Women's Group[8], an enormous improvement has occurred in the psychological well-being of the women. Consequently their physical health has also improved, and their ability to cope with stress situations. The children have benefited from their mothers' well-being, and where they might have gone into care because their mothers were unable to cope in some way, they are now able to stay in a stable family. These self-help groups, of course, have to have the backup of both medical and para-medical services, and, as in the case of KLEAR, some Vocational Education Committee or similar aid. In themselves they have achieved a great deal of success in supporting the women in the community in stressful situations, because of their members' own experiences and the sharing of these experiences and advising appropriate action to counter problems occurring.

There are now, and no doubt always will be in spite of all efforts to assist families, some who cannot care adequately for their children for whatever reason. One or all of the children must be removed. Where this happens the care given should be as close to a stable family setting as possible. The difficulty of achieving that is summed up by Berridge (1985, p.128) when he speaks of the "awesome responsibility of devising effective ways of meeting the needs of children in care". Parker (1966) had previously noted that findings in other studies had demonstrated that stable care situations in both residential and foster placements are frequently difficult to maintain. The real issue here then is, as Packman *et al* (1986, p.4) would see it, not in the numbers in care, and how to make them shrink, but in the nature and purpose of care and its appropriateness as a means of meeting the social needs that give rise to it. "Care" is, of course, at present in any case, potentially a number of different things. It can be the provision of short-term relief, a supplement to parental care, or a permanent substitution for it. It will be argued later that only in the case where a permanent substitute is called for should it be necessary to place a child in care.

Having discussed the need for support of the family in general, particular aspects of reforms necessary will now be examined. The 'social need' concept has been discussed in the Introduction and within the perception of social need or deprivation, some important issues arise.

Some Reformative Issues

Within the social deprivation perception of children, a number of contemporary reformative issues are found. Most centre on different conceptualisations of the family, and the relative rights of parents and children. Indeed, the

8. KLEAR (Kilbarrack Local Education for Adult Renewal).

conceptualisation of the family itself as an institution would be regarded as an issue. These reformative issues can be grouped into three main types, according as they concern themselves with:

(i) Changes in adoption laws.
(ii) Changes in criteria used to place children in different types of care.
(iii) Increased support for certain family types.

Changes in Adoption Laws

The first Adoption Act was passed in 1952 and has so far been amended in 1964, 1974 and 1976[9]. It contains our present law on adoption and, as it stands, an adoption order can only be made in respect of a child who is an orphan, illegitimate (Adoption Act, 1952, Section 10(c)), or who has been legitimated by virtue of the Legitimacy Act, 1931, but whose birth has not been re-registered under that Legitimacy Act (Adoption Act, 1964, Section 2). The child must be resident in the State and not less than six weeks old (Adoption Act, 1974, Section 8). If a child is over seven years of age at the date of the application for his adoption, although the maximum age for adoption was set at seven, Section 3 of the 1964 Act as amended by the Adoption Act, 1974 permits the Adoption Board to set this limit aside in particular circumstances. Responsibility for Adoption Services was transferred from the Minister for Justice to the Minister for Health with effect from 1 January 1983.

Legitimate children cannot be adopted at present as a direct result of Articles 41 and 42 of the Irish Constitution, where the family's "inalienable and imprescriptible right, antecedent and superior to all positive law" (41 (i)) is protected. The very important new Bill, *Adoption (No 2) Bill, 1987,* aimed at extending the categories of children who may be legally adopted was published in June 1987. In particular the Bill when passed will enable the adoption, in certain very restricted and exceptional circumstances, of legitimate children in foster care for one year, but who have a parent or parents alive. This could reduce the numbers of legitimate children in long-term foster care, but no provision is made for similar children in residential care. That every child has a right to a permanent home is a precept on which those concerned with child care would agree. It is considered that a permanent home is one where either both natural parents or adoptive parents are present. The high numbers of legitimate children, especially in long-term residential care, is a persuasive argument for the extension of the right of adoption for legitimate and extra-marital children in residential care.

9. For details of these amendments, see *Report of the Review Committee on Adoption Services, 1984,* and Shatter, 1977, p.164. A further amendment is planned through the *Adoption (No. 2) Bill,* 1987.

The provisions of the Bill will also permit the adoption of an illegitimate child whose mother has not given the initial consent to placement for adoption. It will allow both type of adoptions only in those instances where, for a continuous period of not less than 12 months immediately preceding the time of the making of the application, the parent(s) of the child, for physical or moral reasons, have failed in their duty towards the child; that it is likely that such failure will continue without interruption until the child attains the age of 18 years; that such failure constitutes an abandonment on the part of the parents of all parental rights (whether under the Constitution or otherwise) with respect to the child (see *Adoption Bill, 1987, Explanatory Memorandum*).

The value of adoption to a child is emphasised by Abramson (1984) who notes the "temporising dislocation for a child" which may be present even in long-term foster care and stresses that the values of permanency and continuity are implicit in adoption, but not necessarily so in other forms of child-care placement, outside the biological family. Keniston (1977, p.188) echoes this notion feeling that foster care is by definition temporary and transitional and children crave continuity. Ayres (1985) considered that

> ... every effort should be made to keep children in their own families to prevent care, to restore children as quickly as possible to their own families following a care episode or to select permanent placement options, namely adoption, if prevention or rehabilitation have genuinely failed, within a timescale which relates closely to the chronological age of the child (p.18).

The Explanatory and Financial Memorandum of the *Adoption (No 2) Bill, 1987* is quoted as saying that it was not possible to estimate the numbers of children to whom the new Bill would apply, but it was certain that some children to whom it applied would secure a permanent, stable environment through the introduction of the proposed legislation. The huge decrease in the numbers of children of single mothers placing their children for adoption means that there is probably a large pool of prospective adopters awaiting the availability for adoption of children at present in foster care or likely to be in the future. However, they may be difficult older children, whose parents have abandoned them. Success is most likely where the foster parents become the adoptive parents, and this may not always be possible.

Changes in Placement Criteria

The move away from large residential homes to smaller units within them, or to group homes, began with the *Kennedy Report* in 1970. The *Task Force Report* (1980) agreed with these changes. However, it suggested that, ideally if children

must be placed in care all children have a right to have foster care as an option. It also suggested that provision should be made for dispensing with parental consent to a child's placement in foster care, where it is in the child's interests to be in foster care (*Task Force Report,* 1980, p.218). At present a Health Board cannot place a child in foster care against the parents' wishes, if that child was not admitted on the basis of a Court Order. The *Children (Care and Protection) Bill,* 1987, includes a provision which enables a health board to place any child in its care in foster care, and although the first version of the Bill was altered in many respects, this provision was not challenged. It was regarded by all involved in child care as a positive step. The emphasis on foster care is, of course, always assuming that this type of care is in the best interest of the child.

Criteria for keeping children in residential care as noted on the Questionnaire completed by the social workers involved with the families include keeping a child with its siblings, which often precludes foster care for any of them. Goldstein *et al.,* (1979, p.46) suggest that keeping children with their siblings should not be a factor preventing a child from being placed in foster care. Others suggest that placing children with siblings is not as important as is often presumed (Parker, 1966; George, 1970). Berridge (1985, pp.124/125) on the other hand, regards keeping siblings together in care as often providing the strongest basis of long-term support for them. Each case must be judged on its merits.

Increased Support for Certain Family Types

One-parent families, especially those headed by single mothers, are increasing and the pattern of outcomes of illegitimate births has changed over the years. 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. Table 6.1 shows that, for instance, from 1981-1985 the number and proportion of adoptions has consistently decreased, while the number and proportion of illegitimate children born increased.

Adoption, as an option has obviously declined in popularity for unmarried mothers. The numbers and proportions of children placed in care as being from "one-parent family unable to cope" and the majority of these children being illegitimate, gives cause for concern about some mothers keeping their babies and finding later that they cannot cope and must place their child in care. Who are these particular women and what problems do they face to arrive at a stage where they cannot cope? A popular assertion is that a number of young girls see pregnancy as a way of obtaining an income and in 1986, the then Deputy Alice Glenn suggested this in the Dail. Deputy Tony Gregory agreed that it

may not be unusual for many young girls to become pregnant to obtain an Unmarried Mother's Allowance, as there are few choices for these girls in a disadvantaged area. "There's no possibility of getting a job", says Deputy Gregory, "and if they were a single parent then they would at least have their independence, some money and a flat of their own" (see *Sunday Tribune*, 2 March 1986). Indeed, in Newcastle-on-Tyne in Britain, a conference was held in June 1987 on "Motherhood, an Alternative Career", noting this phenomenon of some young single girls in Britain admitting to becoming pregnant as a means of independence and obtaining State support financially (Reported on BBC Radio Four Woman's Hour, 16 June 1987). Efforts were made by the author to obtain more information on this Conference, but so far without success.

Table 6.1: *Adoptions as Proportion of Illegitimate Children Born 1981-1985*•

Year	*Number of Illegitimate Children Born*	*Number of Adoption Orders Made*	*Percentage Adopted*	*Overall Percentage of Illegitimate Children Born*
1981	3,911	1,191	30.5	5.4
1982	4,351	1,191	27.4	6.1
1983	4,517	1,184	26.2	6.8
1984	5,030	1,195	23.8	7.8
1985	5,268	882	16.7	8.5

•Although Adoption Orders in any year are likely to be in respect of children born in that year, these are the closest comparable data available.

No evidence exists in Ireland over time or on a sample survey basis, however, of a link between illegitimacy and income supports. Questions arising would include: do income supports intervene only at the point of a decision to retain custody or adopt a child, or do these supports affect the choice leading to pregnancy in the first place? Do income supports have any influence at all? The rate of illegitimacy is increasing very rapidly in Ireland (1979 — 4.6; 1985 8.5 — see Table 2.11) but whether there is any correlation between the increase in the illegitimacy rate and the income supports provided has never been studied. If, however, even the likelihood of such a situation existing in some cases and even some girls becoming pregnant as a means of independence and livelihood then an examination of this whole area of young women leaving school, without hope of employment, should be undertaken and some alternatives provided.

If then, even some unmarried mothers have children as a means of independence and support, or when they have a child decide to keep it because

of these supports, it would be interesting to know who are the mothers now placing their children for adoption? What social class backgrounds do they have and does the Unmarried Mothers' Allowance appear unattractive to these girls? Are middle class unmarried mothers more likely to place their child for adoption than working class girls? These latter questions and those above suggest themselves as worthy of study because of the high proportions of illegitimate children being admitted to care.

As regards services for unmarried mothers, an unpublished study carried out in 1978 by the Federation of Services for Unmarried Parents and their Children (FSUPC) notes that the present specialist approach towards them may make for more efficient delivery of service and heightened appreciation of need, but on the other hand, this approach is segregationist and treats unmarried mothers as a caste apart – the very prejudice that enlightened contemporary opinion is trying to change.

Other one-parent families, either widows or deserted wives, presumably have some problems that are similar to those of unmarried mothers. It would be difficult, however, to collect accurate data in order to compare the actual probabilities of legitimate children of one-parent families with the probability of illegitimate children, in similar circumstances, being taken into care. Figures would be required on the numbers of such families and these are not available. An in-depth study of, for instance, a community care area would probably discover representatives of both these categories. Whether or not there are problems peculiar to unmarried mothers and not obtaining in other one-parent families could be examined in such a study. It is doubtful whether the problems are all that different, and if they are not, then an overall policy to assist all types of one-parent families to avoid the possibility of their children being placed in care, should be initiated.

Although children of one-parent families, and particularly illegitimate children are disproportionately vulnerable to placement in care, legitimate children of two-parent families are vulnerable also. As noted in the Introduction deprivation is not confined to one-parent families. Marital disharmony, neglect, and abuse may be the result of inability to cope financially, psychologically or emotionally for two-parent families. It is not only one-parent families who are "unable to cope", but because of their over-representation among those with children in care, the author has concentrated on them here.

There is, no doubt, a range of possibilities with regard to all child-rearing circumstances. The fact that the circumstances are unspecified in the published statistics, however, does leave social service planners in a difficult situation. It is difficult to know, for instance, how many of these "cases" constitute a

particularly vulnerable one-parent family set-up, if such situations are becoming more prevalent, and thus to plan supportive services on the appropriate number of, say, pre-nuptial conceptions (Walsh, 1980) and 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 or as much instability as some marriages. Nevertheless, the increase in the numbers of the single mother one-parent family, 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, then the proportion of children born out of wedlock will increase even though the stock of children overall 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 no doubt the number, if not the proportion, of those regarded as unable to cope will also increase.

Keniston (1977, p.188) would argue that in too many cases the State's intervention means that the child is going to be removed from home. "This is a drastic and wrenching solution" concludes Keniston "yet the State too seldom uses any other formula that might help keep the family together. The separation is probably hardest on the children it is meant to protect". The irony, of course, is that, as Keniston points out, when society removes children from their homes, it usually ends up paying more and doing less for the child than if money had been available to help the original family. Parker (1980) notes that the preoccupation with the quasi-family on the part of the care authorities has prevented them from looking creatively at the care experience and from developing new residential and day-care services.

So the importance of a coherent family policy, defining family as either a two-parent or one-parent family, not necessarily founded on marriage, has been argued. Within this policy, family income, housing, environmental amenities, marriage counselling, day-care facilities, psychological and emotional supports and encouragement to form self-help groups, would all feature. The author would see all these factors as being instrumental in greatly reducing, and ideally in the long-term eliminating, the number and proportion of children entering care. 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 (1968, p.203) describes, and as mentioned previously, there comes a point when a child's accommodation, maintenance

and upbringing becomes so *im*proper and *in*adequate, that it better suits his welfare to risk deprivation by separation, than to allow him to continue in his 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. Also, in the circumstances where a child has to be removed from his/her home, adoption can now be an appropriate response, ensuring security and continuity for the child. The supports in the community should be sufficient and efficient enough to cope with all other emergencies.

The total elimination of the necessity to place children in care by responding to the social needs that give rise to this necessity may finally be unattainable. "The issue of cyclical deprivation, inadequate parenting and multi-problem situations is a huge one – the deprivation is never arrested" (Personal note to author from a social worker). But it is surely one of the main issues at which family policy should be aimed. So far there is, as the *Commission on Social Welfare Report* notes (1968, p.14) an inefficient delivery of even existing services, so the extension of them or the introduction of new ones would, no doubt, prove problematic, until a coherent workable family policy is introduced.

Policy Recommendations

So what are the implications of the findings of this study for future policy? Previous mention has been made of Packman's (1968) assertion that the vital thing at present is not the numbers of children in care and the way to make them shrink that is important, but the social needs that give rise to the necessity for placement in care. It follows, however, that if the social needs are met, the numbers of children in care will shrink anyway and that, in the final analysis, is the goal at which child care policy must be aimed. Eight years ago, the *Task Force Report* recommended that because the children who require child care services are likely to be the most vulnerable and needy of children, the services provided for them must receive a very high priority and must be of the highest possible quality (p.66). The Report emphasised that child care services cannot be regarded as a separate, exclusive form of provision which can be organised independently of what happens in the areas of family support services, social services for children and social planning for children. The Report goes on to recommend various family support services, e.g., home help, day-care services, group work for parents and for children: self-help groups for parents; case work; family therapy; advice and counselling; supervision of both parents and children in accordance with a court order. The importance of the family to a child and the need for the parents to be able to care for him/her without undue intervention by the State is regarded by the *Task Force Report* (p.67) as the greatest good that can be conferred on

a child. It is impossible to argue with this, or any of the recommendations made in the Report. (Recommendations particularly relevant here are those in Section 4.6.3, p.72, and Chapter 8 pp.115-117). It is difficult to find something to add to the recommendations of that Report, and indeed commentators and those involved in child care have continued to quote the Report and request the implementation of its recommendations, which they regard as crucial.

Some progress towards implementing recommendations numbers 16.5.3 on illegitimate children, the recommendations of Chapters 13 and 15 on foster and residential care, section 16.6.2 on parental rights, and section 16.6.3 on extra-marital and abandoned children being made available for adoption, has been made with the introduction of the three Bills relating to children already described. *Status of Children Bill,* 1985, *Children (Care and Protection) Bill,* 1987, and the *Adoption (No 2) Bill,* 1987. However, much remains to be done to close the gap between what the Task Force discovered through their deliberations to be essential to the maintenance of the family or permanent substitute family, as the best, if not the only, proper environment for the rearing of children. Children are often removed from their homes when what is required in their interests and those of their families is the provision of support services of various kinds, e.g., support in the home or five-day care which maintains close links with home. And, from the point of view of sheer economics as has already been mentioned when a child is removed from his/her home, society usually ends up paying more and doing less for that child than if money had been available to help the original family.

Recommendations to be proposed here then would be first, in general, that the recommendations of the *Task Force Report* be implemented. The emphasis this author would favour would be at two levels — prevention and protection of the interests of parents and children placed in care. Some of the main preventive measures needed to help children escape from the unfavourable consequences of problem families, and consequent vulnerability to placement in care will be considered first. Then what practices are desirable to limit the possible damage to a child and what provision is necessary for its family to enable the speedy return to it of the child.

Resources should be directed at prevention. As Gilligan (1986) points out, resources can affect the quality of parenting, and as already stated above, 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 (see also NESC, 1980). Prevention, as Crellin *et al.,* state must be both short term and long term. First, what is already known needs to be applied now. Second, there is an urgent need to find out more. 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 (pp.113-114). The main difficulty in providing preventive services is that, in the literal sense, there is nothing to show for it. Children who do not have to go into care because of a service provided do not show up on any statistics.

Legitimate socially disadvantaged children share the vulnerability of the socially disadvantaged illegitimate children Crellin *et al.* studied and any measures suggested for these latter would not differ essentially from those required for all other vulnerable groups. Prevention then 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 at present seems to be not to support, but to replace (see, for instance, Moroney, 1976, pp.27-28). The availability of marriage and parental counselling at community level as well as creche and babysitting schemes, could well be incorporated in the Neighbourhood Resource Centre projects advocated by the *Task Force Report.* Some pilot projects have already been undertaken in the Neighbourhood Resource so we may see some progress there. Children need attachment, continuity of care, predictable secure futures and stable parenting and periods in care can be damaging. As noted in the Introduction, care is disruptive to continuity and attachment, and is potentially harmful, especially to pre-school children (see Crellin *et al.,* p.113). McQuaid, in 1971, wrote that in order to treat and prevent 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.

Once children have entered care, the author 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 his/her natural parents, or, where this is not possible, the development of a new permanence within another familial setting;
- the minimisation of the ill effects of care (see *Task Force Report,* 1980; Richardson, 1984, 1985, etc.).

Unfortunately a huge bulk of children appear to be held in care from year to year (Chapter 3). The undesirability of this situation is obvious. Clearly, a new permanence has not been granted these children. Many of them are illegitimate children – the legal provision stands that they can be adopted, but

some are older than the apparent ideal age for adoption – less than three years. A policy of finding adoptive parents for these children, which no doubt is already in existence, should be implemented and supported. It may have been that, for instance, the consent of the mother was not forthcoming, and in that case the *Adoption Bill (No 2) 1987*, may provide a solution to that problem in certain circumstances. If adoption is not possible for whatever reason, the idea of a family befriending a child, which was experimented with by some of the Health Boards and not continued, but is being reviewed at present, will hopefully be reintroduced. The hazards of such a scheme are obvious, as families can be subject to whims about befriending children in care, taking them out for some months and then never contacting them again. This was apparently the reason for discontinuing it originally. If carefully monitored, however, it might provide a child in long-term care with a sustained relationship with a family.

The minimisation of the ill effects of care relates to the issues discussed earlier. It also relates to the internal placement of a child once in care. Although a great many children were said to have been in residential care because it was best suited to their needs (Chapter 4, p.122) this author found that the main differentiating factors between children placed in foster and residential care were non-individualistic factors like birth status and age at admission.

Where residential homes are concerned, clear and up-to-date records should be obtained for all children. Residential homes should experiment with day-care schemes. Legitimate children in residential care should be available for adoption. More work is needed on placement of older children for adoption. Placement of a child in a residential home as near as possible to his/her own should be a priority. Assistance and encouragement should be given to parents to visit their children in care, perhaps a family visiting scheme or befriending scheme could be implemented.

Among the main explicit reasons given for residential placements was the need for a child to be with his/her siblings, a placement criterion regarded by some as somewhat controversial. All in all, there would appear to be a need for a rational schema of placement criteria, based on individual need. Planning for children in care implies planning also to avoid being placed in care as Richardson (1984, p.240) notes about children in residential care, but it is applicable to all children in care.

One of the findings of the *Report of the Committee of Inquiry into Industrial Schools and Reformatories* was that very little information was available on children coming into residential care. This had changed somewhat, as Richardson (1985) shows, but nevertheless, she had considerable problems administering her questionnaire to the staff of the residential homes. She found that not all residential homes

had files on the children and some respondents had not been in the home at the time the child was admitted. This was a particular problem with children in care for a long time. Richardson's (1985) data were collected in 1976, so that situation may not still apply.

Although the proportion of children in care as a result of abuse, either physical, emotional, or sexual, was small, yet for these children and any others who are being abused but not discovered, it is extremely serious. This author would agree with Duncan (1986) that an addition should be made to the *Children (Care and Protection) Bill,* 1987, providing that certain categories of persons, such as school teachers and doctors, should be required by law to report cases of suspected abuse. The use of barring orders against all persons who are a continuing source of risk to a child in her household, would be a useful move. At present barring orders can only be sought by a spouse against a spouse.

Another point, made by Lowe (1986) particularly in regard to sexual abuse, is that the child who is sexually abused inside the family is afforded less protection by the State than the child who is abused by a stranger. Lowe urges that the 1987 *Bill* should correct this injustice. Scully (1986) adds to this that a person, parent or otherwise, should not be allowed bail in a case of abuse as they inevitably return to the house to harass the child. No data are available here on the background from which the abused child came. For instance, was there unemployment or had the parents themselves experienced abuse as children?

A new phone-in service for children modelled on the British service *Childline* was set up in February 1988. No evaluation has been possible so far. The service is being availed of but what extent of the problem of child abuse is being tapped by it is not yet possible to gauge.

Acknowledgement must also be given to the alternative view that compulsory reporting of abuse is not helpful to children and exacerbates a problem which might otherwise have been resolved with some assistance rather than dramatic intervention. As previously noted, reporting of child abuse does not necessarily greatly reduce the risk. Planned programmes of intervention including day and nursery care facilities, preventive work with parents and families availability of staff to adequately support and counsel at-risk groups, specific services, e.g. child guidance clinics, which offer assessment and treatment, are all essential parts of effective child care policy.

On this point of prevention, it has been suggested by social workers involved in this work, who were in touch with the author, that with the current level of demand on services (primarily due to an increase in the numbers of child abuse referrals), agencies seem increasingly unable to be involved in effective prevention due to a lack of resources.

On the side of the parents of a child in care, Gilligan (1986) cites the right of parents to information about the child. Having a named social worker was no guarantee that the child or his/her family receive the services of a social worker. Social workers should be able and encouraged to liaise with the families. A resource group for the parents of children in care has been set up. 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 in Dublin.

Given the substantial numbers who remain in care until they reach the legal age limit or become self-sufficient (over 10 per cent (130) of 1982 discharges) it is imperative that certain after-care measures should be undertaken to support these children in their early adulthood.

Research Needs

At a general level the *Task Force Report* (1980, p.69) asserts the problems which lead to care are patterned in a particular way. We looked at certain studies which suggested that class and family type variables accounted in large part for much of this patterning. However, no comprehensive study has been carried out which can conclusively confirm (or deny) the place of socio-economic and other social background factors in relation to family breakdown vulnerabilities. Such a study is needed urgently if we are to plan a co-ordinated and effective preventive care service.

A first step in such a study might be the compilation by the Department of Health of a data bank on children in care. Apart from the data used in the present study, very little data are available on children in care. As noted, one of the findings of the *Kennedy Report* (1970) was that so little information was available on children in residential care. This has changed only somewhat (see Richardson, 1985). It was amply demonstrated throughout this study how limited is the present Census of Children in Care, the data source used. This Census could be developed and prove very useful in assessing future needs and required interventions to reduce the numbers of children admitted to care. It is proposed here that the questionnaire used in the Census be extended to include (a) socio-demographic information on the parents; (b) more refined and mutually exclusive reasons for placement of children in care and (c) more detailed information on the care careers of children. The child cannot be treated in isolation and, as indicated throughout the study, even with the limited data available the problems leading to the child's admission to care are not intrinsic to the child, but are very much family problems. The present information cannot tap the real problems of the family, and only a very incomplete picture can be built up. Regarding (c) above, at present no more detail than the number of times a child was in

care is available. Information is required on how many times a child experienced care, the length spent in care each time, and the type of care on each placement. Was there a change in the type of care during placement and if so, why? Continuity of care has been stressed by many of the studies quoted as probably being the single most important ingredient for the emotional and psychological well-being of any child. Other pieces of necessary information in this regard would be the likelihood, in so far as they could be measured, of (a) that this child would remain the shortest possible time in care and (b) what were the chances of that child re-entering care again, at a later stage?

Research also needs to be carried out at community care area level, to assess the effectiveness of existing strategies of family support. In this way plans can be drawn up to utilise more effective measures, and to develop others, to strengthen preventive services. Are the services fragmented? How are the services used? What is the take-up rate of any particular service and does it appear to be effective if it is taken up? What different categories of families have children in care? What proportion are traveller children? How much impact has drug abuse (including alcohol abuse) both in respect of parent drug abusers whose children have to be placed in care, and children who are themselves drug abusers and are placed in care for protection? What part does parental unemployment play in problems for families leading to placement in care? How far is marital breakdown and disharmony responsible for placement in care, and could suitable intervention have been made to avoid the problems in the marriages reaching a critical stage? Are the parents ambivalent towards the child in their relationship with him/her? How important is age of the parents where one-parent families, or indeed two-parent families, are concerned?

These are all questions which could be answered if the background data were available and would enable the scenarios which led to children being taken into care, either for the first time or a subsequent placement, to be drawn. It would also differentiate between parents' inability, through social problems or whatever, and parents' unwillingness, for whatever reason, to care for their children. Different interventions would be needed in these situations. With the limited data available at present, a model cannot be set up of what is happening and why, because of the gaps in the information. When a child has been placed in care, gaps in the data prevent one from knowing what care experiences any child has. By this is meant, is there continuity of care or has the child experienced changes in placements during its stay in care? Can any effects of these changes be measured?

Other questions, such as existence or otherwise of Regional Programme Manager's support for social workers in taking difficult decisions intrinsic to

child care need to be asked. It is the social workers on the ground who have to cope with the day to day crises of inadequate or unfortunate families. These workers may be left to make harsh decisions, and take the responsibility for a child's future, reporting to their senior who must also take part in the decision of whether or not to remove a child from his/her family. It is also important to know if, for instance, the attitudes of the social workers discourage parents from visiting their children when in care, attitudes such as "contact upsets the child" (see, for instance, Gilligan, 1986). To what extent is the practical problem of travel distance to blame for infrequent contact or is the parents' own insecurity or guilt feelings about their child being in care responsible for low level of contact, remembering that high level of contact appears to facilitate speedy return of the child to his/her home (see Aldgate, 1977; Millham, 1983 and Franshel, 1978).

In summary, the object of all 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 breakup 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. The intransigence of some people, the defeatism and despondency of others, are understandably very difficult to overcome. Perhaps some early warning signs might be detectable so that social workers would not have to work at almost crisis level, leaving them with only one option — to take a particular child or children into care.

These research recommendations are mainly practical in nature but other research needs to be done, aetiological, cognitive and cultural. While this study is useful, it is purely aetiological in nature, being exclusively concerned with some characteristics of children in care. The data available do not lend themselves to any other type of study. O'Sullivan (1979) criticises the total reliance on the aetiological approach and states that in Ireland there is little to indicate an awareness of the social derivation of ideas and practices in child care. He pleads that we look critically at what seems "obvious" about the child who comes into care, about child-care objectives and intervention strategies — in short, that we divert some of our attention to the cultural, cognitive and evaluative bases of our child-care thought and practice. More fundamental definitions of the child in care are required if we are to make progress in our child care legislation and services.

REFERENCES

ABRAMSON, H. J., 1984. *Issues in Adoption in Ireland,* Broadsheet No.23, ESRI, Dublin.

ADCOCK, M., 1980. "Dilemmas in Planning Long-Term Care", in Triseliotis, J. (ed.), *New Developments in Foster Care and Adoption,* London: Routledge and Kegan Paul.

ALDGATE, J., 1977. *Identification of Factors Influencing Children's Length of Stay in Care,* Unpub. Ph.D. thesis, University of Edinburgh,

AYRES, M., 1985, "Defining a Child Care Policy", *Adoption and Fostering,* British Association for Adoption and Fostering, Vol.9, No.1, pp.17-21.

BARTON, R., 1959. *Institutional Neurosis,* J. Wright,

BERRIDGE, DAVID, 1985. *Children's Homes,* London, Basil Blackwell,

BOWLBY, J., 1953. *Child Care and Growth of Love,* Harmondsworth: Pelican.

CLANCY, P., 1984. "Demographic Changes and the Irish Family", in *The Changing Family,* Dublin: Family Studies Unit, UCD.

CRELLIN, E., M.L.K. PRINGLE, and P. WEST, 1971. *Born Illegitimate,* A Report of the National Children's Bureau, Windsor: National Foundation for Educational Research.

CURRY, J., 1980. *The Irish Social Services,* Dublin: Institute of Public Administration.

DARLING, V., 1984. *And Baby Makes Two,* Dublin: FSPUC.

DAVIES, B., 1976. *Social Control and Education,* London: Methuen.

DAVIES, B., A. BARTON and I. McMILLAN, 1972. *Variations in Children's Services Among British Urban Authorities.* London: Bell.

deMAUZE, L., (ed.), 1974. *The History of Childhood,* London Souvenir Press,

DONNISON, D., 1975. "An Approach to Social Policy" in National Economic and Social Council Report, No.8, Dublin: The Stationery Office.

DONOHUE, F.J. 1987. "The Role of the Health Boards in Providing Services for the Homeless and the Role of Hostels and Institutional Care in these Services", Paper delivered at Conference: *Focus on Homelessness — Towards a Housing Policy for the Homeless* organised by FOCUSPOINT, January.

DUNCAN, W., 1986. "The Protection of Children, Some Legal and Constitutional Controversies" *Seminar on Children (Care and Protection) Bill,* 1985, held at Trinity College, Dublin, February.

EEC, *One Parent Families in Poverty in the EEC,* Copenhagen, 1982.

FAHLBERG, V., 1981. *Helping Children When They Must Move,* Practice Series:6, British Association for Adoption and Fostering.

FAMILY LINK, 1987. *Your Child in Care,* Dublin.

FAMILY STUDIES UNIT, 1984. *The Changing Family,* Papers presented at a Seminar, June, University College, Dublin.

FARMER, M., 1979. *The Family,* London: Longmans.

FEDERATION OF SERVICES FOR UNMARRIED PARENTS AND THEIR CHILDREN (FSPUC), 1981. *Why Children of Unmarried Parents Come into Care,* Dublin, carried out in 1978 by the Medico-Social Research Board.

FEDERATION OF SERVICES FOR UNMARRIED PARENTS AND THEIR CHILDREN (FSPUC), 1985. *Annual Report 1984/85,* Dublin.

FRANSHEL, D., and E., SHINN, 1978. *Children in Foster Care: A Longitudinal Investigation,* Columbia University Press.

GEORGE, V., 1970. Foster Care: *Theory and Practice,* London: Routledge and Kegan Paul.

GILL, D., 1977. *Illegitimacy, Sexuality and Status of Women,* Oxford: Basil Blackwell,

GILLIGAN, R., 1985, "Spelling Out What is Needed in Child Care Reform", in *No Fixed Abode,* No.5, pp.2-4.

GILLIGAN, R., 1986. "Where Stand Parents under the Children's Bill"? *Seminar on Children (Care and Protection) Bill,* 1985, Trinity College, Dublin, February.

GILLIGAN, R., N. KEARNEY and W. LORENZ, 1987. "Intermediare Hilfestjsteme Personen Bezogener Dienstleistungen in Der Republik Irland" in R. Bauer, and A. Thianhardk (eds.) *Verbandliche Wohlfahrtspflege im Internationelen Vergleich (Voluntary Welfare Provision from an International Perspective)* Opladen: Westdeutscher Verlag.

GOLDSTEIN, J., A. FREUD, A. SOLNIT, 1979. *Beyond the Best Interests of the Child,* The Free Press.

GRAHAM, J.M., 1980. *Children in Care in Northern Ireland,* DHSS, No.10.

GREAT BRITAIN, DHSS, 1985. *Social Work Decisions in Child Care. Recent Findings and their Implications,* London, HMSO.

HOLMAN, C., 1974. *Trading in Children,* London: Routledge and Kegan Paul.

HYMAN, C.A., 1978. "Some Characteristics of Abusing Families Referred to the NSPCC", *British Journal of Social Work,* Vol. 8, No. 2.

IRELAND: BUNREACHT NA h-EIREANN (The Irish Constitution) 1937, Dublin: The Stationery Office.

IRELAND: DEPARTMENT OF JUSTICE, 1936. *Committee of Inquiry into the Reformatory and Industrial Schools System Report* (The Cussen Report), Dublin, The Stationery Office.

IRELAND: DEPARTMENT OF JUSTICE, 1970. *Report on Industrial Schools and Reformatories* (The Kennedy Report), Dublin, The Stationery Office.

IRELAND: DEPARTMENT OF JUSTICE, 1985. *The Status of Children,* Dublin, The Stationery Office.

IRELAND: DEPARTMENT OF HEALTH, 1987. *Children (Care and Protection) Bill, 1987,* Dublin, The Stationery Office.

IRELAND: 1986. Commission on Social Welfare Report, Dublin: Stationery Office.

IRELAND, 1980. *Task Force Report on Children's Services and Supplementary Report,* Dublin: The Stationery Office.

IRELAND, NATIONAL ECONOMIC AND SOCIAL COUNCIL, 1976. *An Approach to Social Policy,* Report No.8, Dublin: The Stationery Office.

IRELAND, NATIONAL ECONOMIC AND SOCIAL COUNCIL, 1980. *Alternative Strategies for Family Income Support,* Report No. 47, Dublin: The Stationery Office.

IRELAND, NATIONAL ECONOMIC AND SOCIAL COUNCIL, 1987. *Community Care Services: An Overview.* Report No. 84, Dublin: The Stationery Office.

IRELAND, NATIONAL PLAN, 1984. *Building on Reality,* Dublin: The Stationery Office.

IRELAND, *Report of the Review Committee on Adoption,* 1984. Dublin: The Stationery Office.

IRELAND, DEPARTMENT OF HEALTH, 1987. *Adoption Bill,* 1987, Dublin: The Stationery Office.

IRELAND, DEPARTMENT OF HEALTH, 1987. *Adoption (No 2) Bill, 1987,* Dublin: The Stationery Office.

IRISH FOSTER CARE ASSOCIATION, 1984. *Open Door,* Dublin: IFCA.

JOYCE, L., and A. McCASHIN, 1982. *Poverty and Social Policy,* Dublin: Institute of Public Administration.

KELLEHER, P., 1988. *Interim Report to Advisory Committee. Recommendations regarding the Development of Integrated Strategies for the Housing and Settlement of Homeless People.* Combat Poverty (forthcoming).

KELLMER-PRINGLE, M., 1975. *The Needs of Children,* London: Hutchinson.

KENNEDY, S. (ed.) 1987. *Streetwise. Homelessness Among the Young in Ireland and Abroad.* Dublin: The Glendale Press Ltd.

KEMPE, R.S., and C.H. KEMPE, 1978. *Child Abuse,* London: Fontana.

KENISTON, K., 1977. *All Our Children,* New York: Harcourt Brace.

KORNITZER, M., 1968. *Adoption and Family Life,* London: Putnam.

LASSON, I., 1980. *Where's My Mum? A Study of Forgotten Children in Long-Term Care,* Birmingham: Pepar Publications.

LOWE, F., 1986. "The Criminal Justice System and Child Sexual Abuse" Seminar on *Children (Care and Protection) Bill 1985,* held at Trinity College, Dublin, February.

McCARTHY, P. 1988. *A Study of Work Skills, Experience and Preferences of Simon Community Residents,* Dublin: Simon Community.

McCARTHY, P. forthcoming. *Annual Census of the Young Homeless,* Dublin: Streetwise.

McQUAID, P., 1971, "Problem Children and Their Families", *Studies,* Vol.60, No.238, pp.155-168.

MILLHAM, S., 1983. *Predicting Children's Length of Stay in Care,* Darlington Social Research Unit, University of Bristol.

MILLHAM, S., R. BULLOCK, K. HOSIE, M. HAAK, 1986. *LOST IN CARE. The Problems of Maintaining Links between Children in Care and their Families.* London: Gower.

MORONEY, R.M., 1976. *The Family and the State,* London: Longman Group Ltd.

NIC GHIOLLA PHADRAIG, M., 1974, *Social and Cultural Factors in Family Planning,* The Changing Family, Family Studies Unit, UCD, Dublin, pp.58-97.

O CINNEIDE, S., 1972, "The Extent of Poverty in Ireland", *Social Studies,* Vol.1., No.4, pp.383-400.

O'HARE, A., M. DROMEY. 1988. *Mothers Alone?,* Dublin: FSUPC.

O'SULLIVAN, D., 1979. "Social Definitions in Child Care in the Irish Republic: Models of the Child and Child Care Intervention", *Economic and Social Review,* Vol.10, No.3, pp.209-229.

PACKMAN, J., 1968. *Child Care, Needs and Numbers,* London: Allen and Unwin Ltd.

PACKMAN, J., J. RANDALL, and N. JACQUES, 1986. *Who Needs Care? Social Work Decisions About Children,* London: Basil Blackwell.

PARKER, R., 1966. *Decision in Child Care,* London: Allen and Unwin.

PARKER, R., 1980. *Caring for Separated Children,* London: Macmillan.

RAYNOR, L., 1980. *The Adopted Child Comes of Age,* National Institute Social Services Library, No.36, London: Allen and Unwin.

RICHARDSON, V., 1984, "When Families Fail", in *The Changing Family,* Dublin: Family Studies Unit, pp.124-175.

RICHARDSON, V., 1985. *Whose Children?* Family Studies Unit, UCD, Dublin.

ROBINS, J., 1980. *The Lost Children: A Study of Charity Children in Ireland, 1700-1900,* Dublin: The Institute of Public Administration.

ROWE, J. and L. LAMBERT, 1973. *Children Who Wait; A Study of Children Needing Substitute Care,* London: Association of British Adoption Agencies.

RUTTER, M., 1975. *Helping Troubled Children,* Harmondsworth: Penguin.

RUTTER, M., 1981. *Maternal Deprivation Re-Assessed,* Harmondsworth: Penguin (Revised Edition).

SCHAFFER, H.R., 1985. "Child-care in a Changing Society",in Robertson,A., and Osborn A., (eds.), *Planning to Care: Social Policy and the Quality of Life,* London: Gower Publications.

SCULLY, P., 1986. "Care Proceedings, The Legal Mechanics", Paper delivered at Seminar on the *Children (Care and Protection) Bill, 1985,* at Trinity College Dublin, February.

SEXTON, J.J., and M.M. DILLON, 1984. "Some Recent Changes in Irish Fertility", *Quarterly Economic Commentary,* May.

SHATTER, A., 1977. *Family Law in the Republic of Ireland,* 2nd ed., Dublin: Wolfhound Press.

SHEEHAN, M., 1975. "Existing in Poverty and Living with Poverty", *Social Studies,* Vol.4, No.1, pp.60-66.

STEIN, M., and K. CAREY, 1986. *Leaving Care,* London: Basil Blackwell.

STUDY COMMISSION ON THE FAMILY, 1983. *Families in the Future,* London: SCF.

TRISELIOTIS, J., (ed.), 1980. *New Developments in Foster Care and Adoption,* London: Routledge and Kegan Paul.

TRISELIOTIS, J., 1985. "Adoption with Contact", in *Adoption and Fostering,* Vol.9, No.4.

UNITED NATIONS, *Demographic Year Book,* 1981.

VERNON, J., and D. FRUIN, 1986. *IN CARE: A Study of Social Work Decision Making,* London: National Children's Bureau.

WALSH, B.M., 1980. "Recent Demographic Changes in the Republic of Ireland", *Population Trends,* No.21, London: HMSO, Office of Population Censuses and Surveys, Autumn.

WEDGE, P., and H. PROSSER, 1973. *Born to Fail?* London: Arrow Books.

WILLIAMS, G.J., and J. MONEY, (eds.), 1980. *Traumatic Abuse and Neglect of Children at Home,* Baltimore: The Johns Hopkins University Press.

WILLIAMS, J., 1961. "Children Who Break Down in Foster Homes: A psychological study of patterns and personality growth in grossly deprived children". *Journal of Child Psychology and Psychiatry.* Vol. 2, pp. 5-20.

Appendix Table : A Age at Admission by Status: (a) at 31st December 1982 (2,446); (b) at any time during 1982 (3,675)

Age at Admission	Status												Total			
	Legitimate				Illegitimate				Extra Marital							
	(a)	(%)	(b)	(%)	(a)	(%)	(b)	(%)	(a)	(%)	(b)	(%)	(a)	(%)	(b)	(%)
0-6 months	141	(9.7)	208	(9.9)	349	(38.0)	706	(47.8)	35	(43.8)	42	(41.2)	525	(21.5)	956	(26.0)
7-23 months	177	(12.2)	256	(12.2)	192	(20.9)	267	(18.1)	25	(31.3)	32	(31.4)	394	(16.1)	555	(15.1)
2-3 years	209	(14.4)	313	(14.9)	160	(17.4)	205	(13.9)	13	(16.3)	17	(16.7)	382	(15.6)	535	(14.6)
4-5 years	241	(16.6)	322	(15.4)	85	(9.3)	116	(7.9)	2	(2.5)	2	(2.0)	328	(13.4)	440	(12.0)
6-7 years	196	(13.5)	269	(12.8)	49	(5.3)	59	(4.0)	2	(2.5)	3	(2.9)	247	(10.1)	331	(9.0)
8-9 years	177	(12.2)	251	(12.0)	26	(2.8)	42	(2.8)	1	(1.2)	2	(2.0)	204	(8.3)	295	(8.0)
10-11 years	147	(10.2)	206	(9.8)	26	(2.8)	31	(2.1)	0	(0.0)	0	(0.0)	173	(7.1)	237	(6.4)
12-13 years	96	(6.6)	150	(7.2)	24	(2.6)	35	(2.4)	1	(1.2)	1	(1.0)	121	(4.9)	186	(5.1)
14-15 years	47	(3.3)	86	(4.1)	4	(0.4)	10	(0.7)	1	(1.2)	3	(2.9)	52	(2.1)	99	(2.7)
16 +	17	(1.2)	35	(1.7)	3	(0.3)	6	(0.4)	0	(0.0)	0	(0.0)	20	(0.8)	41	(1.1)
Total	1448	(100.0)	2096	(100.0)	918	(100.0)	1477	(100.0)	80	(100.0)	102	(100.0)	2446	(100.0)	3675	(100.0)

Appendix Table B: Age at Admission by Community Care Area: (a) on 31 December 1982 (2446); (b) in care at any time during 1982 (3675)

Community Care Area	0-6 months		7-23 months		2-3 years		4-5 years		6-7 years	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Eastern Health Board										
1. Dunlaoghaire	15 (19.0)	32 (26.0)	14 (17.7)	22 (17.9)	15 (19.0)	19 (15.4)	6 (7.6)	9 (7.3)	7 (8.9)	10 (8.1)
2. Dublin South-East	27 (34.6)	41 (41.4)	14 (17.9)	16 (16.2)	13 (16.7)	15 (15.2)	5 (6.4)	5 (5.1)	4 (5.1)	5 (5.0)
3. Dublin South-Central	16 (24.2)	25 (27.5)	6 (9.1)	9 (9.9)	9 (13.6)	11 (12.1)	9 (13.6)	13 (14.3)	9 (13.6)	13 (14.3)
4. Dublin South-West	23 (26.4)	41 (29.3)	9 (10.3)	17 (12.1)	13 (14.9)	16 (12.9)	9 (10.3)	17 (12.1)	10 (11.5)	13 (9.3)
5. Dublin West	12 (11.3)	21 (14.0)	14 (13.2)	16 (10.7)	14 (13.2)	16 (10.7)	22 (20.5)	27 (18.0)	12 (11.3)	15 (10.0)
6. Dublin North-West	4 (10.0)	18 (22.2)	6 (15.0)	11 (13.6)	11 (27.5)	17 (21.0)	3 (7.5)	7 (8.6)	4 (10.0)	6 (7.4)
7. Dublin North-Central	16 (12.2)	47 (19.7)	29 (22.1)	47 (19.7)	26 (19.9)	49 (20.5)	22 (16.8)	28 (11.8)	13 (10.0)	19 (7.9)
8. Dublin North	35 (17.9)	46 (17.4)	27 (13.9)	35 (13.3)	17 (8.7)	30 (11.4)	22 (11.3)	32 (12.1)	26 (13.3)	32 (12.1)
9. Kildare	10 (17.9)	22 (24.4)	9 (16.1)	14 (15.5)	6 (10.5)	10 (11.2)	14 (25.0)	16 (17.8)	9 (16.0)	10 (11.2)
10. Wicklow	32 (49.2)	38 (37.6)	5 (7.7)	13 (12.9)	5 (7.7)	9 (9.0)	7 (10.7)	11 (10.9)	7 (10.8)	11 (10.9)
South-Eastern Health Board										
11. Carlow/Kilkenny	15 (17.1)	18 (13.3)	24 (22.8)	25 (20.8)	15 (14.3)	20 (14.8)	16 (15.2)	15 (13.4)	12 (11.4)	18 (13.4)
12. Tipperary (S.R.)	16 (16.8)	22 (15.7)	13 (13.7)	19 (12.8)	24 (25.3)	32 (22.8)	14 (14.7)	20 (14.3)	8 (8.4)	11 (7.9)
13. Waterford	7 (14.3)	41 (38.3)	14 (28.5)	23 (21.5)	11 (22.5)	14 (13.1)	6 (12.3)	10 (9.3)	7 (14.3)	8 (7.3)
14. Wexford	17 (24.6)	26 (28.0)	8 (11.6)	9 (9.7)	11 (15.9)	12 (12.9)	9 (13.0)	13 (14.0)	9 (13.0)	12 (12.9)
Southern Health Board										
15. Cork North Lee	21 (23.1)	28 (16.6)	16 (17.6)	28 (16.6)	14 (15.4)	28 (16.6)	16 (17.4)	33 (19.6)	8 (8.8)	17 (10.0)
16. Cork South Lee	10 (27.8)	12 (25.5)	9 (25.0)	12 (25.5)	8 (22.2)	10 (21.3)	3 (8.3)	4 (8.5)	2 (5.6)	4 (8.5)
17. North Cork	3 (6.1)	3 (5.3)	5 (10.2)	6 (10.5)	11 (22.4)	12 (21.1)	11 (22.4)	13 (22.8)	11 (22.4)	13 (22.8)
18. West Cork	6 (21.4)	7 (16.7)	8 (28.5)	10 (23.8)	4 (11.2)	6 (14.2)	5 (17.8)	7 (16.7)	0 -	1 (2.4)
19. Kerry	24 (32.0)	33 (31.7)	11 (14.6)	16 (15.4)	12 (16.0)	17 (16.4)	9 (12.0)	11 (10.6)	3 (4.0)	3 (2.9)
Mid-Western Health Board										
20. Limerick	26 (15.3)	41 (20.8)	24 (16.9)	36 (18.3)	22 (15.5)	29 (14.7)	27 (19.1)	29 (14.7)	14 (9.8)	19 (9.7)
21. Tipperary (N.R.)	12 (9.7)	19 (12.5)	16 (12.9)	21 (13.9)	13 (10.9)	16 (10.5)	16 (12.9)	16 (10.5)	16 (12.9)	19 (12.5)
22. Clare	19 (31.1)	60 (54.1)	13 (21.3)	16 (14.4)	4 (6.6)	7 (6.3)	6 (9.5)	8 (7.2)	7 (11.5)	7 (6.3)
Western Health Board										
23. Galway	19 (23.2)	62 (39.0)	14 (17.1)	22 (13.8)	9 (11.0)	16 (10.1)	14 (17.0)	18 (11.3)	10 (12.2)	12 (7.5)
24. Mayo	13 (25.5)	25 (35.7)	2 (3.9)	4 (5.7)	11 (21.6)	11 (15.7)	8 (15.6)	9 (12.8)	6 (11.8)	7 (10.0)
25. Roscommon	14 (51.8)	20 (45.5)	6 (22.2)	9 (20.4)	1 (3.7)	2 (4.6)	0 -	1 (2.3)	0 -	0 -
North-Western Health Board										
26. Donegal	12 (24.5)	47 (47.5)	7 (14.3)	11 (11.1)	11 (22.4)	15 (15.2)	5 (10.2)	5 (5.0)	4 (8.2)	7 (7.1)
27. Sligo/Leitrim	21 (34.4)	31 (33.7)	9 (14.7)	11 (11.9)	7 (11.5)	12 (13.0)	11 (18.0)	14 (15.2)	2 (3.3)	3 (3.3)
North-Eastern Health Board										
28. Cavan/Monaghan	14 (24.1)	26 (33.8)	14 (24.1)	15 (19.5)	15 (25.9)	17 (22.1)	4 (6.9)	5 (6.5)	3 (5.2)	3 (3.9)
29. Louth	17 (27.4)	27 (30.3)	10 (16.1)	14 (15.7)	9 (14.5)	13 (14.6)	5 (8.1)	8 (9.0)	6 (9.7)	7 (7.8)
30. Meath	17 (34.0)	20 (36.4)	9 (18.0)	10 (18.2)	5 (10.0)	5 (9.1)	7 (14.0)	7 (12.7)	4 (8.0)	4 (7.3)
Midland Health Board										
31. Laois/Offaly	19 (15.3)	37 (22.0)	23 (18.6)	27 (16.0)	23 (18.6)	29 (17.2)	13 (10.5)	18 (10.7)	11 (8.8)	13 (7.8)
32. Longford/Westmeath	10 (15.2)	20 (22.0)	6 (11.0)	9 (9.9)	13 (23.6)	18 (19.8)	4 (7.2)	8 (8.8)	3 (5.5)	9 (9.9)
Total	525	956	394	553	382	535	328	440	247	331

8-9 years		10-11 years		12-13 years		14-15 years		16 + years		Totals		Area
(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	
4 (5.1)	9 (7.3)	13 (16.5)	14 (11.4)	4 (5.1)	5 (4.0)	1 (1.3)	2 (1.6)	0 -	1 (0.8)	78 (100.0)	123 (100.0)	1.
3 (3.5)	5 (5.0)	4 (5.1)	4 (4.0)	3 (3.5)	3 (3.0)	3 (3.5)	3 (3.0)	2 (2.6)	2 (2.0)	76 (100.0)	99 (100.0)	2.
7 (10.6)	8 (8.8)	4 (6.1)	4 (4.4)	4 (6.1)	5 (5.5)	2 (3.0)	3 (3.3)	0 -	0 -	66 (100.0)	91 (100.0)	3.
8 (9.2)	10 (7.2)	7 (8.0)	5 (5.7)	6 (6.9)	10 (7.1)	0 -	2 (1.4)	2 (2.3)	4 (2.9)	87 (100.0)	140 (100.0)	4.
7 (6.6)	16 (10.6)	11 (10.4)	21 (14.0)	9 (8.5)	11 (7.3)	4 (3.8)	5 (3.3)	1 (0.9)	2 (1.3)	106 (100.0)	150 (100.0)	5.
5 (12.5)	9 (11.1)	3 (7.5)	6 (7.4)	2 (5.0)	4 (4.9)	2 (5.0)	2 (2.5)	0 -	1 (1.2)	40 (100.0)	81 (100.0)	6.
13 (10.0)	15 (6.3)	7 (5.4)	11 (4.6)	3 (2.3)	11 (4.7)	2 (1.6)	8 (3.4)	0 -	3 (1.2)	131 (100.0)	238 (100.0)	7.
20 (10.3)	26 (9.9)	23 (11.8)	30 (11.4)	11 (5.7)	15 (5.7)	11 (5.6)	15 (5.7)	3 (1.5)	3 (1.2)	195 (100.0)	264 (100.0)	8.
5 (8.9)	7 (7.7)	2 (3.6)	6 (6.6)	1 (1.8)	1 (1.1)	0 -	3 (3.3)	0 -	1 (1.1)	56 (100.0)	90 (100.0)	9.
4 (6.1)	9 (9.0)	2 (3.1)	2 (2.0)	1 (1.5)	3 (3.0)	1 (1.5)	3 (3.0)	1 (1.5)	2 (2.0)	65 (100.0)	101 (100.0)	10.
7 (6.7)	13 (9.6)	9 (8.6)	11 (8.1)	3 (2.9)	5 (3.7)	1 (1.0)	4 (2.9)	0 -	0 -	105 (100.0)	135 (100.0)	11.
10 (10.5)	15 (10.7)	7 (7.4)	12 (8.5)	3 (3.2)	5 (3.6)	0 -	2 (1.4)	0 -	3 (2.1)	95 (100.0)	140 (100.0)	12.
3 (6.1)	7 (6.5)	0 -	2 (1.9)	1 (2.0)	1 (0.9)	0 -	0 -	0 -	1 (0.9)	49 (100.0)	107 (100.0)	13.
7 (10.1)	11 (11.8)	3 (4.3)	3 (3.3)	3 (4.3)	5 (5.4)	2 (2.9)	2 (1.1)	0 -	0 -	69 (100.0)	93 (100.0)	14.
6 (6.6)	11 (6.5)	6 (6.6)	10 (6.0)	3 (3.3)	12 (7.2)	1 (1.1)	2 (1.2)	0 -	0 -	91 (100.0)	169 (100.0)	15.
0 -	0 -	0 -	0 -	4 (11.2)	5 (10.7)	0 -	0 -	0 -	0 -	36 (100.0)	47 (100.0)	16.
5 (10.2)	6 (10.5)	1 (2.0)	2 (3.6)	1 (2.0)	1 (1.8)	0 -	0 -	1 (2.0)	1 (1.8)	49 (100.0)	57 (100.0)	17.
1 (3.6)	2 (4.8)	2 (7.2)	2 (4.8)	1 (3.6)	3 (7.2)	0 -	2 (4.8)	1 (3.6)	2 (4.8)	28 (100.0)	42 (100.0)	18.
10 (13.3)	12 (11.5)	3 (4.0)	4 (3.8)	3 (4.0)	7 (6.7)	0 -	1 (1.0)	0 -	0 -	75 (100.0)	104 (100.0)	19.
14 (9.9)	19 (9.6)	11 (7.7)	15 (7.7)	4 (2.8)	6 (3.0)	0 -	3 (1.5)	0 -	0 -	142 (100.0)	197 (100.0)	20.
11 (8.8)	13 (8.6)	14 (11.2)	16 (10.5)	14 (11.2)	15 (9.9)	7 (5.6)	10 (6.5)	5 (4.0)	7 (4.6)	124 (100.0)	152 (100.0)	21.
7 (11.5)	8 (7.2)	3 (4.9)	3 (2.7)	2 (3.3)	2 (1.8)	0 -	0 -	0 -	0 -	61 (100.0)	111 (100.0)	22.
6 (7.4)	9 (5.7)	3 (3.6)	6 (3.8)	5 (6.1)	9 (5.6)	1 (1.2)	4 (2.5)	1 (1.2)	1 (0.6)	82 (100.0)	159 (100.0)	23.
5 (9.8)	5 (7.1)	2 (3.9)	2 (2.9)	4 (7.8)	5 (7.1)	0 -	1 (1.4)	0 -	1 (1.4)	51 (100.0)	70 (100.0)	24.
2 (7.4)	3 (6.8)	2 (7.4)	3 (6.8)	1 (3.7)	5 (11.3)	1 (3.7)	1 (2.3)	0 -	0 -	27 (100.0)	44 (100.0)	25.
5 (10.2)	6 (6.0)	2 (4.0)	2 (2.0)	1 (2.0)	2 (2.0)	2 (4.1)	4 (4.0)	0 -	0 -	49 (100.0)	99 (100.0)	26.
1 (1.6)	6 (6.5)	5 (8.2)	9 (9.8)	3 (4.9)	4 (4.3)	0 -	0 -	2 (3.3)	2 (2.2)	61 (100.0)	92 (100.0)	27.
3 (5.2)	6 (7.8)	3 (5.2)	3 (3.9)	1 (1.7)	1 (1.3)	1 (1.7)	1 (1.3)	0 -	0 -	58 (100.0)	77 (100.0)	28.
6 (9.7)	6 (6.7)	5 (8.1)	7 (7.9)	1 (1.6)	2 (2.2)	3 (4.8)	1 (1.1)	0 -	1 (1.1)	62 (100.0)	89 (100.0)	29.
3 (6.0)	3 (5.5)	1 (2.0)	1 (1.8)	3 (6.0)	3 (5.5)	1 (2.0)	2 (3.6)	0 -	0 -	50 (100.0)	55 (100.0)	30.
10 (8.1)	12 (7.2)	11 (8.8)	12 (7.2)	10 (8.1)	12 (7.2)	3 (2.4)	5 (3.0)	1 (0.8)	3 (1.8)	124 (100.0)	168 (100.0)	31.
6 (10.9)	8 (8.8)	4 (7.3)	6 (6.6)	6 (10.9)	5 (5.5)	3 (5.4)	5 (5.5)	0 -	0 -	55 (100.0)	91 (100.0)	32
204	295	173	237	121	186	52	99	20	41	2446	3675	Total

Appendix Table C Age of children in care at 31 December, 1982 by Community Care Area

Community Care Area	0 - 1	per cent	1 year	per cent	2 - 3	per cent	4 - 6	per cent	7 - 11	per cent	12 - 14	per cent	15 +	per cent	Totals	per cent
1. Dun Laoghaire	3	3.8	1	1.3	8	10.1	8	10.1	28	35.4	21	26.6	10	12.7	79	100.0
2. Dn Sth. East	4	5.1	5	6.4	6	7.7	14	17.9	12	15.4	20	25.6	17	21.8	78	100.0
3. Dn Sth. Central	1	1.5	4	6.1	12	18.2	10	15.2	20	30.3	14	21.2	5	7.6	66	100.0
4. Dn Sth. West	11	12.6	6	5.9	11	12.6	9	10.3	19	21.8	20	23.0	11	12.6	87	100.0
5. Dublin West	3	2.8	2	1.9	11	10.4	23	21.7	36	34.0	17	16.0	14	13.2	106	100.0
6. Dn Nth. West	1	2.5	1	2.5	4	10.0	10	25.0	7	17.5	4	10.0	13	32.5	40	100.0
7. Dn Nth. Central	4	3.1	9	6.9	19	14.5	27	20.6	42	32.1	17	13.0	13	9.9	131	100.0
8. Dublin North	3	1.5	10	5.1	13	6.7	42	21.5	61	31.3	36	18.5	30	15.4	195	100.0
9. Kildare	0	0.0	2	3.6	3	5.4	9	16.1	18	32.1	11	19.6	13	23.2	56	100.0
10. Wicklow	3	4.6	5	7.7	0	0.0	14	21.5	16	24.6	5	7.7	22	33.8	65	100.0
11. Carlow/Kilkenny	0	0.0	3	3.2	8	7.6	14	13.3	35	33.3	25	23.8	20	19.0	105	100.0
12. Tipperary (S.R.)	5	5.3	4	4.2	16	16.8	13	13.7	25	26.3	19	20.0	13	13.7	95	100.0
13. Waterford	1	2.0	2	4.1	4	8.2	7	14.3	11	22.4	14	28.6	10	20.4	49	100.0
14. Wexford	2	2.9	2	2.9	11	15.9	10	14.5	19	27.5	13	18.8	12	17.4	69	100.0
15. Cork N. Lee	2	2.2	6	6.6	11	12.1	17	18.7	33	36.3	13	14.3	9	9.9	91	100.0
16. Cork S. Lee	2	5.6	2	5.6	4	11.1	5	13.9	8	22.2	9	25.0	6	16.7	36	100.0
17. Nth. Cork	1	2.0	0	0.0	3	6.1	10	20.4	20	40.8	7	14.3	8	16.3	49	100.0
18. W. Cork	2	7.1	3	10.7	4	14.3	8	28.6	1	3.6	4	14.3	6	21.4	28	100.0
19. Kerry	16	21.4	3	4.1	5	6.7	9	12.0	19	25.3	13	17.3	10	13.3	75	100.0
20. Limerick	6	4.2	3	2.1	14	9.9	17	12.0	47	33.1	32	22.5	23	16.2	142	100.0
21. Tipperary (N.R.)	1	0.8	4	3.2	9	7.3	15	12.1	36	29.0	35	28.2	24	19.4	124	100.0
22. Clare	18	29.5	3	4.9	6	9.8	9	14.8	15	24.6	8	13.1	2	3.3	61	100.0
23. Galway	9	10.9	2	2.4	4	4.9	15	18.3	25	30.5	15	18.3	12	14.6	82	100.0
24. Mayo	5	9.8	4	7.8	9	17.6	5	9.8	8	15.7	11	21.6	9	17.6	51	100.0
25. Roscommon	4	14.8	3	11.1	4	14.8	3	11.1	5	18.5	3	11.1	5	18.5	27	100.0
26. Donegal	6	12.2	1	2.0	1	2.0	7	14.3	17	34.7	13	26.5	4	8.2	49	100.0
27. Sligo/Leitrim	3	4.9	4	6.6	4	6.6	13	21.3	13	21.3	8	13.1	16	26.2	61	100.0
28. Cavan/Monaghan	2	3.4	5	8.6	12	20.7	11	19.0	15	25.9	7	12.1	6	10.3	58	100.0
29. Louth	3	4.8	8	12.9	13	21.0	9	14.5	13	21.0	11	17.7	5	8.1	62	100.0
30. Meath	0	0.0	5	10.0	6	12.0	11	22.0	12	24.0	7	14.0	9	18.0	50	100.0
31. Laois/Offaly	11	8.8	6	4.8	11	8.9	21	16.9	34	27.4	20	16.1	21	16.9	124	100.0
32. Longford/W'meath	5	9.1	1	1.8	6	10.9	12	21.8	11	20.0	11	20.0	9	16.4	55	100.0
	137	5.6	119	1.8	252	10.3	407	16.6	681	27.8	463	18.9	387	15.8	2446	100.0

Appendix Table D: Age Structures of Children in Care at December 31st, 1982, by Health Board (Responsible) (a) and Probability of being in Care in each Health Board by age (b)

Ages	Eastern (%)		Midland (%)		Mid Western (%)		North Eastern (%)		North Western (%)		South Eastern (%)		Southern (%)		Western (%)		Total (%)	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
< 1	3.7	.0013	8.9	.0036	7.6	.0038	2.9	.0008	8.2	.0021	2.5	.0010	8.2	.0022	11.3	.0026	5.6	.0019
> 1	5.0	.0018	3.9	.0015	3.1	.0015	10.6	.0027	4.5	.0011	3.5	.0013	5.0	.0013	5.6	.0013	4.9	.0016
2 - 3	9.6	.0019	9.5	.0020	8.9	.0023	18.2	.0025	4.5	.0006	12.3	.0023	9.7	.0013	10.6	.0013	10.3	.0018
4 - 6	18.4	.0024	18.4	.0026	12.5	.0021	18.2	.0017	18.2	.0016	13.8	.0019	17.6	.0016	14.4	.0012	16.6	.0020
7 - 11	28.7	.0021	25.1	.0021	30.0	.0031	23.5	.0013	27.3	.0015	28.3	.0023	29.0	.0015	23.8	.0011	27.8	.0019
12 - 14	18.3	.0024	17.3	.0025	22.9	.0042	14.7	.0015	19.1	.0017	22.3	.0031	16.5	.0015	18.1	.0066	18.9	.0023
15 - 21	16.4	.0009	16.8	.0012	15.0	.0013	11.8	.0006	18.2	.0008	17.3	.0012	14.0	.0006	16.3	.0006	15.8	.0009
	100% N=903	.0017	100% N=179	.0020	100% N=327	.0025	100% N=170	.0013	100% N=110	.0013	100% N=318	.0019	100% N=279	.0013	100% N=160	.0011	100% N=2446	.0016

See Table 3.6 for population figures on which these probabilities are based.

$X^2 = 110.99774$ with 42 df. $p < 0.0000$

Appendix Table E: Sex of Children in Care, by Community Care Area plus total population up to 19 years and probability of being in Care at 31st Dec. 1982

Area	Children in Care			Population up to and including 19 yrs.			Probability of being in Care		
CCA	Females	Males	Total	Females	Males	Total	Females	Males	Total
1. Dunlaoghaire	32	47	79	23725	23878	47603	.0013	.0020	.0017
2. Dn Sth East	42	36	78	19829	19283	39112	.0021	.0019	.0020
3. Dn Sth Central	23	43	66	15824	15511	31335	.0015	.0028	.0021
4. Dn Sth West	37	50	87	26792	27989	54781	.0014	.0018	.0016
5. Dublin West	37	69	106	19883	20993	40876	.0019	.0033	.0026
6. Dn Nth West	20	20	40	25768	26260	52028	.0008	.0008	.0008
7. Dn Nth Central	64	67	131	23642	24224	47866	.0027	.0028	.0027
8. Dublin North	96	99	195	44070	43275	87345	.0022	.0023	.0022
9. Kildare	25	31	56	21354	23959	45313	.0012	.0013	.0012
10. Wicklow	33	32	65	17621	18327	35948	.0019	.0017	.0018
11. Carlow/Kilkenny	47	58	105	21913	22960	44873	.0021	.0025	.0023
12. Tipperary (S.R.)	45	50	95	14774	16225	30999	.0030	.0031	.0031
13. Waterford	25	24	49	17618	18561	36179	.0014	.0013	.0014
14. Wexford	30	39	69	19714	20952	40666	.0015	.0019	.0017
15. Cork N. Lee	39	52	91	31871	29322	61193	.0012	.0018	.0015
16. Cork S. Lee	19	17	36	26077	24867	50944	.0007	.0007	.0007
17. Nth Cork	26	23	49	14317	13684	28001	.0018	.0017	.0017
18. W. Cork	13	15	28	8958	8511	17469	.0015	.0018	.0016
19. Kerry	34	41	75	22445	23621	46066	.0015	.0017	.0016
20. Limerick	70	72	142	31997	33517	65514	.0022	.0021	.0022
21. Tipperary (N.R.)	56	68	124	11425	12041	23466	.0049	.0056	.0053
22. Clare	25	36	61	16677	17466	34143	.0015	.0021	.0018
23. Galway	50	32	82	32921	34573	67494	.0015	.0009	.0012
24. Mayo	29	22	51	21042	21726	42768	.0014	.0010	.0012
25. Roscommon	15	12	27	9632	10298	19930	.0016	.0012	.0014
26. Donegal	24	25	49	24540	25376	49916	.0010	.0010	.0010
27. Sligo/Leitrim	35	26	61	14520	15427	29947	.0024	.0017	.0020
28. Cavan/Monaghan	26	32	58	19394	20860	40254	.0013	.0015	.0014
29. Louth	27	35	62	17959	18775	36734	.0015	.0019	.0017
30. Meath	27	23	50	21303	19738	41041	.0013	.0012	.0012
31. Laois/Offaly	64	60	124	21808	23685	45493	.0029	.0025	.0027
32. Longford/Westmeath	29	26	55	19280	18172	37452	.0015	.0014	.0015
	1164	1282	2446	678693	694056	1,372,749	.0017	.0018	.0018

APPENDIX F: QUESTIONNAIRE

Form CC1/82

CHILDREN IN CARE OR UNDER SUPERVISION OF HEALTH BOARDS IN 1982

IMPORTANT: Complete only in respect of child not in care at end of 1981 and admitted into Care in 1982

[ ] Responsible Health Board (1) [ ] Community Care Area (2-3) [ ] (4) Child Identification Number [ ] (5-9)

1. Date of Birth: DAY | MONTH | YEAR (10-15)
2. Sex (M. or F) (16)
3. Status (Legit = A, Illegit = B, Ex-marital = C) Enter A or B or C (17)
4. Health Board in which child is receiving care (if different from above) (18)

5. Date of Current Admission to Care: DAY | MONTH | YEAR (19-24)
6. How many previous admissions to care since Jan 1st 1980 has child had? (None=A, 1-3 admissions = B, 4-5 admissions = C, greater than 5=D) Enter A, B, C, or D. (25)
7. Was current admission on basis of a Court Order (Y or N) (26)
8. Siblings of the Child in Care
   (i) No. of Siblings (27-28)
   (ii) No. of Siblings in care (if applicable) (29-30)
9. Precipitating Reason for Current Admission
   Enter one only of A - L (31)
   a. Physical Abuse of Child
   b. Sexual abuse of child
   c. Emotional abuse of child
   d. Neglect of child
   e. One parent family unable to cope
   f. Marital disharmony
   g. Child out of control
   h. Child abandoned
   j. Both parents dead
   k. Short-term Crisis
   L. Child awaiting adoption
10. Type of Care Provided (Current Admission)
    Enter one of A - F (32)
    A. Short-Term Foster Care
    B. Long-Term Foster Care
    C. Short-term Residential Care
    D. Long-term residential care
    E. Private Foster care
    F. Supervision at home in accordance with the terms of a Court Order
11. Number of Placements under current admission prior to that at 10 above. (A=1, B=2, C=3 or more) Enter A or B or C (33)

12. This Section does not apply either to (i) a child in care for less than 3 months or (ii) a child awaiting adoption. (ie. If entry at 9 is L.

    Primary reason child not re-united with family

    Enter one only A - M

    No Home Here (34)
    a. No parents or whereabouts unknown
    b. No relatives willing to accommodate
    c. Parents unwilling/unable to accommodate.

    Adverse Parental Factors
    d. Physical illness/disability
    e. Mental disorder
    f. Inability to cope
    g. Alcoholism/Drug Addiction

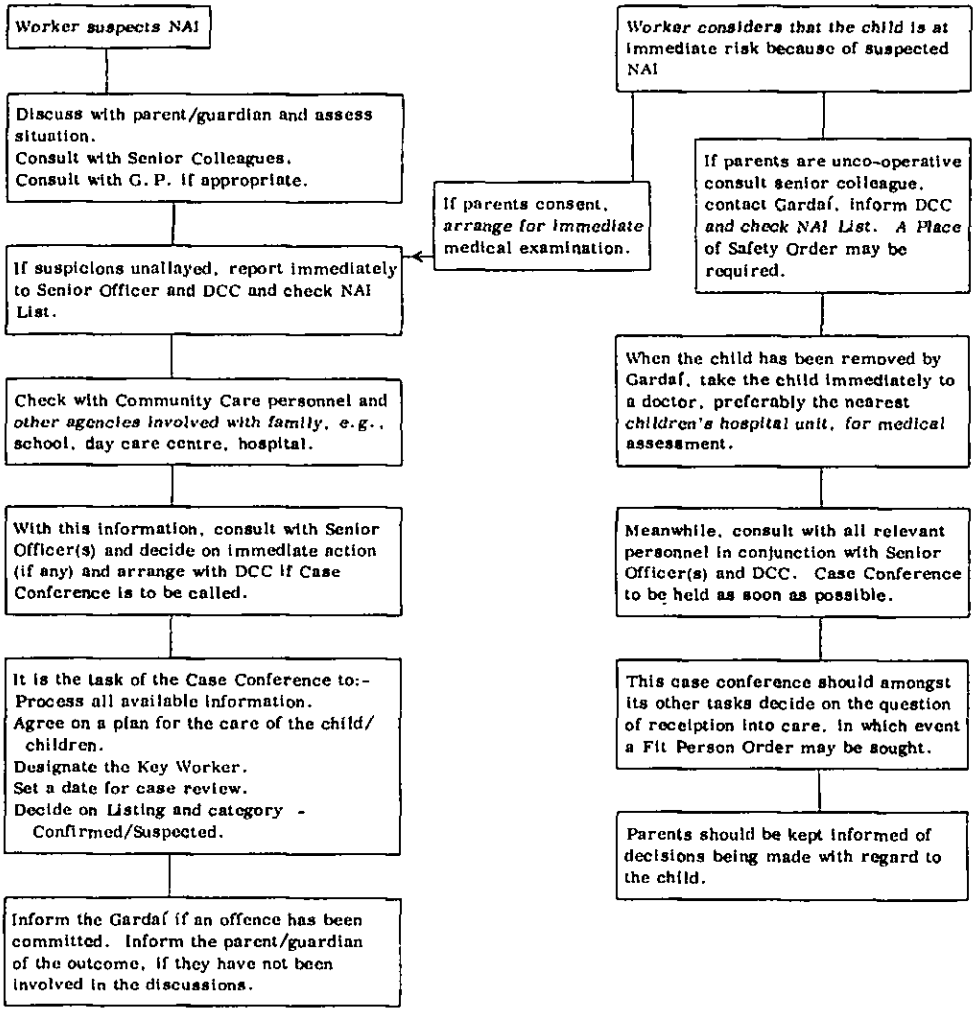
    Family Instability
    h. Promiscuous Environment
    j. Marital disharmony
    k. Physical violence.

    Parental Control
    l. Inconsistent
    m. Over protective
    n. Rejecting

13. Reason why child is in Residential Care
    Enter one only A - M (35)
    a. No short-term foster home available
    b. No suitable long-Term Foster Home Available
    c. Breakdown in Foster Placement
    d. Child with siblings in same residential home.
    e. Awaiting adoption.
    f. Parents refuse to allow child to be fostered.
    g. Residential care most suitable for child's need
    h. Other reason (please specify).
14. Is child in employment (Y or N) (36)
15. Date of last care review: DAY | MONTH | YEAR (37-42)
16. Was child in care on 31st December 1982 (Y or N) (43)
17. If entry at 16 (r N please indicate. Reason for leaving Care
    Enter only A - N (44)
    A. Reached legal age limit
    B. Re-united with family/relatives
    C. In After Care/Self-sufficient
    D. Adopted
    E. Absconded
    F. Admitted to specialised unit.
    G. Death of Child
    H. Other (please specify).
18. Date child left care: Day | Month | Year (45-50)

Appendix Table G

Summary of Procedures for Health Board Field Workers



Source: Non-Accidental Injury to Children. Department of Health, 1983. The above should be read in conjunction with Pars. 2-6 of the guidelines.

Appendix Table H: Types of Care by Age at Admission (a) Those in care on 31 December 1982 (2446); (b) Excluding adoptees (2390)

Types of Care	0-6 months		7-23 months		2-3 years		4-5 years		Age at Admission 6-7 years		8-9 years		10-11 years		12-13 years		14-15 years		16 years +		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Short-term Foster	76 (14.5)	59 (12.4)	16 (4.1)	16 (4.1)	20 (5.2)	19 (5.0)	6 (1.8)	6 (1.8)	7 (2.8)	7 (2.8)	7 (3.4)	7 (3.4)	4 (2.3)	4 (2.3)	2 (1.7)	2 (1.7)	4 (7.7)	4 (7.7)	0 -	0 -	142 (5.8)	124 (5.2)
Long-term Foster	266 (50.7)	261 (54.7)	263 (66.8)	260 (67.2)	183 (47.9)	183 (48.0)	155 (47.3)	155 (47.3)	97 (39.3)	97 (39.3)	67 (32.8)	67 (32.8)	48 (27.7)	48 (27.7)	36 (29.8)	36 (29.8)	10 (19 2)	10 (19.2)	5 (25.0)	5 (25.0)	1130 (46.2)	1122 (46.9)
Short-term Residential	42 (8.0)	27 (5.7)	12 (3.0)	11 (2.8)	21 (5.5)	21 (5.5)	12 (3.7)	12 (3.7)	5 (2.0)	5 (2.0)	14 (6.9)	14 (6.9)	7 (4.0)	7 (4.0)	7 (5.8)	7 (5.8)	7 (13.5)	7 (13.5)	1 (5.0)	1 (5.0)	125 (5.2)	112 (4.7)
Long-term Residential	77 (14.7)	76 (15.9)	88 (22.3)	88 (22.7)	150 (39.3)	150 (39.4)	150 (45.7)	150 (45.7)	135 (54.7)	135 (54.7)	113 (55.4)	113 (55.4)	112 (64.7)	112 (64.7)	74 (61.2)	74 (61.2)	31 (59.6)	31 (59.6)	14 (70.0)	14 (70.0)	944 (38.6)	943 (39.5)
Private Foster Care	64 (12.2)	54 (11.3)	15 (3.8)	12 (3.1)	7 (1.8)	7 (1.8)	4 (1.2)	4 (1.2)	1 (0.4)	1 (0.4)	0 -	0 -	1 (0.6)	1 (0.6)	1 (0.8)	1 (0.8)	0 -	0 -	0 -	0 -	93 (3.8)	80 (3.3)
Supervision at home	0 -	0 -	0 -	0 -	1 (0.3)	1 (0.3)	1 (0.3)	1 (0.3)	2 (0.8)	2 (0.8)	3 (1.5)	3 (1.5)	1 (0.6)	1 (0.6)	1 (0.8)	1 (0.8)	0 -	0 -	0 -	0 -	9 (0.4)	9 (0.4)
Total	525 (100.0)	477	394 (100.0)	387	382 (100.0)	381	328 (100.0)	328	247 (100.0)	247	204 (100.0)	204	173 (100.0)	173	121 (100.0)	121	52 (100.0)	52	20 (100.0)	20	2446 (100.0)	2390

Appendix Table J: Types of Care and Status by Age at Admission

Types of Care by Status		0-6 months	7-23 months	2-3 years	4-5 years	6-7 years	8-9 years	10-11 years	12-13 years	14-15 years	16 years	Total
Short-term Foster	Legit.	14 (9.9)	12 (6.8)	10 (4.8)	6 (2.5)	7 (3.6)	5 (2.8)	4 (2.7)	2 (2.1)	4 (8.5)	0 -	64 (4.4)
	Illegit.	59 (16.9)	4 (2.1)	8 (5.0)	0 -	0 -	2 (7.7)	0 -	0 -	0 -	0 -	73 (8.0)
	E.M.	3 (8.6)	0 -	2 (15.4)	0 -	0 -	0 -	0 -	0 -	0 -	0 -	5 (6.3)
Long-term Foster	Legit.	66 (46.9)	92 (52.0)	70 (33.5)	95 (39.4)	65 (33.2)	50 (28.2)	34 (23.1)	20 (20.8)	7 (14.9)	4 (23.5)	503 (34.7)
	Illegit.	171 (49.0)	149 (77.6)	106 (66.3)	59 (69.4)	30 (61.2)	16 (61.5)	14 (53.8)	15 (62.5)	2 (50.0)	1 (33.3)	563 (61.3)
	E.M.	29 (82.9)	22 (88.0)	7 (53.8)	1 (50.0)	2 (100.0)	1 (100.0)	0 -	1 (100.0)	1 (100.0)	0	64 (80.0)
Short-term Residential	Legit.	13 (9.2)	3 (1.7)	11 (5.3)	9 (3.7)	5 (2.6)	13 (7.3)	5 (3.4)	6 (6.3)	7 (14.9)	1 (5.9)	73 (5.0)
	Illegit.	28 (8.0)	7 (3.6)	7 (4.4)	3 (1.2)	0 -	1 (3.8)	2 (7.7)	1 (4.2)	0 -	0 -	49 (5.3)
	E.M.	1 (2.9)	2 (8.0)	3 (23.1)	0 -	0 -	0 -	0 -	0 -	0 -	0 -	6 (9.5)
Long-term Residential	Legit.	44 (31.2)	69 (39.0)	114 (54.5)	127 (52.7)	117 (59.7)	106 (59.9)	103 (70.1)	66 (68.8)	29 (61.7)	12 (70.6)	787 (54.5)
	Illegit.	32 (9.2)	18 (9.4)	35 (21.9)	22 (25.9)	18 (36.7)	7 (26.9)	9 (34.6)	8 (33.3)	2 (50.0)	2 (66.7)	153 (16.7)
	E.M.	1 (2.9)	1 (4.0)	1 (7.7)	1 (50.0)	0 -	0 -	0 -	0 -	0 -	0 -	4 (5.0)
Private Foster	Legit.	4 (2.8)	1 (0.6)	3 (1.4)	4 (1.7)	1 (0.5)	0 -	0 -	1 (1.0)	0 -	0 -	14 (1.0)
	Illegit.	59 (16.9)	14 (7.3)	4 (2.5)	0 -	0 -	0 -	1 (3.8)	0 -	0 -	0 -	78 (8.5)
	E.M.	1 (2.9)	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	1 (1.3)
Supervision at home	Legit.	0 -	0 -	1 (0.5)	0	1 (0.5)	3 (1.7)	1 (0.7)	1 (1.0)	0 -	0 -	7 (0.5)
	Illegit.	0 -	0 -	0 -	1 (1.2)	1 (2.0)	0 -	0 -	0 -	0 -	0 -	2 (0.2)
	E.M.	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -
Totals	Legit.	141	177	209	241	196	177	147	96	47	17	1448
	Illegit.	349	192	160	85	49	26	26	24	4	3	918
	E.M.	35	25	13	2	2	1	0	1	1	0	80

Appendix Table K: Age by Type of Care

Type of Care	Age (a) All children in care on 31 December 1982 (b) All non-adoptees in care on 31 December 1982							Totals
	Less than 1 year	1 year	2-3 years	4-6 years	7-11 years	12-14 years	15+	
Short-term Foster Care	(a) 58 (42.3)	13 (10.9)	28 (11.1)	17 (4.2)	16 (2.3)	7 (1.5)	3 (0.8)	(a) 142 (5.8)
	(b) 41 (45.1)	13 (11.7)	27 (10.8)	17 (4.2)	16 (2.3)	7 (1.5)	3 (0.8)	(b) 124 (5.2)
Long-term Foster Care	(a) 28 (20.4)	66 (55.5)	147 (58.3)	233 (57.2)	307 (45.1)	176 (38.0)	173 (44.7)	(a) 1130 (46.2)
	(b) 23 (25.3)	64 (57.7)	146 (58.4)	233 (57.2)	307 (45.1)	176 (38.0)	173 (44.7)	(b) 1122 (46.9)
Short-term Residential Care	(a) 37 (27.0)	9 (7.6)	19 (7.5)	22 (5.4)	26 (3.8)	9 (1.9)	6 (1.6)	(a) 128 (5.2)
	(b) 22 (24.2)	8 (7.2)	19 (7.6)	22 (5.4)	26 (3.8)	9 (1.9)	6 (1.6)	(b) 112 (4.7)
Long-term Residential Care	(a) 4 (2.9)	19 (16.0)	48 (19.0)	109 (26.8)	311 (45.7)	260 (56.2)	193 (49.9)	(a) 944 (38.6)
	(b) 3 (3.3)	19 (17.1)	48 (19.2)	109 (26.8)	311 (45.7)	260 (56.2)	193 (49.9)	(b) 943 (39.5)
Private Foster Care	(a) 10 (7.3)	12 (10.1)	10 (4.0)	24 (5.9)	16 (2.3)	9 (1.9)	12 (3.1)	(a) 93 (3.8)
	(b) 2 (2.2)	7 (6.3)	10 (4.0)	24 (5.9)	16 (2.3)	9 (1.9)	12 (3.1)	(b) 80 (3.3)
Supervision at home	(a) 0 -	0 -	0 -	2 (0.5)	5 (0.7)	2 (0.4)	0 -	(a) 9 (0.4)
	(b) 0 -	0 -	0 -	2 (0.5)	5 (0.7)	2 (0.4)	0 -	(b) 9 (0.4)
Totals	(a) 137	119	252	407	681	463	387	(a) 2446
	(b) 91	111	250	407	681	463	387	(b) 2390

Appendix Table I.- Numbers and Probability of Being in Foster or Residential Care, 31 December 1982

Health Board	C.C. Area	No. of Children in Foster Care			No. of Children in Residential Care			Probability of Being in Foster Care by Total Population under 19 in CCA			Probability of Being in Resid. Care by Total Population under 19 in CCA		
		Long-term	Short-term	Total	Long-term	Short-term	Total	Long-term	Short-term	Total	Long-term	Short-term	Total
Eastern	1	37	6	43	27	7	34	.0008	.0001	.0009	.0006	.0001	.0007
	2	25	5	30	35	1	36	.0006	.0001	.0006	.0008	.0000	.0009
	3	23	0	23	31	4	35	.0007	.0000	.0007	.0010	.0001	.0011
	4	32	5	37	36	-	36	.0008	.0001	.0007	.0007	.0000	.0007
	5	34	2	36	64	10	74	.0008	.0000	.0006	.0016	.0002	.0018
	6	14	7	21	18	1	19	.0003	.0001	.0004	.0003	.0000	.0004
	7	26	3	29	78	13	91	.0008	.0001	.0008	.0018	.0005	.0019
	8	51	5	56	100	11	111	.0006	.0001	.0006	.0011	.0001	.0013
	9 Kildare	32	6	40	13	1	14	.0007	.0002	.0008	.0003	.0000	.0003
	10 Wicklow	17	1	18	25	1	26	.0004	.0000	.0005	.0008	.0000	.0007
Total for EHB		291	42	333	425	51	476	.0006	.0001	.0006	.0008	.0001	.0009
South Eastern	11 Carlow/Kilkenny	39	5	61	40	4	44	.0012	.0000	.0013	.0008	.0001	.0009
	12 Tipp. (S.R.)	43	2	51	42	2	44	.0014	.0001	.0015	.0013	.0001	.0013
	13 Waterford	19	1	20	29	0	29	.0005	.0000	.0005	.0007	.0000	.0007
	14 Wexford	34	3	37	19	3	22	.0008	.0001	.0008	.0007	.0001	.0007
Total for SEHB		160	9	169	140	9	149	.0010	.0001	.0010	.0008	.0001	.0009
Southern	15 Cork Nth Lee	45	3	48	39	2	41	.0007	.0000	.0008	.0006	.0000	.0007
	16 Cork Sth Lee	22	1	23	12	1	13	.0004	.0000	.0005	.0002	.0000	.0003
	17 North Cork	8	1	9	39	0	39	.0003	.0000	.0003	.0014	.0000	.0014
	18 West Cork	34	1	35	3	0	3	.0014	.0001	.0014	.0002	.0000	.0002
	19 Kerry	26	3	29	32	13	45	.0004	.0001	.0006	.0006	.0002	.0009
Total for SHB		135	9	134	125	16	141	.0008	.0000	.0008	.0006	.0001	.0006
Mid-Western	20 Limerick	66	5	93	49	0	49	.0012	.0001	.0013	.0007	.0000	.0007
	21 Tipp (NR)	62	5	67	51	6	57	.0025	.0002	.0027	.0020	.0002	.0023
	22 Clare	33	15	51	10	0	10	.0008	.0006	.0014	.0003	.0000	.0003
Total for MWHB		163	20	211	110	6	116	.0013	.0002	.0016	.0008	.0000	.0009
Western	23 Galway	52	2	54	19	6	25	.0007	.0000	.0007	.0002	.0001	.0003
	24 Mayo	26	14	40	8	3	11	.0006	.0002	.0008	.0002	.0001	.0002
	25 Roscommon	10	4	14	10	3	13	.0006	.0002	.0007	.0006	.0001	.0008
Total for WHB		88	20	108	37	12	49	.0008	.0001	.0008	.0003	.0001	.0003
North-Western	26 Donegal	35	1	36	7	6	13	.0007	.0000	.0007	.0001	.0001	.0002
	27 Sligo-Leitrim	26	5	31	26	4	30	.0008	.0002	.0010	.0008	.0001	.0009
Total for NWHB		61	6	67	33	10	43	.0007	.0001	.0008	.0004	.0001	.0005
North Eastern	28 Cavan/Mon.	36	0	36	20	1	21	.0005	.0000	.0006	.0005	.0000	.0005
	29 Louth	38	2	40	9	13	22	.0019	.0001	.0019	.0002	.0003	.0006
	30 Meath	36	3	39	11	0	11	.0006	.0001	.0009	.0003	.0000	.0003
Total for NEHB		110	5	115	40	14	54	.0009	.0000	.0008	.0003	.0001	.0004
Midland	31 Laois/Offaly	78	6	84	31	9	40	.0016	.0001	.0017	.0006	.0002	.0008
	32 Longford/W. Meath	34	17	51	3	1	4	.0008	.0004	.0012	.0001	.0000	.0001
Total for MHB		112	23	135	34	10	44	.0012	.0003	.0015	.0004	.0001	.0005
Overall Totals and Probabilities		1130	142	1272	944	128	1072	.0008	.0001	.0009	.0006	.0001	.0007

Appendix Table M: Age at Admission by basis for admission controlling for status
(a) All admissions in 1982
(b) All admissions less children placed for Adoption in 1982.

Age at Admission	Voluntary			Court Order			Totals
	Legitimate	Illegitimate	Extra-Marital	Legitimate	Illegitimate	Extra-Marital	
Under 1 year	(a) 97 (19.5) (16.8)	355 (71.3) (73.0)	20 (4.0) (55.5)	(a) 11 (2.2) (7.6)	13 (2.6) (38.2)	2 (0.4) (50.0)	498 (100.0) (a) (38.8)
	(b) 95 (35.1) (16.5)	136 (50.2) (51.7)	14 (5.1) (48.3)	(b) 11 (4.1) (7.6)	13 (4.8) (38.2)	2 (0.7) (50.0)	271 (100.0) (b) (25.8)
1 year	(a) 50 (55.6) (8.7)	26 (28.9) (5.3)	3 (3.3) (8.3)	(a) 8 (8.9) (5.5)	2 (2.2) (5.9)	1 (1.1) (25.0)	90 (100.0) (a) (7.0)
	(b) 50 (58.1) (8.7)	23 (26.7) (8.7)	2 (2.3) (6.9)	(b) 8 (9.3) (5.5)	2 (2.3) (5.9)	1 (1.7) (25.0)	86 (100.0) (b) (8.2)
2 - 3 years	(a) 91 (53.8) (15.8)	42 (24.9) (8.6)	8 (4.7) (22.2)	(a) 19 (11.2) (13.1)	8 (4.7) (23.6)	1 (0.6) (25.0)	169 (100.0) (a) (13.2)
	(b) 91 (54.2) (15.8)	41 (24.4) (15.6)	8 (4.8) (27.6)	(b) 19 (11.3) (13.1)	8 (4.8) (23.6)	1 (0.6) (25.0)	168 (100.0) (b) (16.0)
4 - 6 years	(a) 120 (59.7) (20.8)	33 (16.4) (6.8)	3 (1.5) (8.3)	(a) 39 (19.4) (26.9)	6 (3.0) (17.6)	0	201 (100.0) (a) (15.7)
	(b) 120 (59.7) (20.9)	33 (16.4) (12.5)	3 (1.5) (10.3)	(b) 39 (19.4) (26.9)	6 (3.0) (17.6)	0	201 (100.0) (b) (19.1)
7 - 11 years	(a) 115 (65.0) (19.9)	20 (11.3) (4.1)	1 (0.6) (2.8)	(a) 37 (20.9) (25.5)	4 (2.3) (11.8)	0	177 (100.0) (a) (13.8)
	(b) 115 (65.0) (20.0)	20 (11.3) (7.6)	1 (0.6) (3.4)	(b) 37 (20.9) (25.5)	4 (2.3) (11.8)	0	177 (100.0) (b) (16.9)
12 - 14 years	(a) 69 (65.1) (12.0)	8 (7.5) (1.6)	1 (0.9) (2.8)	(a) 27 (25.5) (18.6)	1 (0.9) (2.9)	0	106 (100.0) (a) (8.3)
	(b) 69 (65.1) (12.0)	8 (7.5) (3.0)	1 (0.9) (3.4)	(b) 27 (25.5) (18.6)	1 (0.9) (2.9)	0	106 (100.0) (b) (10.1)
15 years +	(a) 35 (85.4) (6.1)	2 (4.9) (0.4)	0	(a) 4 (9.7) (2.8)	0	0	41 (100.0) (a) (3.2)
	(b) 35 (85.4) (6.1)	2 (4.9) (0.8)	0	(b) 4 (9.7) (2.8)	0	0	41 (100.0) (b) (3.9)
Totals	(a) 577 (45.0) (100.0)	486 (37.9) (100.0)	36 (2.8) (100.0)	(a) 145 (11.3) (100.0)	34 (2.7) (100.0)	4 (0.3) (100.0)	1282 (100.0) (a) (100.0)
	(b) 575 (54.8) (100.0)	263 (25.0) (100.0)	29 (2.8) (100.0)	(b) 145 (13.8) (100.0)	34 (3.2) (100.0)	4 (0.4) (100.0)	1050 (100.0) (b) (100.0)

Appendix Table N: Children in Residential Care by Community Care Areas and Reason why the Child is in Residential Care

Reason why child is in Residential Care	Eastern Health Board										South-Eastern Health Board			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
No short-term foster home available	0 -	3 (6.8)	0 -	1 (2.1)	2 (2.6)	0 -	4 (3.8)	2 (1.6)	0 -	0 -	0 -	2 (3.8)	0 -	0 -
No suitable long term foster home available	12 (30.8)	7 (15.9)	13 (30.2)	21 (44.7)	21 (27.3)	3 (12.0)	21 (20.2)	3 (2.4)	0 -	7 (15.6)	0 -	1 (1.9)	0 -	0 -
Breakdown in foster placement	1 (2.6)	2 (4.5)	0 -	3 (6.4)	1 (1.3)	0 -	1 (1.0)	1 (0.8)	0 -	0 -	2 (4.3)	2 (3.8)	1 (3.0)	0 -
Child placed with siblings in same residential home	8 (20.5)	9 (20.5)	4 (9.3)	5 (10.6)	11 (14.3)	2 (8.0)	32 (30.8)	29 (23.6)	7 (50.0)	6 (13.3)	29 (61.7)	31 (59.6)	16 (48.5)	8 (25.0)
Awaiting Adoption	0 -	0 -	0 -	0 -	0 -	2 (8.0)	2 (1.9)	1 (0.8)	0 -	16 (35.6)	0 -	3 (5.8)	0 -	0 -
Parents refuse to allow child to be fostered	0 -	1 (2.3)	5 (11.6)	0 -	8 (10.4)	2 (8.0)	2 (1.9)	0 -	0 -	0 -	5 (10.6)	4 (7.7)	0 -	0 -
Residential care most suitable to child's needs	17 (43.6)	18 (40.9)	21 (48.8)	17 (36.2)	29 (37.6)	16 (64.0)	40 (38.5)	87 (70.7)	7 (50.0)	16 (35.6)	10 (21.3)	7 (13.5)	9 (27.3)	14 (43.8)
Other	1 (2.6)	4 (9.1)	0 -	0 -	5 (6.5)	0 -	2 (1.9)	0 -	0 -	0 -	1 (2.1)	2 (3.8)	7 (21.2)	10 (31.2)
	39	44	43	47	77	25	104	123	14	45	47	52	33	32

Southern Health Board					Mid-Western Health Board			Western Health Board			North Western H. B.		North Eastern Health Board			Midland H. B.		Total	Reason in Residential Care
15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32		
0 -	0 -	1 (2.5)	0 -	1 (2.0)	0 -	0 -	0 -	0 -	3 (27.3)	0 -	2 (8.3)	0 -	0 -	0 -	0 -	0 -	0 -	21	No short-term foster care available
3 (6.7)	0 -	1 (2.5)	0 -	0 -	12 (24.5)	1 (1.7)	0 -	1 (3.7)	0 -	0 -	18 (75.0)	3 (8.8)	1 (4.2)	9 (31.0)	2 (16.7)	2 (5.0)	0 -	162	No suitable long-term foster care available
5 (11.1)	0 -	3 (7.5)	1 (33.3)	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	1 (2.9)	0 -	2 (6.9)	0 -	0 -	3 (30.0)	29	Breakdown in foster placement
26 (57.8)	2 (15.4)	4 (10.0)	0 -	20 (40.8)	19 (38.8)	18 (31.6)	3 (30.0)	8 (29.6)	0 -	6 (28.5)	0 -	12 (35.3)	9 (37.5)	7 (24.1)	4 (33.3)	25 (62.5)	0 -	359	Child placed with siblings in same residential home
0 -	0 -	27 (67.5)	0 -	2 (4.1)	0 -	0 -	0 -	5 (18.5)	0 -	1 (7.7)	3 (12.5)	0 -	1 (4.2)	6 (20.7)	1 (8.3)	0 -	3 (20.0)	73	Awaiting Adoption
0 -	0 -	0 -	0 -	5 (16.3)	2 (4.1)	0 -	0 -	2 (7.4)	0 -	3 (23.1)	0 -	1 (2.9)	3 (12.5)	1 (3.4)	1 (8.3)	2 (5.0)	3 (20.0)	53	Parents refuse to allow child to be fostered
11 (24.4)	10 (76.9)	0 -	2 (66.6)	18 (36.7)	13 (26.5)	38 (66.7)	7 (70.0)	9 (33.3)	6 (54.5)	4 (30.8)	1 (4.2)	17 (50.0)	9 (37.5)	2 (6.9)	4 (33.3)	11 (27.5)	6 (40.0)	476	Residential care most suitable to the child's needs
0 -	1 (7.7)	4 (10.0)	0 -	0 -	3 (6.1)	0 -	0 -	2 (7.4)	2 (18.2)	0 -	0 -	0 -	1 (4.2)	2 (6.9)	0 -	0 -	0 -	47	Other
45	13	40	3	49	49	57	10	27	11	13	34	34	24	29	12	40	15	1220	

Appendix Table P: Age at Admission by Health Board: (a) in care at 31st December 1982 (2,446); (b) in care at any time during 1982 (3,675)

Age at Admission	Health Boards																Total	
	Eastern		Midland		Mid-Western		North-Eastern		North-Western		South-Eastern		Southern		Western			
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
0-6 months	190 (21.0)	331 (24.0)	29 (16.2)	57 (22.0)	57 (17.4)	120 (26.1)	48 (28.2)	73 (33.0)	33 (30.0)	78 (40.8)	58 (18.2)	107 (22.5)	64 (22.9)	83 (19.8)	46 (28.8)	107 (39.2)	525 (21.5)	956 (26.0)
7-23 months	133 (14.7)	200 (14.5)	29 (16.2)	36 (13.9)	53 (16.2)	73 (15.9)	33 (19.4)	39 (17.6)	16 (14.5)	22 (11.5)	59 (18.6)	78 (16.4)	49 (17.6)	72 (17.2)	22 (13.8)	35 (12.8)	394 (16.1)	555 (15.1)
2-3 years	129 (14.3)	194 (14.1)	36 (20.1)	47 (18.1)	39 (11.9)	52 (11.3)	29 (17.1)	35 (15.8)	18 (16.4)	27 (14.1)	61 (19.2)	78 (16.4)	49 (17.6)	73 (17.4)	21 (13.1)	29 (10.6)	382 (15.6)	535 (14.6)
4-5 years	119 (13.2)	165 (12.0)	17 (9.5)	26 (10.0)	49 (15.0)	53 (11.5)	16 (9.4)	20 (9.0)	16 (14.5)	19 (9.9)	45 (14.2)	61 (12.8)	44 (15.8)	68 (16.2)	22 (13.8)	28 (10.2)	328 (13.4)	440 (11.9)
6-7 years	101 (11.2)	134 (9.7)	14 (7.8)	22 (8.5)	37 (11.3)	45 (9.8)	13 (7.6)	14 (6.3)	6 (5.5)	10 (5.2)	36 (11.3)	49 (10.3)	24 (8.6)	38 (9.1)	16 (10.0)	19 (7.0)	247 (10.1)	331 (9.0)
8-9 years	76 (8.4)	114 (8.3)	16 (8.9)	20 (7.7)	32 (9.8)	40 (8.7)	12 (7.1)	15 (6.8)	6 (5.5)	12 (6.3)	27 (8.5)	46 (9.7)	22 (7.9)	31 (7.4)	13 (8.1)	17 (6.2)	204 (8.3)	295 (8.1)
10-11 years	76 (8.4)	106 (7.7)	15 (8.4)	18 (6.9)	28 (8.6)	34 (7.4)	9 (5.3)	11 (5.0)	7 (6.4)	11 (5.8)	19 (6.0)	28 (5.9)	12 (4.3)	18 (4.3)	7 (4.4)	11 (4.0)	173 (7.1)	237 (6.4)
12-13 years	44 (4.9)	68 (4.9)	16 (8.9)	20 (7.7)	20 (6.1)	23 (5.0)	5 (2.9)	6 (2.7)	4 (3.6)	6 (3.1)	10 (3.1)	16 (3.4)	12 (4.3)	28 (6.7)	10 (6.3)	19 (7.0)	121 (4.9)	186 (5.1)
14-15 years	26 (2.9)	46 (3.3)	6 (3.6)	10 (3.9)	7 (2.1)	13 (2.8)	5 (2.9)	7 (3.2)	2 (1.8)	4 (2.1)	3 (0.9)	8 (1.7)	1 (0.4)	5 (1.2)	2 (1.2)	6 (2.2)	52 (2.1)	99 (2.7)
16 +	9 (1.0)	19 (1.4)	1 (0.3)	3 (1.2)	5 (1.5)	7 (1.5)	-	1 (0.5)	2 (1.8)	2 (1.1)	-	4 (0.8)	2 (0.7)	3 (0.7)	1 (0.6)	2 (0.7)	20 (0.8)	41 (1.1)
Total	903 (100.0)	1377 (100.0)	179 (100.0)	259 (100.0)	327 (100.0)	460 (100.0)	170 (100.0)	221 (100.0)	110 (100.0)	191 (100.0)	318 (100.0)	475 (100.0)	279 (100.0)	419 (100.0)	160 (100.0)	273 (100.0)	2446 (100.0)	3675 (100.0)

Note: * figures in parentheses are percentages.

Appendix Table Q: Type of care by age, controlling for birth status, (a) all children in care on 31 December 1982
(b) all non-adoptees in care on 31 December 1982

Type of Care		Age																					
		Less than 1 year			1 year			2-3 years			4-6 years			7-11 years			12-14 years			15+			Totals		
		Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.	Legit.	Illegit. (%)	E.M.
Short-term Foster Care	(a)	13 (39.4)	42 (44.7)	3 (30.0)	8 (12.8)	8 (11.1)	0	14 (14.4)	13 (9.6)	1 (5.3)	9 (4.3)	8 (4.5)	0	13 (2.8)	2 (1.0)	1 (5.6)	7 (2.0)	0	0	3 (1.2)	0	0	64 (4.4)	73 (8.0)	5 (4.3)
	(b)	13 (40.6)	27 (42.9)	1 (12.5)	8 (12.8)	8 (12.3)	0	14 (14.4)	12 (9.0)	1 (5.3)	9 (4.3)	8 (4.5)	0	13 (2.8)	2 (1.0)	1 (5.6)	7 (2.0)	0	0	3 (1.2)	0	0	64 (4.4)	57 (6.6)	3 (2.9)
Long-term Foster Care	(a)	8 (34.2)	14 (14.9)	6 (60.0)	20 (51.3)	41 (54.9)	5 (62.5)	39 (40.2)	93 (68.4)	15 (78.9)	88 (47.1)	116 (65.5)	19 (86.4)	158 (33.8)	133 (67.9)	18 (88.9)	95 (27.3)	80 (70.2)	1 (100.0)	85 (33.2)	86 (66.7)	2 (100.0)	503 (34.7)	563 (61.3)	64 (88.0)
	(b)	8 (25.0)	9 (17.6)	6 (75.0)	20 (51.3)	39 (60.0)	5 (71.4)	39 (40.2)	92 (68.7)	15 (78.9)	88 (47.1)	116 (65.5)	19 (86.4)	158 (33.8)	133 (67.9)	18 (88.9)	95 (27.3)	79 (70.2)	1 (100.0)	85 (33.2)	86 (66.7)	2 (100.0)	503 (34.8)	555 (64.1)	64 (83.0)
Short-term Residential Care	(a)	9 (27.3)	27 (34.7)	1 (10.0)	4 (10.3)	3 (4.2)	2 (25.0)	10 (10.3)	7 (5.1)	2 (10.6)	14 (6.7)	7 (4.0)	1 (4.5)	22 (4.7)	4 (2.0)	0 -	8 (2.3)	1 (0.9)	0	6 (2.3)	0	0	73 (5.0)	49 (5.3)	4 (7.5)
	(b)	8 (25.0)	13 (28.5)	1 (12.5)	4 (10.3)	3 (4.6)	1 (14.3)	10 (10.3)	7 (5.2)	2 (10.6)	14 (6.7)	7 (4.0)	1 (4.5)	22 (4.7)	4 (2.0)	0 -	8 (2.3)	1 (0.9)	0	6 (2.3)	0	0	72 (5.0)	35 (4.0)	4 (6.5)
Long-term Residential Care	(a)	3 (9.1)	1 (1.1)	0	10 (25.6)	8 (11.1)	1 (12.5)	32 (33.0)	15 (11.0)	1 (5.3)	82 (38.4)	26 (14.7)	1 (4.5)	268 (57.4)	42 (21.4)	1 (5.6)	227 (66.7)	28 (24.6)	0	160 (62.5)	33 (25.6)	0	787 (54.4)	153 (18.7)	4 (6.0)
	(b)	3 (9.4)	0 -	0 -	10 (25.6)	8 (12.3)	1 (14.3)	32 (33.0)	15 (11.2)	1 (5.3)	82 (38.4)	25 (14.7)	1 (4.5)	268 (57.4)	42 (21.4)	1 (5.6)	222 (64.7)	28 (24.6)	0	160 (62.5)	33 (25.6)	0	787 (54.4)	152 (17.6)	4 (6.2)
Private Foster Care	(a)	0	10 (18.6)	0	0	12 (16.7)	0	2 (2.1)	8 (5.9)	0	4 (1.9)	19 (10.7)	1 (4.5)	9 (8.4)	14 (7.1)	0	4 (1.1)	5 (4.4)	0	2 (0.8)	10 (7.8)	0	14 (1.0)	78 (8.8)	1 (1.3)
	(b)	0	2 (3.9)	0	0	7 (10.8)	0	2 (2.1)	8 (6.0)	0	4 (1.9)	18 (10.7)	1 (4.5)	2 (8.4)	14 (7.1)	0 -	4 (1.1)	5 (4.4)	0	2 (0.8)	10 (7.8)	0	14 (1.0)	65 (7.5)	1 (1.3)
Supervision at home	(a)	0	0	0	0	0	0	0	0	0	1 (0.5)	1 (0.6)	0	4 (0.9)	1 (0.5)	0	2 (0.6)	0	0	0	0	0	7 (0.5)	2 (0.2)	0
	(b)	0	0	0	0	0	0	0	0	0	1 (0.5)	1 (0.6)	0	4 (0.9)	1 (0.5)	0	2 (0.6)	0	0	0	0	0	7 (0.5)	2 (0.2)	0
Totals	(a)	33	94	10	38	72	8	97	136	19	208	177	22	467	196	18	348	114	1	256	129	2	1448	918	80
	(b)	32	51	8	39	65	7	97	134	19	208	177	22	467	196	18	348	114	1	256	129	2	1447	866	77

Appendix Table B: Reason for Admission by Age at Admission

Children admitted in 1982*

Age at Admission	Reason											Totals
	Physical abuse (1)	Sex abuse (2)	Emotional abuse (3)	Neglect (4)	One parent unable to cope (5)	Marital disharmony (6)	Child out of control (7)	Child abandoned (8)	Child orphaned (9)	Short-term crisis (10)	Awaiting adoption (11)	
0–6 months	5 (12.2)	0 -	11 (11.4)	9 (10.2)	112 (40.7)	9 (10.1)	0 -	9 (26.5)	0 -	59 (18.0)	218 (94.0)	432 (33.7)
7–23 months	10 (24.4)	0 -	9 (9.4)	7 (8.0)	38 (13.8)	20 (22.5)	1 (1.2)	6 (17.6)	0 -	52 (15.9)	13 (5.6)	156 (12.2)
2–3 years	9 (21.9)	0 -	22 (22.9)	12 (13.6)	39 (14.2)	14 (15.7)	1 (1.2)	5 (14.7)	0 -	66 (20.1)	1 (0.4)	169 (13.2)
4–5 years	3 (7.3)	1 (9.1)	17 (17.7)	11 (12.5)	26 (9.5)	15 (16.9)	1 (1.2)	3 (8.8)	0 -	50 (15.3)	0 -	127 (9.9)
6–7 years	3 (7.3)	0 -	12 (12.5)	10 (11.4)	9 (3.3)	10 (11.2)	1 (1.2)	5 (14.7)	0 -	24 (7.3)	0 -	74 (5.8)
8–9 years	4 (9.8)	2 (18.2)	12 (12.5)	13 (14.8)	23 (8.4)	7 (7.9)	2 (2.4)	3 (8.8)	0 -	36 (11.0)	0 -	102 (7.9)
10–11 years	3 (7.3)	0 -	11 (11.4)	10 (11.4)	11 (4.0)	4 (4.5)	18 (20.9)	1 (2.9)	1 (50.0)	16 (4.9)	0 -	75 (5.8)
12–13 years	2 (4.9)	2 (18.2)	2 (2.1)	8 (9.1)	10 (3.6)	5 (5.6)	31 (36.0)	0 -	0 -	12 (3.7)	0 -	72 (5.6)
14–15 years	1 (2.4)	6 (54.5)	0 -	7 (8.0)	5 (1.8)	4 (4.5)	20 (23.2)	2 (5.8)	0 -	7 (2.1)	0 -	52 (4.1)
16 +	1 (2.4)	0 -	0 -	1 (1.1)	2 (0.7)	1 (1.1)	11 (12.8)	0 -	1 (50.0)	6 (1.8)	0 -	23 (1.8)
Total	41 (100.0)	11 (100.0)	96 (100.0)	88 (100.0)	275 (100.0)	89 (100.0)	86 (100.0)	34 (100.0)	2 (100.0)	328 (100.0)	232 (100.0)	1282 (100.0)

* Figures in parentheses are percentages.

Appendix Table S: Reason for Admission by Responsible Health Board and Probability of Coming into Care by Reason in Each Health Board

Children admitted during 1982*

Reason	Health Board								Mean Probability	Totals
	Eastern	Midland	Mid-Western	North-Eastern	North-Western	South-Eastern	Southern	Western		
Physical abuse	20 (0.04)	2 (0.02)	3 (0.02)	3 (0.05)	0 -	8 (0.07)	5 (0.03)	0 -	(0.03)	41
Sexual abuse	4 (0.01)	1 (0.01)	0 -	0 -	2 (0.03)	3 (0.02)	1 (0.01)	0 -	(0.01)	11
Emotional abuse	30 (0.06)	9 (0.09)	16 (0.08)	2 (0.03)	2 (0.03)	18 (0.15)	8 (0.05)	11 (0.10)	(0.07)	96
Neglect	41 (0.09)	19 (0.20)	13 (0.07)	11 (0.18)	1 (0.02)	0 -	3 (0.02)	0 -	(0.07)	88
One parent family	92 (0.19)	26 (0.27)	67 (0.35)	14 (0.23)	9 (0.13)	18 (0.15)	31 (0.20)	18 (0.16)	(0.21)	275
Marital disharmony	28 (0.06)	4 (0.04)	14 (0.07)	5 (0.08)	0 -	12 (0.10)	16 (0.10)	10 (0.09)	(0.07)	89
Child out of control	37 (0.08)	1 (0.01)	24 (0.13)	3 (0.05)	1 (0.02)	4 (0.03)	12 (0.08)	4 (0.03)	(0.05)	86
Child abandoned	10 (0.02)	4 (0.04)	4 (0.02)	2 (0.03)	1 (0.02)	5 (0.04)	4 (0.03)	4 (0.03)	(0.03)	34
Child orphaned	1 (0.0)	1 (0.01)	0 -	0 -	0 -	0 -	0 -	0 -	(0.0)	2
Short-term crisis	124 (0.26)	23 (0.24)	41 (0.21)	14 (0.23)	21 (0.30)	28 (0.23)	64 (0.42)	13 (0.11)	(0.25)	328
Awaiting adoption	90 (0.19)	6 (0.06)	9 (0.05)	7 (0.11)	31 (0.45)	25 (0.21)	9 (0.06)	55 (0.48)	(0.20)	232
Total	477	96	191	61	68	121	153	115		1282

* Figures in parentheses are probabilities.

Appendix Table T: Reason for Admission by Birth Status of Child

Children admitted in 1982*

Reason for admission	Birth Status						Totals	
	Legitimate		Illegitimate		Extra-marital			
Physical abuse	30	(4.2)	9	(1.7)	2	(5.0)	41	(3.2)
Sexual abuse	10	(1.4)	1	(0.2)	0	-	11	(0.9)
Emotional abuse	75	(10.4)	20	(3.8)	1	(2.5)	96	(7.5)
Neglect	71	(9.8)	15	(2.9)	2	(5.0)	88	(6.9)
One parent family unable to cope	96	(13.3)	163	(31.3)	16	(40.0)	275	(21.4)
Marital disharmony	80	(11.1)	8	(1.5)	1	(2.5)	89	(6.9)
Child out of control	77	(10.7)	9	(1.7)	0	-	86	(6.7)
Child abandoned	13	(1.8)	16	(3.1)	5	(12.5)	34	(2.6)
Child orphaned	2	(0.3)	0	-	0	-	2	(0.2)
Short-term crisis	266	(36.8)	56	(10.8)	6	(15.0)	328	(25.6)
Awaiting adoption	2	(0.3)	223	(42.9)	7	(17.5)	232	(18.1)
Total	722	(100.0)	520	(100.0)	40	(100.0)	1282	(100.0)

* Figures in parentheses are percentages.

Appendix Table U: Basis for Admission by Reason for Admission

Basis for Admission	Reason											Totals
	Physical Abuse (%)	Sex Abuse (%)	Emotional Abuse (%)	Neglect	One-parent family unable to cope	Marital Disharmony	Child out of Control	Child Abandoned	Child Orphaned	Short-term Crisis	Child for Adoption	
Voluntary	18 (44.0)	2 (18.2)	57 (59.4)	36 (40.9)	254 (92.4)	77 (86.5)	78 (90.7)	22 (64.7)	2 (100.0)	321 (97.9)	232 (100.0)	1099
Court Order	23 (56.0)	9 (81.8)	39 (40.6)	52 (59.1)	21 (7.6)	12 (13.5)	8 (9.3)	12 (35.3)	-	7 (2.1)	-	183
Totals	41	11	96	88	275	89	86	34	2	328	232	1282

Appendix Table V : Reasons for Admission to Care of all Admitted in 1982 by whether Discharged or not in 1982.

	Reason for Admission										Totals
	Physical Abuse	Sex Abuse	Emotional Abuse	Neglect	One-parent family unable to cope	Marital Disharmony	Child out of Control	Child Abandoned	Short-term Crisis	Awaiting Adoption	
Admitted and Discharged in 1982	15 (36.6)	4 (36.4)	23 (24.0)	22 (25.0)	134 (48.7)	60 (67.4)	26 (30.2)	12 (35.3)	287 (87.5)	176 (75.8)	760 (59.3)
Admitted in 1982 Still in Care on 31st Dec. 1982	26 (63.4)	7 (63.6)	73 (76.0)	66 (75.0)	141 (51.3)	29 (32.6)	60 (69.8)	22 (64.7)	41 (12.5)	56 (24.1)	522 (40.7)
Totals	41	11	96	88	275	89	86	34	328	232	1282

Appendix Table W: Probability of Being in Care by levels of Unemployment, Illegitimacy and Medical Card coverage

Area	Probability	Unemployment	Illegitimacy	Medical Cards
		per cent	per cent	per cent
Dublin	.0019	9.1	10.0	25.1
Wicklow	.0018	10.9	4.8	35.5
Kildare	.0012	8.6	3.5	37.3
Eastern Health Board	.0017	9.8	7.8	26.9
Carlow/Kilkenny	.0023	9.8	4.6	50.1
Tipperary S.R.	.0031	11.5	4.5	45.0
Waterford	.0014	11.4	6.3	35.8
Wexford	.0017	13.0	4.6	50.7
South-Eastern Health Board	.0019	11.4	5.2	45.7
Cork	.0013	9.3	5.0	32.9
Kerry	.0016	13.0	3.4	44.9
Southern Health Board	.0013	9.3	5.0	35.7
Limerick	.0022	10.6	4.0	31.3
Tipperary N.R.	.0053	9.1	5.1	35.2
Clare	.0018	8.4	3.6	31.9
Mid-Western Health Board	.0025	10.0	4.4	32.2
Galway	.0012	10.5	3.8	48.7
Mayo	.0012	12.1	1.8	62.0
Roscommon	.0014	6.6	2.4	57.4
Western Health Board	.0012	10.4	2.9	54.6
Donegal	.0010	22.1	3.2	61.1
Sligo/Leitrim	.0020	9.8	3.8	52.1
North Western Health Board	.0013	16.9	3.5	56.9
Cavan/Monaghan	.0014	8.9	2.6	42.3
Louth	.0017	13.0	4.7	45.6
Meath	.0012	9.2	3.5	38.3
North-Eastern Health Board	.0013	10.3	3.6	42.0
Longford/Westmeath	.0015	9.3	4.9	45.7
Laois/Offaly	.0027	9.4	3.3	44.2
Midland Health Board	.0020	9.3	4.1	44.3
IRELAND	.0018	10.5	5.4	36.9

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