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CORRECTION

In our last edition (Vol. 1, No. 1) we omitted to include a contact address with the article by Andrew Fagan "Young People and Violence in Residential Care: A Case Study": Andrew is attached to the Social Work Department, Eastern Health Board Area 9, Basin Street, Naas, Co. Kildare.

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In such an environment, the vast majority of people will not have any form of contact with the 5 in every 1000 children in care in this country. They and their parents, form a silent and invisible group of people, who get few opportunities to voice their opinions. The general public's knowledge of life in care is based, almost exclusively on what they pick up from the media. They will refer to the Madonna House scandal and, of course, to Christine Buckley's story, which was so graphically told in the RTE documentary *Dear Daughter.* The publication of the Mercy report is an effort to achieve a number of objectives, one of which is to close that information gap.

Lives in Care tells us that the 100 children in care in the Mercy centres are well cared for physically but there are great variations, between centres, in almost everything else. The most valuable informants in this study were, of course, the children themselves. The report rightly points out that "children in residential care do not see themselves as in need of a service, or as living in a system. They experience their lives as a series of day-to-day relationships, opportunities and responsibilities. They each bring their personalities, personal histories and expectations....they must each be treated as an individual (and) understand that they have a voice, and their carers will endeavour to listen to them and understand them" (p. 25).

It is blindingly obvious that child care services and facilities should be shaped by what the children tell us but the richness of what they have to say, in this new report, is quite striking. Not only do they express predictable desires e.g. to be reunited with their families but their suggestions, about how the centres could be run better, are extremely practical. For instance, the provision of longer cables on phones, so that they can have privacy when making/receiving calls (by being able to take the phone into a private room) is a simple but very good example of the kind of improvements that mean a lot to children.

While this report was commissioned to look at the children in the care of the Mercy Order, it could equally have focused on any other group of children in care. For example, it has been known for quite some time – from anecdotal evidence – that the fostering regulations are being broken on a daily basis. The practice of most health boards would not stand up to close scrutiny, due to the huge strain being placed on the social work services. Many children in health board care do not even have a designated social worker. Is it any wonder that children 'drift' in care? Some of these youngsters go on to be considered 'out of control' and in need of 'secure' care because the basic services that they required weren't provided when they needed them.

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ACCOMMODATING DIFFERENCE – THE CAMPHILL APPROACH TO MEETING SPECIAL NEEDS

by Gráinne Lawlor

Abstract

The philosophies underlying the approaches which services take to the provision of care for adults with learning disabilities make certain assumptions about matters such as the nature of disability, how a person's life is affected by disability, about the nature of society and about what is the most appropriate way of delivering services to improve the quality of life of people with learning disabilities at any particular point in time. They influence how services are developed and delivered and are often reflected in social policies. The common aim is to maximise quality of life. However, inaccurate or outdated assumptions limit the potential for any approach to achieve its objectives.

The study presented here is adapted from an earlier study (Lawlor, 1997) which, using a combination of documentary research and a case study exploring the life experience of an adult man with a learning disability living in a group home within a Camphill community in the South of England, set out to challenge conventional philosophies of care. Studying the Camphill approach proved to be an interesting and useful way of doing this as Camphill philosophies and beliefs challenge many of the philosophies, policies and practices which tend to be taken for granted in the field of learning disability.

Keywords: Camphill; Learning disability; Care in the community.

Introduction

The study set out with two hypotheses. The first was that there are issues which traditional philosophies underlying different approaches to care in the field of adult learning disability do not adequately address and which limit the potential for these conventional approaches to meet their objectives. The second was that, as Baron and Haldane put it, "...there has been an overhasty rejection of all forms of 'not Community Care'" (1992, p.3) and that the Camphill movement, although seemingly developed on principles significantly divergent from those underlying community care, offers care which meets the emotional, social and physical needs of adults with learning disabilities in an unique and valuable way.

Literature relating to conventional approaches and to the Camphill approach to service development and delivery in the field of learning disability was reviewed. The subject of the case study was a man called Ken who lives in a group home within a Camphill Community in the South of England. A variety of criteria (both subjective and objective) was used to explore Ken's experience of life as an adult in Camphill. Semi-structured interviews were conducted with Ken and two long term co-workers who live with him. Lists of objective criteria by which to observe the environment and Ken's daily activities were devised and used and conversations which took place at a Social Services review of Ken's placement were recorded.

Note: To protect the privacy of the subject of this case study no identifing information has been presented. It should also be noted that this case study does not claim to be representative of life in every Camphill Community. It simply offers a glimpse at life in one particular community for one particular man.

The nature of disability

People's beliefs about the nature of disability and impairment influence how they respond to those who have disabilities. Some, for example, think of disability as resulting from a mistake of nature or from some misfortunate chance happening and accordingly respond with pity and attempts to compensate the individual with a disability for his/her suffering. Some view disability as a deviation from some desired norm and accordingly make efforts to assist the disabled person to become as 'normal' as possible. Others approach the concept from a different angle and look, from the point of view of disabled people, at how "disabling barriers" impose disability on them (Swain et al, 1993). From this perspective the causes of disability are seen to be rooted in the social and physical environment rather than in the individual. Disabled people are seen as victims of an uncaring society rather than as individual victims of circumstance (Oliver, 1990, p.2; Harbison and Smyth, 1994), the idea being that the degree to which a difference becomes a disability or a handicap depends, to a greater extent, on the nature of the society in which one finds oneself.

The nature of society

Drawing on anthropological material Oliver (1990) suggests that definitions of disability and its perception as a problem are related to economic and social structures and to the central values of particular societies. He gives examples of anthropological studies which showed that some cultures had adjusted to disabilities to the extent that they ceased to be disabling (1990 pp. 14-17). Groce (1985), for example, describes how, in the early days of this century in Martha's Vineyard, widespread use of sign language reduced the disabling effects of deafness. Certain types of societies can accommodate impairments and differences better than others. Within our society certain norms are created and a particular value system prevails. Some hold the view that the norms and value system of modern industrialised society strongly favour the able-bodied (Dunne, 1986; Lukes, 1973; Sands, 1992; Branson and Miller, 1989; Stone, 1995; Dossa, 1992, p.1). Dossa suggests that the emphasis on independence, rather than interdependence, serves the market economy and furthers the isolation and segregation of people with developmental disabilities (1992, p.4). Barns and Oliver argue that direct, indirect and passive discrimination against disabled people are institutionalised in the very fabric of British society and find evidence of this in abortion laws, the educational system, the labour market, health and welfare services and in the built environment (1995, p.114).

The important point for the purposes of this study is that if we accept that disability does not result entirely from impairments in the individual and that society contributes to its creation, it becomes important to explore the nature of the society in which we live and to think carefully about what in fact it has to offer to its learning disabled members.

Philosophies underlying conventional approaches to service development and delivery in the field of adult learning disability.

The philosophies which have been most influential in shaping current approaches to service development and delivery in the field of learning disability have been those which underly the medical model, the philosophy of normalisation and the philosophy of care in the community.

The medical model:

The definition of disability as a personal tragedy is a feature of the medical model. Based in biological sciences, this model centres on a conception of a normal human condition against which those who exhibit differences are measured and categorised. Some differences can be remedied and with treatment/rehabilitation differences can be minimised and those included can reach degrees of normality. Certainly advances in medical science have increased life expectancy and eradicated many disabling conditions through preventative and corrective measures. The medical model has however been criticised for its over emphasis on diagnosis and proccedures and its under emphasis on the individual experiences of those living with disability (Oliver, 1990, p.28). From initial diagnosis to death the medical profession tend to be centrally involved in the lives of those with disabilities. Toolan (1994, p.148) points out that in Ireland most services pertaining to disabled people are administered at some stage by the Department of Health. For some this may be appropriate but for the majority, it is argued, medicine has far exceeded its legitimate role (Finkelstein, 1993; Toolan, 1994, pp.194-195; Oliver, 1990, p.48; Ryan and Thomas, 1987, pp14-15).

Normalisation:

For over twenty years now the philosophy of normalisation has influenced approaches to the provision of services to those with learning disabilities. Wolfensberger (1972) presented normalization as both a goal and a process saying that it was about the "Utilisation of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible." (1972, p.28). He argued that "Since deviancy is by definition in the eyes of the beholder it is only realistic to attend not only to the limitations in a persons repertoire of potential behaviour, but to attend as much or even more to those characteristics and behaviours which mark a person deviant in the sight of others."(1972, p.28). In this way the hope was that the person with special needs might overcome his devalued status in society and be more easily integrated, the assumption being that this would lead to a more fulfilling life. The influence of the philosophy of normalisation has been enormous. It is to be valued for the positive contribution it has made to the development of more dignified and humanising conditions for those with special needs, but the unbalanced and piecemeal way its principles have been applied in practice has left it open to criticism. Dunne argues that its potential is limited because it does not put enough emphasis on the value system of society as the barrier to integration rather than simply on how the handicapped person is presented or spoken about (Dunne, 1986, p.194-195) and Sands suggests that, under the influence of the philosophy of normalisation, services have responded with energy and creativity to skill development but suggests that less attention has been paid to the development of the whole human being (1992, p.42). Ryan and Thomas point out that if the right to normality is not to become a whole series of pressures on mentally handicapped people to change and conform to other peoples standards, it must include the right to question, and possibly reject, these standards of normality and to choose an alternative more enriching way of living (1987, pp. 133-134).

Care in the Community:

Since the 1960s, in both Ireland (Report of the Commission of Inquiry on Mental Handicap, 1965) (Report of the Review Group on Mental Handicap Services, 1991, p.1) and the United Kingdom (Baron and Haldane, 1992, p.3), there has been a bias towards care in the community, but many authors, although welcoming deinstitutionalisation, consider that there has not been a corresponding development of adequate services to support it (Ayer and Alaszewski, 1984) (Beardshaw, 1988) (Baron and Haldane, 1992, p.3) (Redmond, 1996).

The move to care in the community was consistent with the widely accepted philosophy of normalisation and, along with the economic advantages for the state, it was assumed that Care in the Community would facilitate integration. Living in the community it was assumed that those with learning disabilities would be in a better position to participate in community life and to lead more normal and fulfilling lives. The idea was that proximity to community affairs would create the opportunity for people with learning difficulties to form friendships with non-handicapped people (Lloyd, 1993, p.2). The degree to which this has been achieved however is questionable. According to Rose, "...examples of true integration into mainstream leisure activities remain scarce" (1993, p.93) and Quinn puts it bluntly when he writes, "Quite simply, the situation of individuals with disabilities is one of exclusion in varying degrees from all sectors" (1993, p.1).

Life in the community: Integration or Exclusion?

Studies conducted over the last number of years indicate that policies of deinstitutionalisation and the emphasis on normalisation as both a goal and a process have done much to improve the living conditions of those with intellectual disabilities but that the degree to which they have led to real integration into the community is limited.

In the United Kingdom Margaret Flynn (1989) interviewed eighty eight people who had moved from hospitals to houses in the community. She found that although professionals considered that many of them were leading successful lives in the community their average income was very low and a quarter of them reported experiencing problems due to victimisation by neighbours. Few seemed to have friends in the community (1989). Jahoda and Markova's 1990 study in the United Kingdom of people with severe to moderate learning difficulties found that only three per cent of all interactions for those living in hostels and one per cent of all interactions for those living in hospital settings were with outsiders. They found also that, although more meaningful in the hostel setting, interpersonal interactions between staff and residents in both settings tended to be of a functional rather than a personal nature (1990). In Ireland, Lundstrom-Roche's interviews with fifty four trainees attending sheltered workshops revealed that, although living in the community, few had friends or out of home activities to

Doctor he practised medicine with a special interest in retardation and residential care and in 1938, on Germany's annexation of Austria, himself and a group of friends who shared his outlook on life, fled to Scotland as refugees. On the 1st June 1940 they moved into Camphill House near Aberdeen and when they took twelve children with varying degrees of disability to live with them, the life and work of Camphill began. Reflecting on those early days Konig later wrote,

> "... we dimly felt that the handicapped children, at that time, were in a position similar to ours. They were refugees from a society which did not want to accept them as part of their community. We were political, these children were social, refugees...they provided us with the conviction that we fulfilled a necessary task and were not superfluous and useless members of this country. The most important fact was, however, that these children demanded of us a special way of life. It was not only up to us to educate and train them; it was also they who, through the simple fact of their special existence, asked of us a set of qualities which we had to develop."
>
> (Konig, 1993, p.15).

Thus, from the outset, a number of themes were apparent. From the outset handicapped children had a respected and valued place in Camphill. They had an important role and contribution to make. The atmosphere was one of mutual help. The theme of refuge from society is fundamental. It is similar to the need for refuge perceived by Jean Vanier when he uses the name "L'Arche" meaning "the Ark" (1982, p.9).

Rudolf Steiner

Steiner's teachings have remained central to Camphill's approach and those within the movement continue to look to his teachings for guidance. Born in Hungary in 1861 to Austrian parents he wrote and gave lectures on a diverse range of subjects such as philosophy, theology, karma and reincarnation, science, mysticism, agriculture, art, horticulture and education. Steiner applied scientific methods to the study of the spiritual and developed a science he called Anthroposophy. He believed that as man became more materialistic and exercised his increasing power over the natural world he was distancing himself further and further from his instinctive self . Steiner sought redirection to bring alive again what he considered to be the lost values (Van der Post, 1990, p.8).

The Camphill Movement

There are now Camphill communities, schools and villages scattered throughout the world. Most centres were started in response to calls from parents to provide something for their disabled children. Dr Konig's lectures on Camphill's principles and on his belief that all children could be educated regardless of the severity of their disabilities gave hope to those overwhelmed by the burden of handicap and surrounded by pessimism about the limited choices and opportunities for their disabled children.

By the late 1940s those who had come to Camphill as children early in the decade were reaching adulthood and appropriate settings for meeting their special needs as adults had to be found. Konig envisaged that village communities could grow around four or five small houses where adults could do some limited work in the various kitchens, workshops, farms and gardens and live a safe, secure, sheltered life in small family houses rather than in dormitories (Bock, 1990, p.p. 50-53). This was at a time when the approach to caring for both adults and children with disabilities was still largely institutional but in 1954 Konig's vision came to life with the establishment of the first Camphill village, Botton village, on the Yorkshire moors. Throughout the 1950s, 1960s and 1970s the movement grew and similar communities were established and organised into seven regions around the world.

The 1980s are marked by diversification into work with the elderly and by the growth of communities in urban settings but the 1980s also brought an increase in Government regulations regarding care of those with disabilities. Matters such as staff qualifications and registration of centres had to be addressed. This caused and continues to cause difficulties and dilemmas for Camphill as their philosophies and practices are not always compatible with policy developments.

Camphill and the nature of disability:

For Camphill, disability is merely a facet of the individual's existence. It requires recognition in practical terms but an individual is never defined in terms of his disability. For Steiner, "Intellectual concepts are only one of the means we have to understand the things of the world, and it is only to the materialistic thinker that they appear as the sole means." (Steiner, 1981, p.36). Steiner and his Anthroposophical followers were asserting the educatability of every child, suggesting that to achieve this it is necessary to go beyond the experiences of the senses and to get in touch with mans innate self. The medium for achieving this, he believed, is human relationship. The goal of education or training for Anthroposophists and for Camphill is not to make the individual more socially acceptable so that he or she can compete more effectively for a place in society, rather, it is to enable the innate potential and individuality of each person to shine. In contrast to the medical model, disability is not seen as a mistake of nature. It is not acquired by chance or misfortune. It has a definite meaning for the individual and is meant to change his life. The goal is to facilitate the emergence of each persons individuality, the challenge being to not only to maximise the developmental potential of the individual with a disability but also to stimulate the spiritual development of all those who live with him and of society in general. Stephen Baron (1992) discusses this "purposive construction" of the individual with three year old sister who works as a comis chef and lives away from home. As a child Ken was diagnosed as being moderately mentally handicapped. He was slow to develop physically, verbally and in independence. His parents were aware from Ken's first few years that he would require special education and they went to visit various special schools to find a place for him. They came across a Camphill Sheiling school and were impressed by the peaceful rural setting and the holistic approach to child development. Despite the fact that Ken would have to leave home to go to school there they decided that this was the right place for him. They had difficulty getting the Social Services to support their decision financially as the school was not within their catchment area but, due to the shortage of other options, the Social Services eventually agreed and Ken's life in Camphill began. Ken showed a very poor aptitude for numeracy and literacy and throughout his school years he received extra tuition in these areas. At seventeen, after formal schooling, he went on to do a young adult training course where he tried his hand at various types of work such as gardening, agricultural work, cooking, woodwork, crafts and so on and continued with numeracy and literacy tuition. At twenty one he was ready to leave having mastered a range of skills to help him in the adult world. Teachers and trainers recommended that Ken go on to live in a Camphill community and suggested a community in the south of England which could provide the right balance between support and independence for him. The Social Services, on the other hand, believed that Ken should be integrated into life in the wider community and suggested that he should move home to live with his parents and attend a sheltered workshop near them.

The Cottage

However, following much negotiation between Ken's parents and the Social Services Ken moved into the Cottage, a group residence within a community in the South of England. At the time of the study the Cottage was home to five men with learning disabilities, two long-term co-workers Fintan and Maria and their two young children, and one short term female co-worker committed to one year with the community. Fintan and Maria are firmly committed to an Anthroposophic way of life and do not view themselves as care workers but rather as individuals who have chosen to live with people who have learning disabilities. The community has a dairy farm, sheep, pigs and poultry, a vegetable garden, a weavery and a wood work workshop. Each residence has its own self-catering accommodation. The community receives a certain amount of state funding and sells some produce from the farm and workshops. Nobody receives a wage for working in the community although co-workers and residents receive small allowances. People work according to their abilities where they are needed.

A Social Services review of Ken's placement took place in the Cottage during the period of the study. It was attended by Ken, Maria, Ken's parents, Ken's social worker from the Social Services and the researcher. A number of differences in

approach between the Social Services and Camphill in relation to Ken were illustrated by the opinions expressed by his social worker and Maria. While it is not possible in an article such as this to present the findings of the case study in full, the issues highlighted below illustrate some of the differences in approach between the Social Services and Camphill.

One of the main differences observed was the Social Services emphasis on skill acquisition. Most of the discussion during the review centred around a skills check list which Ken's social worker filled out. The researcher observed that although Ken's social worker was obviously intent on maximising Ken's potential and phrased questions in a sensitive, encouraging manner, the result was that most of the conversation during the review concentrated on areas where Ken lacked skills and focused on his deficits.

Ken's Work

Ken works as a cook in one of the other residences in the community in the mornings. Within his family being a cook is a respected occupation and Ken is aware of this,

> "I am a cook...I like cooking. I can cook nice things. Do you have a sister? My sister is a cook too you know. She cooks in a hotel. I was there. It's lovely. You should go there ... My uncle is a chef in a restaurant. That's like a cook you know. And my sister."
>
> Ken

He is also aware that it is an important job within the community and has some sense that he makes a worthwhile contribution and that he is needed,

> "They get hungry if they don't get lunch. You have to eat you know. Wait till it's ready I say."
>
> Ken

There is evidence that he is needed to the extent that he is missed when he is not at work,

> "When Ken got his toe nail done Pam missed him in the kitchen... If he was ill for longer someone else would have been needed to help out."
>
> Maria

> "I went to the chiropodist and got my toe nail off last week...The next day Pam said "thank goodness you're back Ken."
>
> Ken

Fintan is of the opinion that Ken is good at his job, that he likes it, and that it is important to his identity,

> "Ken should be ready over the next year to move out into the wider community. I feel we should start looking for suitable placements for him. Maybe the workshop near home. Maybe you could live at home and earn your own money Ken. Or you could move to one of our group houses near home."
>
> Social worker

Maria anticipated that in about two or three years time Ken might be ready for more independent living and suggested that he could then consider moving to a Camphill village such as Botton Village in Yorkshire where he could work and lead more independent life in a supported setting.

> "Ken is an adult. Why is it right for him to go home to live with his parents?... Ken is used to Camphill ways. He is used to the rhythm of our life."
>
> Maria

Ken's parents expressed reservations about a move to the wider community,

> "I wouldn't condemn him to a life with us. There's only the two of us at home...What can we give him that's better than here?..He doesn't really know anybody in our village. I would be afraid that he would be lonely. I can't see him fitting in with his own age group very well. I don't know who he would be friends with. In Camphill he has plenty of friends. His own sort. I think he is happy where he is."
>
> Ken's mother

> "I don't think he is cut out for life in the city. I don't think money is all that important to him. As far as I can see he is doing OK here. He has the things he wants."
>
> Ken's father

It was agreed that Ken and his parents would visit various group homes and sheltered workshops before the next review in six months time. However, following the review both Fintan and Maria expressed reservations about the possibility of Ken fitting into life outside Camphill.

> "People are not used to his ways. Ken talks to people because he has got a warm heart and he is friendly but people do not see this and they think he is being strange somehow. He is so easily hurt. I would worry about him... I fear that Ken would be left out. I don't think the world is a kind place for people who rock back and forth and say strange things. Somehow the real Ken would be lost."
>
> Maria

> "He has a problem with touching people. Sometimes he comes up too close to people and holds them and touches them. It makes people uncomfortable. You have to be firm with him. But he forgets. It puts people off... He has friends here and people who care about him. We are happy to go the extra distance to meet him. We see beyond his handicaps. We see who he is. He doesn't stand out as being odd. We don't expect him to be like everybody else. We are all different ..."
>
> Fintan

> "We are busy. We work hard... But we are busy in a different way. The pace of life is slower somehow... People are the most important thing. There is room for everybody fast or slow... Within the community here it is safe for Ken to wander around and do things for himself. Outside it is more dangerous. He would have less freedom somehow."
>
> Maria

The data collected in this study suggests that within Camphill Ken's learning disability does not prevent him from participating fully in community life. He has a job which he likes, which he is good at and which is a recognised occupation within his family. It is a real job and has not been created just to keep him busy. It is productive and varied. He is depended upon to the extent that he is missed if he is not there. He has friends of his own and makes choices about the activities he engages in. He is not the passive recipient of care. There was no evidence to suggest that his dependence was experienced by his co-workers as a burden. During his review there was evidence to suggest that the Social Services agenda focused on his deficits. Throughout the study his co-workers focused on his capabilities and positive qualities. Skill acquisition was emphasised only to the extent that it opens opportunities for his personal fulfilment. Maria and Fintan have reservations about a move to care in the wider community for Ken. They believe that his differences are not easily understood by others who do not know him. They are concerned that he might be hurt or left out because he does not conform to socially accepted ways of behaving. Although Maria is protective she clearly respects Ken as an adult. She does not see it as normal for a person Ken's age to live with his parents, indeed the fact that Ken's younger sister lives away from home could indicate that it is not considered normal within his family either. Fintan and Maria suspect that in the wider community Ken would in fact be more dependant and isolated and that his talents and capabilities would not be appreciated.

For the social services Camphill is a form of residential care which segregates and which does not fit easily with philosophies of integration, normalisation and the preference for care in the community. Ken's social worker appears to favour a move to the wider community for him. If this is the ultimate goal then Camphill is probably not the right placement for Ken. Camphill has chosen to remove itself from the demands of materialism and is, thus, not well equipped to prepare him for life outside its communities.

Baron, S. (1992) 'Innovation and Regulation in the Care of those with Special Needs: The Disaggregation of Care' in Baron, S. and Haldane J.D. (ed) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 115-130.

Baron, S. and Haldane D. (1992), 'Community, Therapy and the Individual with Special Needs: A Framework', in Baron, S. and Haldane J.D. (ed) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 3-11.

Beardshaw, V. (1988) *Last on the List: Community Services for People with Physical Disabilities.* London: The Kings Fund Institute.

Bock, F. (1990) 'The history and development of Camphill' in Pietzner, C. (ed), *A Candle on the Hill: Images of Camphill Life.* Edinburgh: Floris Books, pp. 36-55.

Branson, J. and Millar, D. (1989) 'Beyond Integration Policy - The Deconstruction of Disability' in Barton, L. (ed) *Integration: Myth or Reality.* East Sussex: The Falmer Press, pp. 144-167.

Brigden. P. (1993) 'Personal Relationships' in Brigden, P. and Todd, M. (eds) *Concepts in Community Care for People with a Learning Difficulty.* Hampshire: The MacMillan Press Ltd., pp. 78-82.

Briggs, A. and Oliver, J. (1985) *Caring - Experiences of looking after disabled relatives.* London: Routledge & Keegan Paul.

Christie, N. (1992) 'Six Ways of Dealing With Stigma: In Defence of the Ghetto' in Baron, S. and Haldane J.D. (ed) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 151-161.

Committee on Registration on Behalf of the Association of Camphill Communities, (1987) *Camphill Communities, An Introduction: Therapeutic communities living and working with children, young people and adults in need of special care and understanding.* North Yorkshire: Camphill Press.

Cullen, C. (1992) 'Disability, Society and Community Care: A Commentary', in Baron, S. and Haldane J.D. (ed) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 133-139.

Dossa, P. A. (1992) 'Ethnography as narrative discourse: community integration of people with developmental disabilities', *International Journal of Rehabilitation Research,* Vol. 15, pp. 1-14.

Dunne, J.(1986) 'A Radical Philosophy for mental Handicap Services' in Mc Ginley, P.(ed) *Research and Practice in the Service of People with Learning Difficulties.* Galway: Woodlands Centre, pp 189-205.

Ferguson, R.V. (1988) 'Environmental Design for Disabled Persons' in Brown, R.I. (ed) *Quality of Life for Handicapped People.* Kent: Croom Helm Ltd.

Finkelstein, V. (1993) 'The commonality of disability' in Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds) *Disabling Barriers-Enabling Environments.* London: SAGE Publications.

Flynn, M. (1989) *Independent Living for Adults with Mental Handicap*: "A Place of My Own". London: Cassall Educational.

Fraser, W. I., (1992) 'The Professions, Knowledge and Practice', in Baron, S. and Haldane J.D. (ed) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 25-38.

Groce, N.E. (1985) *Everyone Here Spoke Sign Language: Hereditary Deafness on Martha's Vineyard.* Cambridge: Harvard University Press.

Hales, G. (ed) (1996) *Beyond Disability: Towards and Enabling Society.* London: SAGE Publications Ltd.

Haldane, D. and Baron, S. (1992) 'Negotiating Polarities' in Baron, S. and Haldane J.D. (ed) Community, Normality and Difference: Meeting Special Needs. Aberdeen: Aberdeen University Press, pp. 165-173.

Hansmann, H. (1992) *Education for Special Needs: Principles and Practice in Camphill Schools.* Edinburgh: Floris Books.

Harbison, J. and Smith, M. (1994) 'Disability, Employment Status and Quality of Life in N. Ireland' in *Disability, Exclusion and Poverty: A Policy Conference.* Papers from the National Conference organised by the Combat Poverty Agency, the forum of People with Disabilities and the National Rehabilitation Board, Dublin, pp. 25-44.

Herbert, M. (1990) *Planning a Research Project: A Guide for Practitioners and Trainees in the Helping Professions.* London: Cassell Educational Limited.

Jahoda, A. and Markova, I. (1990) *Quality of Care for People with Moderate to Severe Mental Handicap in a Long-Stay Hospital and in the Community.* Final Report to the Scottish Home and Health Department, Department of Psychology, University of Stirling.

Kernan, K. and Sabsay, S. (1989) 'Communication in Social Interactions: Aspects of an Ethnography of Communication of Mildly Mentally Handicapped Adults', in Beveridge, M., Conti-Ramsden, G. and Leudar, I. (eds) *Language and Communication in Mentally Handicapped People.* London: Chapman and Hall, pp. 229-253.

Konig K. (1986) *In need of Special Understanding: Camphill Conferences on Living with Handicapped Adults.* North Yorkshire: Camphill Press.

Konig, K. (1990) 'Camphill Essentials', in Pietzner, C. *A Candle on the Hill: Images of Camphill Life.* Edinburgh: Floris Books, pp. 27-35.

Konig, K. (1993) *The Camphill Movement.* North Yorkshire: TWT Publications Ltd.

Lawlor, G. (1997) *Appreciating Human Diversity: Current Approaches and Camphill.* Unpublished.

Leane, M. and Powell F.W. (1991) *Community Living: A Quality of Life Study of Adults with Mental Handicap Returned to Community Living in Waterford.* Eire: Social Policy Research Unit, Department of Social Administration and Social Work, University College Cork, Cork.

Leudar, I., (1989) 'Communicative Environments for Mentally Handicapped People' in Beveridge, M. Conti-Ramsden, G. and Leudar, I. (eds) *Language and Communication in Mentally Handicapped People.* London: Chapman and Hall, pp. 274-300.

Lindenberg, C.A. (1990) 'Karl Konig - a portrait' in Pietzner, C. (ed), *A Candle on the Hill: Images of Camphill Life.* Edinburgh: Floris Books, pp. 19-26.

Lissau, R. (1987) *Rudolf Steiner: Life, work, inner path and social initiatives.* Stroud: Hawthorn Press.

Lloyd, J. (1993) 'Introduction' in Brigden, P. and Todd, M. (eds) *Concepts in Community Care for People with a Learning Difficulty.* Hampshire: The MacMillan Press Ltd., pp. 1-4.

Lukes, S. (1973) *Individualism.* Oxford: Basil Blackwell.

Lundstrom - Roche, F. (1981) *Our Lives.* Dublin: Irish Committee for the International Year of Disabled People.

Markova, I. and Jahoda, A. (1992) ' The Language of Special Needs' in Baron, S. and Haldane J.D. (eds) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 12-24.

Mc Conkey, R. (1987) *Who Cares? Community Involvement with Mental Handicap.* London: Souvenir Press.

Mc Conkey, R. and Conliffe, C. (eds) (1989) *The Person with Mental Handicap: Preparation for an adult life in the community.* Belfast: Institute of Counselling and Personal Development.

Mc Dermot, R.A. (ed) (1984) *The Essential Steiner: Basic Writings of Rudolf Steiner.* San Francisco: Harper and Row.

Mulvihill, A. (1986) 'The Importance of Communication' in Mc Ginley, P.(ed) *Research and Practice in the Service of People with Learning Difficulties.* Galway: Woodlands Centre, pp 89-95.

Mulvihill, A. (1986) 'Non-speech Communication Modes' in Mc Ginley, P.(ed) *Research and Practice in the Service of People with Learning Difficulties.* Galway: Woodlands Centre, pp. 98-105.

Nirje,B. (1969) 'The Normalisation Principle and its Human Management Implications' in Kugel, R. and Wolfensberger, W. (eds) *Changing Patterns in Residential Services for the Mentally Retarded.* Washington D.C.: President's Committee on Mental Retardation, pp. 179-195.

O'Connor, J., Smyth, E. and Whelan, B. (1988) *Caring for the Elderly - Part I: A Study of Carers at Home and in the Community.* Dublin, The Stationery Office: National Council for the Aged Report Number 18.

Oliver, M. (1992) 'Changing the Social Relations of Research Production' in Disability, Handicap and Society. *Special Issue: Researching Disability,* Volume 7, Number 2, Oxford: Carfax Publishing Company, pp. 101-114.

Oliver, M. (1990) *The Politics of Disablement.* London: The MacMillan Press Ltd.

Oliver, M. and Barnes, C. (1992) 'Discrimination, Disability and Welfare: From Needs to Rights' in Bynoe, I., Oliver, M. and Barnes, C. *Equal Rights for Disabled People: The case for a new law.* London: Institute for Public Policy Research, Social Policy Paper No. 7, pp. 7-16.

Parmenter, T.R. (1994) 'Quality of Life as a Concept and Measurable Entity'. *Social indicators Research,* Vol. 33, pp. 9-46.

Pietzner, C. (1990) 'Introduction', in Pietzner, C. (ed), *A Candle on the Hill: Images of Camphill Life.* Edinburgh: Floris Books, pp. 15-18.

Quinn, G. (1993) 'Introduction' in Quinn, G., McDonagh, M. and Kimber, C. *Disability, Discrimination and the Law in the United States, Australia and Canada.* Dublin: Oak Tree Press, pp. 1-7.

Redmond, B. (1996) *Listening to Parents - The aspirations, expectations and anxieties of parents about their teenager with a learning disability.* University College Dublin: Family Studies Centre.

Report of The Commission of Inquiry on Mental Handicap (1965). Dublin: The Stationery Office.

Review Group on Mental Handicap Services, (1990) *Needs and Abilities: A Policy for the Intellectually Disabled.* Dublin: The Stationery Office.

Rose, S. (1993) 'Integrated leisure opportunities' in Brigden, P. and Todd, M. (eds) *Concepts in Community Care for People with a Learning Difficulty.* Hampshire: The MacMillan Press Ltd., pp. 93-103.

Ryan, J. and Thomas, F. (1987) *The Politics of Mental Handicap.* London: Free Association Books.

Sands, S. (1992) 'The Task of the Handicapped: Handicap as a Force for Social Change', in Baron, S. and Haldane J.D. (eds) *Community, Normality and Difference: Meeting Special Needs.* Aberdeen: Aberdeen University Press, pp. 39-52.

Sigelman, C., Budd, E.C., Winer, J.L., Schoenrock, C.J. and Martin, P.W. (1982) 'Evaluating alternative techniques of questioning mentally retarded persons.'. *American Journal of Mental Deficiency,* Vol. 86, No. 5, pp. 511-518.

Steiner, R. (1981) *The Education of the Child in the Light of Anthroposophy.* London: Rudolf Steiner Press.

Stone, S. D. (1995) 'The Myth of Bodily Perfection'. *Disability and Society,* Vol. 10, No. 4, pp. 413 - 424.

Super, C. and Harkness, S. (1986) 'The Developmental Niche: a Conceptualisation at the Interface of Child and Culture. *International Journal of Behavioural Development,* a, pp.1-25.

Swain, J., Finkelstein, V., French, S. and Oliver, M. (1993) *Disabling Barriers-Enabling Environments.* London: SAGE Publications.

Toolan, D. (1994) 'Naming Poverty and Exclusion' in *Disability, Exclusion and Poverty: A Policy Conference.* Papers from the National Conference organised by the Combat Poverty Agency, the forum of People with Disabilities and the National Rehabilitation Board, Dublin, pp. 143-152.

Van Der Post, L. (1990) 'Forward' in Pietzner, C. (ed), *A Candle on the Hill: Images of Camphill Life.* Edinburgh: Floris Books, pp. 7-13.

Vanier, J. (1982) *The Challenge of L'Arche.* London: Darton, Longman and Todd.

Vanier, J. (1989) *Community and Growth.* London: Darton, Longman and Todd.

Wolfensberger W. (1972) *The Principle of Normalization in Human Services.* Toronto: National Institute on Mental Retardation.

Wolfensberger, W. (1983) 'Social Role Valorisation; a Proposed New Term for the Principle of Normalisation'. *Mental Retardation,* 21, (6), pp. 234-239.

Wolfensberger, W. (1994) 'The Growing Threat to the Lives of Handicapped People in the Context of Modernistic Values'. *Disability and Society,* Vol. 9, No. 3, pp. 395-413.

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CONFLICTING PARADIGMS: GENERAL PRACTITIONERS AND THE CHILD PROTECTION SYSTEM

by Helen Buckley

Introduction

The Child Care Act 1991, fully implemented by the Irish Government in 1996, compels the health boards to 'promote the welfare of children not receiving adequate care and protection'. In practical terms, this legislation is operationalised by the health boards according to a set of procedures, known as Child Abuse Guidelines, the most recent edition of which was published in 1987 (Department of Health, 1987). Although the guidelines are, at this stage, out of date with both the legislation and the changing administrative structure of the Health boards, and the Department of Health has recently appointed working party to revise them, they still, at this point, represent the only uniform and comprehensive framework for practice available on a national level to child protection professionals. One of their important and fundamental principles is the issue of co-operation between different professions and disciplines in the child protection network, affirmed as 'an essential and integral element of the professional task of attempting to protect children from abuse'(Department of Health, 1987, p.9). The obligations of all professionals whose work brings them into contact with children are clearly spelt out in the injunction that 'any person who knows or suspects that a child is being harmed, or is at risk of harm, has a duty to convey his concern to the local health board'. The role and responsibility of general practitioners in child protection, the subject of this paper, is outlined in the child abuse guidelines, not only in terms of their special position in the identification of child abuse, but also with reference to their ongoing involvement in the co-ordination of its investigation and management. According to the guidelines, general practitioners need to 'recognise the vital role they can play in helping families in the community through such a crisis' (Department of Health, 1987, p.16).

In reality, though, how much of the importance ascribed to the position of the general practitioner in the protection of children is rhetoric, and how much of it is

grounded in reality? This paper explores the assumptions underpinning the allegedly central role ascribed to general practitioners in realising the aspirations inherent in the Child Care Act 1991, and proposes that the effectiveness of their current contribution to the process has been greatly exaggerated. It firstly examines the validity of the key role ascribed to general practitioners as primary 'identifiers' of child abuse, and secondly, it questions the presumption inherent in the official guidance that they are committed members of what can loosely be called the child protection 'network'. The discussion will be informed by evidence gleaned from international research, which will be supported by data obtained in an Irish study carried by this author. In so doing, it will illustrate the range of complex elements which presently combine to impede general practitioners from playing an active, coordinative role in the task of protecting children from abuse.

Keywords: Child protection, child abuse, general practitioners.

Methodological approach

The Irish material on which this paper is based came from a wider case study on child protection practice in the Eastern Health board area carried out between October 1993 and September 1994. Data was gathered through an examination of the total number (72) of child abuse referrals which were made to one Community Care area over a six month period. Cases which survived the initial investigative filters were then followed up over a further six months. A range of professionals associated with these particular cases were interviewed, including five general practitioners. The research took a qualitative approach, the methodological tools comprising of observation and analysis of team meetings, case conferences, and open-ended, in-depth interviews, all of which secured what Denzin and Lincoln (1994) describe as 'rich descriptions', in order to give meaning to the social experience of the actors involved. While most research related to medical matters is quantitative or 'positivist' in nature, one of the major vulnerabilities of such a scientific paradigm would be what Guba and Lincoln (1989) describe as its 'context stripping' tendencies which exclude significant variables, and allow no place for meanings, critiques and sense making, all of which provide important insights into social and professional behaviour and are crucial to a study such as this. In accordance with the strategy adopted, the aim of this research was not to enumerate frequencies, but to expand and generalise theories, following the tradition of qualitative case studies (Yin 1994).

Medical 'ownership' of child abuse work

In order to provide a context for the following discussion, it is worth considering the changing role of medicine as a profession in child abuse work. Although the antecedents of the modern child protection system are traceable to the late nineteenth century (Gordon 1989; Ferguson 1990, 1996), the 1960's brought what has been colloquially referred to as the 'rediscovery' of child abuse. The advance of X-ray technology, and the discovery in the United States in the mid 1940s by Dr. John Caffey of unexplained fractures in children presenting to casualty departments with other injuries, led to the conceptualisation by Dr. Henry Kempe, a paediatrician in Denver, Colorado, of 'the battered child syndrome' in the early 1960s (Kempe *et al.* 1962). The rapid adoption of this 'disease' by radiologists and paediatricians has been linked by Parton (1985) with the desire of these professions to raise their own statuses, which were somewhat in decline at that point in time. Radiology, according to Parton, was regarded as an unexciting, 'safe' occupation. Equally, the formerly vital life-saving position of paediatrics had been upstaged by the development of antibiotic treatments. Ownership of a new syndrome legitimated the importance of these two branches of medicine.

Child abuse in the 1960s, had therefore, come to 'belong' to doctors. Another important consequence, according to Parton (1985), of the colonisation of this field by medicine was that the most accepted explanation for child maltreatment became the 'disease' model, which attributed culpability to individual pathological causes within individuals and families, taking very little cognisance of the social context in which the abuses took place. A patent illustration of this notion is to be found in a 1982 medical textbook, authored by an Irish paediatrician, which located the genesis of child abuse in 'deficient mother-child bonding' which could be 'set right' with 'support and explanation'(O'Doherty, 1982, p.2). Within this framework for practice, the responsibility for and management of the treatment was firmly allocated to either the hospital consultant or 'community physician' (p.46).

In Ireland, the early dominance of child abuse work by the medical profession was reflected in a number of ways. Following the 1970 Health Act, the personal social services, including public health nursing and social work, were designated to the Community Care teams of the country's eight health board under the management of a medical doctor, known as the Director of Community Care. When the increasing recognition of child abuse as a problem began to penetrate Irish social and professional consciousness, the Department of Health's response, through the medium of a medically dominated committee, was to design the first set of procedures for use by professionals in the investigation and management of child abuse. Not surprisingly, these procedures were endowed with a strong medical orientation which continued to underpin later national child abuse guidelines. (Department of Health, 1977, 1980, 1983). In keeping with the prevalent 'disease model', child maltreatment during those years was conceived of solely in terms of deliberate physical harm, known as 'non-accidental injury to children'. Policy for addressing the problem was consequently based on the assumption that doctors, being best placed to identify and diagnose child abuse should play a central role in its 'treatment'.

The general practitioners interviewed by me were inclined to believe that the reason for their low identification of child abuse was more simply explained by the rarity of its occurrence than by any other reason. They confirmed that the cases which they saw in the course of their work were normally brought to their attention by an outside source. As one of them put it 'I wonder what the incidence really is ... I mean, we have our eyes open like everybody else ...but you don't see much evidence'. Another doctor who had been practising in the area for thirteen years and had a large practice including three hundred GMS patients, acknowledged that his current contact with the health board, initiated by the Director of Community Care, was his first exposure to child abuse. He had never realised or even suspected that the children in the particular case, whom he had been treating for virtually all of their lives, had been subjected to gross sexual abuse by their father. As he pointed out: 'You read it in newspapers' but he clearly did not expect to find it in his surgery. Yet the rising awareness and concurrent growth in the rate of child abuse referrals to the Health boards, which has been increasing steadily since the early 80's[1] would seem to belie such 'rarity'. Rather, it would seem fair to speculate that the importance attributed to the general practitioners' strategic position in terms of discovering child abuse may be misplaced.

General practitioners' low rate of identification of child abuse may be explicable on a number of levels. Firstly, as Dingwall, Eekelaar and Murray (1983), point out, certain elements of the doctor/patient relationship can act against the possibility of their forming a negative interpretation of parental 'versions' or accounts of injuries or maltreatments sustained by their children. Doctors, according to Dingwall *et al*, tend to view the situations presented to them through a 'bureaucratic frame' which incorporates the assumption that parents are honest, competent and caring, and that disorders or injuries to their children are natural events. The framing process, according to Dingwall *et al.*, (p.40), is based on three contingencies: firstly the need of general practitioners to keep work at a manageable level by avoiding problematic assessments which may draw them into complicated interdisciplinary fora, secondly, a type of prioritising which diverted their attention from 'mundane' matters towards cases which would be of universal clinical interest to themselves and their peers, and thirdly, their reluctance to identify with the role of 'regulatory agent', preferring to be perceived as benign professionals who assume the respectability of patients until proven otherwise. Another factor which can potentially influence the doctor/patient relationship is proposed by Dingwall *et al*, citing the work of Strong and Horobin (1978) who suggest that doctor/patient relationships may be best understood in terms of the classical market, whereby the attitude of doctors to patients is marked by moral neutrality and surface courtesy. Even though doctors are not always remunerated personally by their clients, they have inculcated this 'accommodative aspiration' into their practice.

General practitioners and the statutory child protection system

Though it appears that general practitioners do not *identify* child abuse as often as the official discourse assumes, it seems, as evidenced in this study, that they are still regarded by members of the lay community as the appropriate persons with whom concerns about child abuse can be usefully discussed. In four of the referred cases in this study, which all concerned sexual abuse, doctors were the first professionals from whom the families concerned sought advice. It would appear therefore that they can, and do, form an important link in the referral chain, by virtue of their position as recipients of vital information. The ultimate disposal of that information by general practitioners, however, can be subject to several contingencies. Though the child abuse guidelines have, for the past twenty years, compelled professionals to inform the health board of any suspicions of child abuse, either their own, or those brought to their attention by others, the referral rate by general practitioners is surprisingly low, given the frequency of their contact with families and children.

Obstacles to the exchange of information between themselves and the statutory authority which this study demonstrated include, as previously outlined, lack of information as to the correct procedures to be followed in reporting suspected child abuse. However, there was also consistent evidence of their indifference to the child protection system. As one of them remarked in his interview with me 'the Health board isn't my first thought when most things arise, you know'. On the contrary, this study illustrated a tendency for general practitioners to act independently, and attempt to deal with the matter in hand without invoking what one of them described as the 'rigours' of the system. This preference for autonomy in practice has already been highlighted in the literature, and has been explained in terms of medical practitioners' reluctance to become embroiled in welfare bureaucracies. As Turner (1987, p.138) argues, the more that doctors are forced to operate within a bureaucratic organisational system, the more 'proletarianized' they become. Dingwall *et al.* (1983, p.105) have observed that where doctors are concerned, 'the promise of personalised discretion is enshrined in the preferred form of work organisation, a collegial model based on loose federations of autonomous practitioners'. During the development of medical services in Ireland in the early part of the twentieth century, one of the greatest scourges of the profession had been the threat of state interference, particularly in ante-natal and paediatric care (Barrington, 1987) and no doubt the legacy of that time continues to haunt doctors.

General practitioners' preference for professional autonomy in matters of child protection is also, it appears from this study, affirmed by a certain level of mistrust in the statutory system. This lack of faith was sufficient for one of them to assert during an interview that he would 'dread the thoughts of going to the Health board' with a sensitive child abuse matter. One doctor in particular had a very poor opinion of the calibre of health board staff, including their medical officers

> I make no secret of it, that I have little or no confidence in the health board or its institutions … I mean, at every level you run into assholes … there's no sense of continuity, you know what I mean … the next thing you know, they're involved in the Measles Eradication Programme, they're involved in everything else. If they were doing one friggin' thing you'd say to yourself, fine … but …

Strong interventive responses by the health board were fearfully anticipated by another general practitioner, who referred to 'that carry on … they went through in Cleveland or the Orkneys'. A different doctor offered the following allegory, suggesting that one consequence of shared information could be that 'the place would be littered with bodies … like, the operation was a success but the patient died …'. In yet another case featuring in the study, the general practitioner, whose perceptions of precipitate action on behalf the health board were less dramatic, reacted more in terms of scepticism about the ability of health board staff to make decisions about families whom he, as their general practitioner, had known for several years. As he put it

> all of a sudden an agency discovers it and it becomes 'what can we do' and 'how quickly can we do it', whereas really you [the general practitioner] know, and you've been aware that the problem has been there for a long time …

This doctor feared that his own input into cases could be easily undermined by what he described as 'others coming along with their wisdom to impose a solution' in a situation about which he considered himself to be much wiser.

Apart from ignorance of and indifference to, the requirement for general practitioners to share information about child abuse cases with the health board, there was evidence in this study of another force at work to impede co-operation; one which has also been identified by Dingwall (1986, p.503)

> The constraints on information flow between and within health, social work and education services derive from a genuine respect for the privacy of family related information. The reluctance to use authority derives from a deep attachment to a non authoritarian ideal of social order (p.503).

This curb on the sharing of information was illustrated by one of the general practitioners in the study who reported that he had 'handled' a previous child sexual abuse case 'on his own' because the family 'did not want to take it further, they did not want to involve the Eastern Health board, community workers, police, etc. etc.' His current contact with the health board over a new case had not been initiated by himself, and though he had been approached by the parents at an earlier stage with information that their daughter had been sexually abused, he had not considered reporting it. He was not prepared to commit a 'breach of confidentiality' and his respect for the family's privacy was such that 'if they say "I don't want it to go any further", that's it … if it was mandatory, that would put me in a different position'. This general practitioner did temper his assertion by stating that if the matter wasn't being appropriately 'handled', in other words if he believed there was a risk of further abuse, he would reconsider his decision not to report. However, he made it clear that it would be himself, not the health board who would be the arbiter of that.

An aspect of the bureaucratisation of statutory child protection work with which general practitioners in this study showed some unease was the increasing involvement of the Garda Siochana in the investigation of cases, now compulsory under procedures introduced in 1995 (Department of Health, 1995). Problems related to conflicting ideological and professional perspectives between police and social workers have already been documented (Buckley 1993, 1997), and the general practitioners in this study did not differ greatly from social workers in this regard. One general practitioner described the necessity to report suspected allegations to the Gardai as 'dynamite … it's like a loose cannon'. This type of attitude has also been reflected in the response made by general practitioners to the Department of Health's discussion paper on mandatory reporting, which very firmly rejected the introduction of a legal requirement to report suspected child abuse to the authorities (Irish College of General Practitioners, 1998). The notion of child protection as 'dirty work', an appelation originally derived from Hughes (1958) has been applied by Blyth and Milner (1990) and Butler (1996) to explain the reluctance of some professionals to become involved in this area. As Butler (1996, p.312) observes, child protection Ireland has the potential to become even 'dirtier', linked as it is to the ambivalence which exists about state intrusion into the family, and the greater possibility of 'opprobrium' ataching to practitioners whose duties involve 'policing' elements.

The potential for partnership in child protection work

One of the principal platforms for sharing information and formulating plans in child abuse cases is the multi-disciplinary case conference. Following the recommendations of the child abuse guidelines, and according to local policy in the area where the study was conducted, general practitioners were asked to all case conferences as a matter of routine. They were the least frequent attendees, coming to only 20% of the meetings to which they were invited during the study period. At the same time, they were the professionals whose absence was most often commented on by other participants, who clearly regarded their contribution as potentially important. Again, the practices of this small Irish sample mirror those found in British research which was carried out on a much larger scale (Hallett and Stevenson, 1980; Simpson *et al.*, 1994, Hallett 1995). The UK studies all identified the timing of case conferences as a major problem, though as Hallett points out, even when general practitioners were offered a choice about the time of meetings, they still failed to attend. Timing also represented a significant problem for the general practitioners in this study, both in terms of the exact time of the meeting, and also in terms of 'finding the time' in a busy schedule. However, time was not the only identified reason for their reluctance to attend, and again their responses indicated a critical attitude towards the way the Health board conducted its child protection business. One general practitioner considered that the case conference was, as he described it, 'the greatest dilly of all time', believing that Directors of Community Care must be 'off their bleeding trolleys' to expect him to leave a surgery full of patients to attend. In his experience, case conferences provided 'opinion ... but you never get any plan ... its "cover your ass time"'. Another of the general practitioners interviewed was critical of the way the professionals at the meeting he had attended spent their time 'hammering out all their own personal agendas ... wasting my time'. A third respondent had been irrated by the lack of 'pragmatism' at case conferences and a tendency for other participants to tell him 'things I knew already ... presenting it as if it had been the first time it had been discovered'.

An additional disincentive to general practitioners' attendance at case conferences, and one which could be seen to threaten the balance of the doctors relationship with his patient, was the growing aspiration on the part of the statutory system to include parents at the meetings. This had been recommended in the Report of the Kilkenny Incest Investigation, and while it was not actually in operation at the time of the study, consciousness about its desirability has been growing, and certain health boards have recently introduced it as a matter of policy (Gilligan and Chapman, 1997). Four out of the five general practitioners interviewed in this study were quite negative about the prospects of such a move, however, believing that parents' presence would not be 'constructive', nor would it permit them to express their views openly. Their reluctance could be explained in terms of their traditional view of the doctor/patient relationship, characterised, according to Morgan, Calnan and Manning (1985, p. 124) by 'deference' on behalf of the patient towards the undisputed rationality of medicine and medical competence. This model would undoubtedly be challenged by a requirement for general practitioners and their patients to join in a democratic discussion process. Dingwall (1980) has asserted that doctors attended case conferences to 'sell' their decision, and if unsuccessful, would deem the meeting time wasting. It seems unlikely, therefore that a participatory, joint decision making forum would attract them.

Two more interlinked factors appear, supported by this study, to augur poorly for increasing partnership between general practitioners and the statutory system. These concern the issues of status, and gender. As Turner (1987, p.132) points out, the medical profession have been accused of exercising 'patriarchal authority and control over subordinate social groups, especially women'. Turner asserts that

doctors subordinate not only women patients, but 'those occupations which are dominated by women'. There is, however, also evidence from this research to indicate that this type of gender discrimination also occurs *within* the medical profession, in this instance between the male dominated occupation of general practitioners and the female dominated occupation of public health doctors. As Parton (1985, p. 53) observes, the medical profession places premiums on 'face to face clinical interaction', and also on 'risky pragmatic enterprise' both of which are features of general practice. By the same token, it could be suggested that public health medicine, lacking the aforementioned high status elements, represents the type of secure, 'nine-to five' employment that suits women doctors with domestic and child care responsibilities, but ranks fairly low in professional terms. It would, therefore, be less likely to elicit the respectful compliance of a more 'macho' profession. This notion is aptly illustrated in the study by a comment made by one of the general practitioners in the study who, speaking of his local Director of Community Care, referred to her as a member of '... the twin set and pearls brigade ... her hubby is probably raking in a hundred and fifty grand somewhere else, she's getting her forty six or forty seven grand a year for sitting on her tush up in [Area X].'

Conclusion

The Irish study upon which this paper is principally based set out to examine professional practice in the child protection system, and focused on a broad range of professionals. It could not be claimed that the small number of general practitioners who participated in the research were representative of their profession in Ireland or elsewhere. The qualitative approach adopted by the study was never intended to enumerate frequencies or measure trends on a large scale. Rather, it set out to explore and explain the practices of a small sample of practitioners at an in-depth level and in the context of their 'real life' work situations. Nevertheless, the data gained from interviews with family doctors, and observation of their contributions to case conferences, has raised some interesting issues, whose validity is affirmed by positive comparisons with research carried out on a much larger scale in Britain. It could also be argued that the limited involvement of general practitioners in this study is a reflection of their minimal participation in the child protection process, evidenced by their low identification and referral rate, and their reluctance to attend case conferences.

By coincidence, in between the time this paper was first submitted for publication, and its final revision, another high profile case has drawn attention to the role of the general practitioner in child abuse work. This time, in addition to a formal inquiry (North Western Health Board, 1998), the case involved a lawsuit in the Dublin High Court. Sophia McColgan, the victim of gross physical and sexual abuse by her father, sued the North Western Health Board and her former general practitioner on behalf of herself and her brothers, for negligence of their

Yin, R. (1994) *Case Study Research: Design and Methods.* Newbury Park and London: Sage.

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THE DUTCH INQUISITORIAL LEGAL SYSTEM: WHAT LESSONS HAS IT FOR CHILD PROTECTION SERVICES WITHIN AN ADVERSARIAL SYSTEM?

by Kieran McGrath

Introduction

This paper examines the Dutch inquisitorial legal system's approach to child protection and contrasts it with the Common Law's adversarial approach. The writer compares and contrasts the adversarial system operating in Ireland, with the inquisitorial system found in The Netherlands. In Ireland, legal disputes concerning children are now part of the legal mainstream, whereas up to relatively recently, they constituted a jurisprudential backwater. The enactment of the 1991 Child Care Act has given child protection work a higher legal status. It has also, however, opened it up to the full rigours of the adversarial legal system which accentuates conflict, which increases the stress experienced by children, their parents and professionals. This has also resulted in a greater use of the legal system in cases where health boards seek to take children into care. The writer's research finds that the influence of the adversarial system on the child protection services in Ireland has been predominantly negative, because of its reliance on conflict, which decreases the possibility of partnership between health board professionals and parents — a stated objective of the 1991 Act. As part of an examination of the adversarial legal system, the writer visited The Netherlands in early 1997 where he interviewed prominent Dutch child protection professionals on the interaction between their inquisitorial legal system and the child protection system. The inquisitorial system relies more on reason than conflict in judicial decision-making. Proposals for the reform of the adversarial system are discussed, including the use of some of the better features of the Dutch system as an example of how the Irish system might be improved. This paper summarises the main findings of an earlier study by the author (McGrath, 1997).

Key words: Adversarial and inquisitorial legal systems, child protection.

Methodology

The research consisted of:

(a) A literature review, including an analysis of the adversarial and inquisitorial legal system; as well as an outline of the development of child protection policies in both Ireland and The Netherlands.

(b) Interviews with social workers and other child protection professionals in The Netherlands on how they see the application of the inquisitorial legal system and its influence on their child protection services. The interviews with the Dutch child protection professionals were semi-structured and were conducted during a visit to The Netherlands in early February 1997. All quotes are from the writer's earlier study (McGrath, 1997), unless otherwise stated. The interviews were audio-taped. In some quotes the wording/grammar has been slightly altered to enhance clarity, without changing the meaning.

The Adversarial and Inquisitorial legal systems

The adversarial and inquisitorial systems have been described as "the two main systems of trial in the civilised world" (Spencer and Flin, 1993, p. 75). The adversarial system is the method of trial found in Britain and Ireland, and most other English speaking countries. It has been described as:

> "a competitive argument between two sides, each presenting the best case for its own side. It is not designed to objectively discover the absolute truth of the matter being tried. The parties are engaged in a struggle with each other, not in a mutual search for the truth. The competitive nature of the process is, in part, an explanation for its reputation as an awesome place for the inexperienced witness under cross-examination" (Mallon and White, 1996, p. 50).

The inquisitorial model, on the other hand, is a model of trial where:

> "the court takes the initiative in gathering information, builds up a file on the matter by questioning all those it thinks may have useful information to offer - including in a criminal case, the defendant – and then applies its reasoning powers to the material it has collected in order to determine where truth lies" (Spencer and Flin, 1993, p. 75).

Background to the present study

The writer's primary degree was in Law and he was, therefore, naturally drawn to considerations of the interface between Law and Social Work. The interest in the legal aspects of child protection work springs directly from his work as Senior Social Worker in St Clare's Unit, The Children's Hospital, Temple Street, Dublin and prior to that, as a social worker and a social work manager, with the Eastern Health Board for seven years.

Between 1988 and 1995, St Clare's Unit – which is one of two child sexual abuse assessment units based in paediatric hospitals in Dublin - dealt with over 2,750 referrals (McGrath, 1996a, p. 62). These units were set up in late 1987, in the midst of a great deal of public and professional disquiet about child sexual abuse. Prior to this, the Sexual Assault Unit in Dublin's Rotunda Hospital had, from the early 1980s, provided a service for adults but had ended up seeing mainly children suspected of having been sexually abused. In common with their colleagues in Our Lady's Hospital, Crumlin, the staff of St Clare's sought to provide a broad, family-based service with the focus, not just on whether abuse may have occurred, but also on the overall psycho-social needs of the child and his/her family. To this end, a multi-disciplinary team employing social workers and clinical psychologists - with a child psychiatrist as unit head - was seen as more appropriate.

It was anticipated that such a structure would make it easier for the assessment process to be more connected to existing services provided by health board social work teams and follow-up treatment services. It was also envisaged that the specialist nature of the units would give the professionals employed there a higher status in court (McGrath, 1996a, p. 61). This appears to have happened. In two important court judgments: Southern Health Board v CH [1996] IFLR 101 and In re S., M., and W. [1996] IFLR 87, the evidence of social workers in specialist assessment units was accepted as "expert" testimony. [According to Cohen (1996) not only do British social workers not have this status in court but are often belittled by judges and lawyers (p. 23).]

As mentioned earlier, 1987 was a year when child sexual abuse had become a very controversial issue both in Ireland and also the United Kingdom (UK). In the UK, the Cleveland Inquiry (Secretary of State for Social Services, 1988) had been set up following "an unprecedented rise in the diagnosis of child sexual abuse during the months of May and June 1987 in the County of Cleveland, principally at Middlesbrough General Hospital" (p. 4). The inquiry team had noted that in "Cleveland the general criticism by the public has been of over-enthusiasm and zeal in the actions taken" (p. 244).

Just a few years previously, in 1984, the first Irish statistics on child sexual abuse had been gathered and by 1987 the Department of Health had noted a very significant increase in reported cases (see Table 1, below).

The precise structure of St Clare's Unit was a conscious effort to respond to this large increase in child sexual abuse referrals in Ireland but also, to avoid the pitfalls of the over-zealous approach which had been identified in Cleveland. This approach was also reflected in the attitude of the discussion document on child sexual abuse by the Law Reform Commission (1989) when it stated that the "Cleveland episode provided startling examples of the way in which the lives of families may be thrown into turmoil by an over-zealous approach to child protection" (p. 7). In this context, the interaction between the mental health and legal fields played a significant role from the outset.

Recent developments on child protection in Ireland

Since the mid-1980s child abuse has become an increasingly politicised issue in Ireland. This has been influenced particularly by the setting up of child abuse inquiries since 1993 (Ferguson, 1996, p. 29). Over this time the rate of reported child abuse in Ireland have risen considerably. In the ten years between 1984 and 1994 the number of suspected cases investigated by health boards rose over ten fold (see Table 1 below).

Buckley (1996) has pointed out that in Ireland "the principle of partnership with families is integral to the Child Care Act 1991". Yet, the inevitable question that arises, therefore, in any interventionist model of child protection, is how one can balance the use of legal measures and still maintain a sense of partnership with clients? In practice, achieving partnership is very difficult "particularly in the early stages of investigation and planning" (Buckley, 1997, pp 116-117). The same author goes on to say that "the shock of being investigated, and the devastation of finding out that their children had been abused by, for example, a trusted family member, often combined to create huge barriers between parents and services" (Buckley, 1997, p. 117). Masson (1997) argues that in the UK similar conflicts between partnership and social policing have emerged (p. 104).

The far greater attention given to child abuse in Ireland in recent times and the public outpourings of outrage - while appropriate at one level - also create other problems, including increased public demand for more punitive and legalistic measures to be used against parents who abuse or neglect their children. This, makes it more difficult for those parents in danger of abusing or neglect their children to seek help, as they will suffer greater stigma and social isolation as a result. Likewise, the long campaign for mandatory reporting in Ireland can be viewed as a movement which could force social workers involved in child protection more in the direction of a social policing role, away from their caring objectives decreasing the possibility of partnership with parents(McGrath, 1996b).

Child care proceedings within the Irish adversarial system

Since the late 1980s, but particularly since the enactment of the 1991 Child Care Act, the legal climate with regard to child care proceedings in Ireland has changed dramatically. As recently as 1981, only 16.3% of children coming into care did so as a result of legal action. By 1989 this figure had jumped to over 50% (Gilligan, 1991, p. 8). Likewise, Roantree (1994) notes "a generally increasing pattern of placement by court order" (p. 2). O'Brien (1997) in her study of 92 children in foster care with relatives, in the Eastern Health Board (EHB), found that 68% were in care by court order.

Overall in the EHB, the trend is towards greater use of court proceedings: Between the years 1994 and 1995 the number of court orders increased by 74% and in some EHB community care areas this increase was over 100% (Lunny, 1997, pp A2-A30).

[In contrast, the rates of children taken into care in The Netherlands by court order averages around 20% (Veldkamp, 1997).]

In the author's experience, these figures represent of a very different legal climate from how it was even a few years ago. Cases that might have taken hours, or at most perhaps a day or two, in the past, can now take weeks. There can be as many as five legal teams, each made up of a solicitor and barrister, involved in each case. Apart from the health board legal team, the parents may be separately represented, the child is also entitled to separate representation and if a guardian *ad litem* is appointed by the court, he/she may also appoint a legal team.

Rising rates of suspected child abuse

The figures below in Table 1 indicate that while the rate of suspected child referrals has risen dramatically, the rate of substantiation has dropped over the years. The overall national figure for 1995 was 35.4%. However, in parts of the Eastern Health Board, this figure was as low as 12.7% for the same year (Lunny, 1997, p. 21). Ireland is quite different to The Netherlands with respect to confirmation rates, in that the substantiation rate among cases monitored by the Office of the 'Confidential Doctor' (OCD) is around 80% (Lamers-Winkelman, 1996b, p. 49).

Table 1: Reported & Confirmed Cases of Child Abuse 1984 - 1995

Year	Total reports Received	Child Sexual Abuse (CSA)	Total No. Confirmed		Total % Confirmed	
			Overall	CSA	Overall	CSA
1984	479	88	182	33	37.9%	37.5%
1985	767	234	304	133	39.6%	56.8%
1986	1015	475	495	274	48.7%	57.6%
1987	1646	926	763	456	46.3%	49.2%
1988	2673	1055	1243	465	46. 5%	50.2%
1989	3252	1242	1658	568	50.9%	45.7%
1990	N/A	N/A	N/A	N/A	N/A	N/A
1991	3856	1507	1465	599	37.9%	39.7%
1992	3812	1362*	1701	587*	44.6%	43.0%*
1993	4110	1791	1609	681	39.1%	38%
1994	5152	1816	1868	557	36.2%	30.6%
1995	6415	2441	2276	765	35.4%	31.3%

(* Figures for one health board on csa not available - included in overall total.)

[Source: Department of Health]

THE DUTCH CHILD PROTECTION SYSTEM

Historical background

In common with other Western countries, The Netherlands can trace the origins of its child protection system back to the latter half of the nineteenth century. This development was influenced by the emergence of Societies for the Prevention of Cruelty to Children in the US and the UK and legislation such as the Prevention of Cruelty to Children Act in England in 1889 (van Montfoort, 1993, p. 53).

Like most modern social movements in The Netherlands, the present Dutch child protection system was shaped by, and still retains influences from, the past. Specifically, the major influences were the 'three pillars' of Dutch society: the Calvinist, Catholic and Socialist/Liberal traditions. The ability to successfully contain these different forces has been described by Lijphart (1968) as the "politics of accommodation". In practice, the politics of accommodation meant that each tradition developed its own distinct institutions, including the establishment of a very large number of different non-governmental organisations (NGOs). This included, for example, various children's homes representing the three independent traditions, as "philanthropists strongly and successfully resisted state custody of children" (van Montfoort, 1993, p. 55). Hetherington et al (1997) claim that in The Netherlands "most of the services for children and families are provided by NGOs" (p. 73).

"Rediscovery" of child abuse in the 1960s

In common with many other Western countries the specific concern of the Dutch authorities and public in the Netherlands over child abuse, first took on concrete form at the end of the 1960s. In 1969 the Dutch Government set up a Committee on Child Abuse, which among other issues, considered child abuse reporting systems. The setting up of this committee was influenced by the ground-breaking work of Kempe et al (1962) who identified the "battered child syndrome". This study was influential in the introduction of mandatory reporting in the US in the 1960s.

The Dutch Committee on Child Abuse published its report in 1970 and rejected both the American mandatory reporting system and the waiver of the doctor-patient privilege. In rejecting mandatory reporting the committee stated that such a system would not fit in with the cultural environment of The Netherlands because "Dutch citizens do not like things that are compulsory" (van Montfoort, 1990, p. 1)

It was envisaged that physicians would, however, need advice and guidance in dealing with cases of abuse. The Office of the 'Confidential' Doctor was conceived as an agency employing specially trained doctors who could advise other physicians on cases of child abuse. The intention was that physicians presented with cases of child abuse, could get help for the children and their families, while simultaneously avoiding a breach of the medical oath of confidentiality. They could achieve this by telling another doctor (ie the Confidential Doctor) of their concerns, rather than going to the police or the Child Protection Board. It is still the case that:

> "The major tasks of the Confidential Doctors are to organise care for the child and the family, to coordinate the efforts of various agencies, to organise follow-up of all cases, and to keep a register to gain insight into the prevalence of child abuse..... Given Dutch society's strong antagonistic feelings toward state intervention in 'family affairs' and its view on child abuse and neglect, including the view that sexual abuse is a 'family affair', the Confidential Doctors seemed to fulfil an important need" (Lamers-Winkelman, 1996b, p. 46).

In 1993 the OCD received 13,500 cases of intrafamilial child maltreatment, of which 81% were verified. Most (54%) of the verified reports concerned neglect, 20% were of physical abuse and 16% concerned sexual abuse (Landelijk Stichting Buro's Vertouwensartem inzake Kindermishandeling; LSBVK, 1994, quoted in Lamers-Winkelman, 1996, p. 49)

The Inquisitorial System

The legal system operated in The Netherlands is inquisitorial, similar to that found elsewhere in Continental Europe. Its emergence can be traced to a reaction to the ancient version of the adversarial/accusatorial system. According to Spencer & Flin (1993) this has its origins in the pre-rational world of ordeals, when the method of trial was for one of the parties to accuse the other, whereupon the court decreed that one or other should be burnt on the hand with a hot iron, or made to swallow a 'cursed morsel' to enable God to show whose cause was just. The theory was that God would save the one telling the truth. In 1215 the Church withdrew its support for ordeals and this caused a general problem throughout Europe. The English and the Scots kept to the traditional pattern, but replaced the judgment of God with a group of neighbours called to give their verdict on the matter: that is, the neighbours were compelled to take an oath, and say whose cause was just, on the basis of their local knowledge, if they had any, or their hunch if they did not. Taking an oath was seen as crucial, as it kept God in the process and, thus, maintained the fear of eternal damnation for perjury.

The Continental European countries, on the other hand, moved from ordeals to a system under which the State appointed an 'inquisitor' to find the truth of the matter by asking questions and applying his powers of reason to the answers. On the face of it this was a far more rational way of doing justice. Over the intervening years, however, the accusatorial system improved and became more rational when the jury developed into an independent group of assessors who learnt the facts from witnesses called by the parties to the dispute. However, the inquisitorial system degenerated when inquisitors took to torturing defendants in order to overcome their reluctance to answering questions. This was a gruesome development that led many contemporary writers on the Continent to praise the humanity of the Common Law adversarial system by comparison with their own, so giving rise to the belief, still firmly held by British and Irish lawyers, that the accusatorial system is the 'envy of the world' (Spencer and Flin, 1993, pp 75-76).

In its modern manifestation, the Dutch legal system developed from the Napoleonic Code in the 19th century. The inquisitorial system is operated on the basis of an inquiry rather than a contest. The judge sees it as his/her task to gather information and to apply powers of reasoning in coming to a decision (Spencer and Flin 1993, p. 76). In The Netherlands, the "court hearing is informal, and the parents and (older) children are able to talk directly to the judge" (Hetherington et al, 1997, p. 74) This model of justice has emerged from the different philosophical traditions found in continental Europe and demonstrates a different type of relationship between the citizen and the state than that found in the British tradition (Hetherington et al, 1997, p. 96).

The Office of the 'Confidential Doctor' in Practice

One of the structural differences between the Dutch and Irish child protection systems is the Office of the Confidential Doctor (OCD). The writer interviewed Dr Rob Bilo, of the OCD in Rotterdam. Bilo describes himself as a "child abuse physician" because he says that the term 'confidential doctor' can be confusing. When he joined the OCD in 1988 he "wanted to be a doctor and not a specialised social worker", which he claims some of his predecessors tried to be. As part of his effort in this regard he developed "intense contacts" with other health services and as a result "even the police came closer" to the OCD.

Up to the recent past most Dutch doctors were slow to report suspected abuse. Bilo refers to this as the "old problem" identified by Kempe et al, referred to above. Now the OCD train family physicians about talking to children and to parents about their suspicions. As a result, health agencies, especially physicians in Rotterdam, are now "more enthusiastic" about referring suspected cases, though Lamers-Winkelman (1996b) claims that, nationally, "only 20% of reports are from the medical profession, including nurses and midwives. Most reports come from neighbours and family members" (p. 46).

According to Bilo, the main task of the OCD is to be a reporting point for other professionals. The OCD offers advice and 'intermediate' service for families, which the OCD does not see as therapy per se. Bilo maintains that:

> "to get therapy one must have a question. For a therapist the first issue is 'what is your question?' Most of the parents who abuse or neglect their children do not ask 'why did I abuse my child?' So, if there is no question there can be no therapy".

Bilo says that the role, therefore, of the OCD is to help the family to clarify the needs of the children and then to put them in touch with agencies/resources that may help them meet these needs. This could, for example, mean help with parenting or learning how to reduce stress.

The preference of the OCD is to intervene through the professionals who are already in touch with the family because the involvement of the OCD brings with it a certain stigma. Bilo claims they get involved in an active way with about 25% or 30% of cases.

In the event, for example, of the parents having serious drug, alcohol or psychiatric problems the first responsibility of the OCD is the child's welfare. If the addiction or other problem prevents adequate care for the child they report the case to the Child Protection Board (CPB) straight away. They "almost never tell the police" but in telling the CPB they are quite aware that their reports can find their way to the police.

The Child Protection Boards

The writer interviewed Mia Lamers, a psychologist with the Child Protection Board (CPB) in Rotterdam and Ton Veldkamp, based in Utrecht, who has both social work and legal training, and works with the CPB but in what he described as a "quality control" role, the Dutch equivalent of a Social Services Inspectorate.

According to Lamers, the CPB sees its role as being to step in to protect children when offers of help by other agencies have been unsuccessful. It is accepted by the CPB that they have a narrow role in this respect. Typically the OCD may have been involved with the case prior to referral and may have advised the CPB of the risks to the children, perhaps after help was turned down or proved inadequate.

The CPB does not have responsibility for providing placements for children that they receive into care; that is provided by another organisation, the Gerinsvoogdy - instelling (Family Custody Agency). In this respect the CPB operates differently to the Irish system where health boards both initiate court proceedings and also have the job of finding places for the children they receive into care.

Child abuse inquiries in The Netherlands

To date there have been no public child abuse inquiries into the death or serious injury of a child in The Netherlands equivalent to, for example, the death of Kimberly Carlile, in England (London Borough of Greenwich, 1987) or Kelly Fitzgerald (Keenan, 1996) in Ireland. There has, however, been one well known Dutch inquiry into allegations of sexual abuse at a day-care centre known as

Bolderkar. This was referred to by a number of the Dutch interviewees as the 'Dutch Cleveland'. The swiftness of the authorities to assume that abuse had occurred, was later viewed by the inquiry as 'overzealous'.

Bilo said that there have been instances where children already known to helping agencies have been killed by their parents/carers but these have not led to large scale, public inquiries. He explained that:

> "It is very painful in the case of a child's death. We all know these things happen but you can't prevent them... I deal with 300 new cases a year, that's six each week. I work in partnership with a social worker on each case. We can't have clear insight each time. We make an estimation of the risk; most of the time it is right but there will always be times when we get it wrong. Many of these situations are completely unpredictable."

Asked about the possibility that the public may think that professionals in helping agencies *should know* the risk to children and are therefore culpable, Bilo said that he believes that this is an unrealistic expectation.

Giving evidence in Dutch courts

Only half of those interviewed in this study had ever been called as witnesses in child protection court cases, though all were familiar with the dilemmas associated with the issue. Bilo, although never a witness himself, was well-versed in courtroom dynamics. He recognises that his agency's reports to the Child Protection Board are used by the CPB in preparing their own court reports. However, the CPB testimony constitutes the main body of evidence in court.

According to Bilo most parents are well prepared for court by the CPB social workers. They are "obviously unhappy" about being in court because they feel judged regarding their ability to raise children. He described it in the following way:

> "They feel neglected, blamed and victimised. They were victimised in their own youth and now they are being victimised again by the people who want to help their children. Overall it is very stressful for parents. The social workers make very lengthy reports (setting out) their case. They are questioned on the details of the report by the judge, though not on every single part of it... Usually there is no lawyer for the CPB and also, in most cases, none for the parents either."

Asked why lawyers are not central to the process, as they are in the adversarial system, Bilo said that this is because:

> "The system is not so repressive. I think the fear of what is going to happen is taken away by the CPB social workers. They explain exactly what is going to happen and if the parents want a lawyer then they get one. I think it is more of a therapeutic than a confronting approach... If there is conflict you can't cooperate with parents and in most cases people want to cooperate with parents... because when the court case is over you must continue to work with the parents and this is easier if there has been cooperation".

Attitudes of Dutch child protection professionals to court attendance

One of the striking differences between Dutch and Irish child protection professionals is their motivation for avoiding court attendance. Of those interviewed for this study, none expressed a fear of actually giving evidence in court. Their reluctance was based on the impact this might have on their on-going relationship with clients. Their Irish counterparts are reluctant for the same reason but also express a dread of the actual court process itself.

One of the Dutch interviewees was Jacquelien Noordhoek-van der Staay who is head of the Boddaert Centre Strichting Boschuis, in Lelystad. She conducted a major piece of research on child abuse in The Netherlands (Noordhoek-van der Staay, 1992). This study involved 2,690 children who were attending residential or day care centres. The study involved interviewing professionals working in these centres, all over The Netherlands, about child abuse.

With regard to giving evidence in court, most of those interviewed by Noordhoek-van der Staay said that they are reluctant to go to court, even if they believed that the child was abused and agreed with the necessity of taking court action. The reason given for wishing to avoid going to court was the difficulty that this presented for them afterwards in their efforts to provide therapeutic help. However, they did not express a fear of going to court per se, which is different to the reactions of many Irish professionals.

The role of the expert witness in Dutch courts

The writer interviewed Francien Lamers-Winkelman who provides therapy to children who have been sexually abused and interviews children suspected of having been abused. She is also a researcher in the Psychology Department in the Free University of Amsterdam. She regularly gives evidence in court as an expert witness in both criminal and civil cases.

(a) Criminal proceedings

Asked about the strengths and weaknesses of the way that the Dutch court system deals with child protection cases, Lamers-Winkelman said that among the strengths is the fact that children under 12 are never brought into court to give evidence in criminal cases. The reports of specially trained police officers who interview the children are used instead as the main testimony. She also cited the fact that the judges take an active, rather than passive, role in court cases as positive. (There are no jury trials in the inquisitorial system.)

Unlike the adversarial system - with its preoccupation with only admitting direct oral evidence from witnesses - the inquisitorial system allows for consideration of police reports based on children's statements rather than hearing the children directly. This would not be allowed under the Irish system. Without direct evidence from the child any other statement of what the child said would be classified as hearsay, and therefore inadmissible.

Inquisitorial criminal courts can hear testimony from expert witnesses who use Statement Validity Analysis (SVA) also called Statement Credibility Assessment. This a process whereby designated specialists, such as Lamers-Winkelman, are allowed to give evidence as to the reliability of the child's statement. She claims that in such a situation the defence lawyers would be, or could be, "fairly tough" in their questioning, but attempts, for example, to denigrate her personally, or as an expert, would be ruled out by the judge. (In the adversarial system it is expected that lawyers will deliberately try to undermine an expert witness.)

(b) Civil proceedings

Lamers-Winkelman said that the reason she is brought in to child protection cases is because children who are the subject of care proceeding are rarely interviewed by social workers. She said that while social workers have great responsibility for children, they have "no training in child care". They are trained in relation to the needs of adults. She described this as "the craziest thing in the world".

She said that in recent times there has been "a great deal of uproar" about deficits in social workers' training. Mostly they are trained in skills to deal with difficult parents rather than in how to deal with children. In response to this, psychologists and orthopedagogues (equivalent of developmental psychologists) have, in recent years, been employed by the Child Protection Boards. Lamers-Winkelman believes that "we don't have a *child* Protection Board, we have a *parent* Protection Board". She says this is because Dutch society is very family orientated, resulting in a reluctance to interfere into the family's 'privacy'[1] .

Changes in legal climate in The Netherlands

The writer interviewed Adri van Montfoort who has a background in Social Work and is also trained as a lawyer. He has previously worked for the Child Protection Board and has also been a university lecturer in child care matters. He currently works as an independent child care consultant and has also been appointed as a specialised appeal judge in the Dutch High Court on a part-time basis.

In common with Bilo, van Montfoort believes that the inquisitorial system in the Netherlands is, in fact, becoming more adversarial in that more cases are being tried in an aggressive fashion and lawyers are adopting an approach with some of the attributes of the adversarial style of the Common Law System. He thinks the Dutch system is moving in the direction of becoming much too legalistic and much more formal. This trend can be seen, for example, in the fact that social workers employed by the Child Protection Board are spending about 25% of their time in court or in preparing for court.

van Montfoort also agreed with Bilo that demands are being made to have children interviewed several times where there are allegations of sexual abuse i.e. looking for second and third opinions. This is being sought as a way of getting evidence that can be used to contest cases and he sees this as an unhealthy development, which is not in the interest of children. van Montfoort recognises that, in the past, the informality in the Dutch system lent itself to criticism and needed to be tightened up. Since November 1995 a new law (Niewe ondertoezichtstelling) was introduced to create more formality. However, van Montfoort thinks that following this change the system is now too legalistic, even allowing for the previous problems caused by informality. By this he means that too much conflict is being introduced into the system and that social workers are being forced into spending too much time defending their position in court, rather than in finding ways of helping the families and children in question.

Summary

In summary, the Dutch system can be characterised as one that is more informal and open than the adversarial system. It relies far more on reason than conflict in decision making. The role of the judiciary is more central than that of the lawyers. It is, nonetheless, becoming more adversarial with more formality and conflict entering its procedures. Nonetheless, it is still flexible enough to allow plenty of scope for child protection social workers to encourage partnership with parents. The Office of the Confidential Doctor, in particular, encourages collaboration with parents and older children. "Lack of procedural pressures frees up time to engage, create trust, and explore choices" (Hetherington et al, 1997, p. 148). This is borne out by the fact that only 20% of children in care are on court orders, in contrast to the much higher figure in Ireland.

This is a striking difference between the two systems. These appointments recognise that the key knowledge required in adjudicating on very complex child care matters is that of children's needs, rather than legal knowledge. It is very rare, in a child care case, for the law to be in dispute but the "facts" or opinions on what is in the best interests of the child, are almost always in conflict. Such a judicial appointment could not occur in the Irish legal system.

(iii) Cross-examination:

In the adversarial system "the aims of cross examination are basically twofold: (a) to advance your own case; and (b) to undermine your opponent's case" (Council for Legal Education, 1991, p. 237). Such attacking words are the language of adversary in action and emphasise the point made earlier that the priority, as in a boxing match, is to win by scoring points off one's opponent. It is expected that lawyers are free to put exaggerated, if not outlandish, propositions to witnesses. They can, for example, essentially accuse witnesses of lying or being deceitful, without any evidence of this. Such an approach has, until recently, equally applied to children as witnesses, in both criminal and civil cases.

In the inquisitorial system, however, witnesses generally, but children in particular, are very protected. Far greater reliance is made of written reports from police and professionals, which prevents aggressive confrontation, by allowing the children's statements to be used as evidence, rather than depending on oral evidence. Likewise for parents involved in care proceedings, while they find being in court very stressful, the system is perceived as being less oppressive.

For professional witnesses too, there is much reduced stress in the inquisitorial system due, in large measure to the neutral questioning of the judge. The reports of other professionals are admitted as evidence without the necessity of oral evidence to back them up, which means that they find it easier to continue therapeutic work with the families afterwards.

(iv) Access to reports

In the adversarial system, efforts are routinely made, as a matter of course, to exclude information that is unfavourable to the interests of each side in the dispute. Only those reports that are seen as favourable to each side are presented, in the first instance. If admitted, reports of the "opposition" are then scrutinised for possible weaknesses. One Irish barrister, known to the writer, refers to this process as "filleting reports for inadmissible evidence". This in-depth exploration of any report from the 'enemy', even if not central to the dispute, offers the opportunity for many skirmishes that may wield the chance to score points or make the 'opposing' witnesses appear to lack credibility. This is particularly so with expert witnesses.

Under the adversarial system court reports must be backed up by oral evidence, so professional witnesses must appear in court and give their own testimony, rather than just supply reports. This has the effect of polarising all witnesses into various "camps". Therefore, professionals who might want to remain neutral must either remain evidentially 'silent' or else risk being drawn into a conflict that leaves them compromised if they are to continue to work with the family afterwards.

In Ireland, health board social work staff are not allowed to give evidence based on reports from other professionals due to the rules against hearsay. However, in the Dutch system, Child Protection Board social workers are allowed to encompass the concerns of other professionals in their court reports, which means that these other professionals do not have to be brought into court as witnesses, making it easier for them to continue to work with the families and the children afterwards.

In the inquisitorial system any available written reports considered relevant to the inquiry are included as evidence, as a matter of routine. In The Netherlands reports supplied by Child Protection Board social workers form the basis of the case, incorporating other professional reports, rather than relying strictly on the oral evidence of those who wrote them. A social worker is questioned primarily by the judge on her/his report but not each and every line of it. This means it is not necessary to tortuously go over each and every point in the various reports but to concentrate instead on the most contentious elements.

(v) Legal representation

In Ireland it is now the norm in child care proceedings to have one, if not two, legal teams representing the parents; as well as the health board legal team and possibly a court-appointed guardian *ad litem* and his/her legal team. Under Section 25 (2) of the 1991 Child Care Act, a child can also be separately legally represented in care proceedings. Thus, it is quite possible to have up to five legal teams involved in an individual case. Obviously, the more legal teams operating in the court room arena, the greater the scope for protracted legal argument, with much re-hashing of evidence with each witness.

In The Netherlands, it is quite common for neither the Child Protection Board nor the parents of the children to be legally represented (Hetherington et al, 1997, p. 100). This emphasises the informal nature of the legal proceedings. The reason given for this by one of the Dutch child protection professionals, interviewed by the author, is that it is "more of a therapeutic than a confronting process."

(vi) Expert testimony

In the adversarial system experts may be called, to give evidence in cases "on any matter which is likely to be outside the knowledge and experience of the judge or jury" (Spencer and Flin 1993, p. 251). Even here, however, the adversarial nature mandatory reporting encourages a more legalistic, and thus, adversarial approach to child protection.

(4) While major structural reform is awaited, Irish judges could make the present system work better by adopting a better system of case management, in line with the recommendations of the Law Reform Commission's report on the Family Courts (Law Reform Commission, 1996).

Bibliography:

Buckley, H. (1996) "Child Abuse Guidelines in Ireland", in *Administration*, Vol 44 No. 2 pp 37-56.

Buckley, H. (1997) "Child Protection in Ireland", in Harder, M. & Pringle, P. (eds) *Protecting Children in Europe*, Aalborg, Denmark:Aalborg University Press .

Bunreacht na h'Eireann: Constitution of Ireland, (1990) Dublin: Government Publications Office.

Carson, D. (1990) *Professionals and the Courts - A Handbook for Expert Witnesses*,, Birmingham: Venture Press.

Cohen, P. (1996) "Silenced Witness", Community Care, July 11-17, pp 22-23.

Council of Legal Education (1991) *Advocacy, Negotiation and Conference Skills*, London: Blackstone Press.

Department of Health (Various years) *Survey of Children in Care in Health Boards*, Dublin: Child Care Division, Department of Health.

Department of Justice (1997) *Going to Court - A Preparatory Pack for Child Witnesses and their Parents/Guardians*, Dublin: Department of Justice.

Ferguson, H (1996) "Protecting Irish Children in Time: Child Abuse as a Social Problem and the Development of the Child Protection System in the Republic of Ireland", *Administration*, Vol 44 No. 2 pp 5-36.

Gilligan, R. (1992) "Implementing the Child Care Act 1991: A Review of Resource Implications", *Irish Social Worker*, Vol. 10 No. 4, pp 7-10.

Gorphe, F. (1927) *La Critique du Temoignage*, 2nd ed. Paris: Dalloz.

Hetherington, R., Cooper A., Smith, P. and Wilford, G. (1997) *Protecting Children - Messages from Europe*, Lyme Regis: Russell House Publishing.

Law Reform Commission(1996) *Family Courts*, Dublin: Law Reform Commission.

London Borough of Brent (1985) *A Child in Trust: The Report of the Panel of inquiry into the the Circumstances Surrounding the death of Jasmine Beckford*, London: HMSO.

Livesey, B. (1990) *Giving Evidence in Court*, Bradford: British Association for the Study and Prevention of Child Abuse and Neglect.

Lunny, L. (1997) *Report of the Eastern Health-Impact Review Group on Child Care & Family Support Services*, Dublin: Eastern Health Board.

McCormack, H. (1992) *Expert Evidence in Child Sexual Abuse Cases*, Toronto: Institute of Prevention of Child Abuse.

McGrath, K. (1992) "Examination and Cross-examination: Survival Strategies". Unpublished paper given to Association of Child Psychology and Psychiatry conference, Dublin (February).

McGrath, K. (1996a) "Intervening in Child Sexual Abuse in Ireland: Towards victim-centred policies and practices", in *Administration*, Vol 44 No 2 pp 57-71.

McGrath, K. (1996b) "Mandatory Reporting of Suspected Child Abuse - Would the Drawbacks Outweigh the Benefits for Irish Children?" *Medico-Legal Journal of Ireland* Vol 2 No 2 pp 44-46.

McGrath, K. (1997) *An examination of the Adversarial Legal System and its implications for Irish Child Protections Services*, Unpublished M.Soc. Sc. thesis, University College Dublin.

McGuinness, C. (1991) "Social Work and the Law", *Irish Social Worker*, Vol 10 No 4 pp 16-19.

McGuinness, C. (1993) *Report of the Kilkenny Incest Investigation*, Dublin: Stationery Office.

McKeown, K., Gilligan, R., Brannick, T., McGuane, B., Riordan, S., and Fitzgerald, G. (1993) *Child Sexual abuse in the Eastern Health Board region of Ireland in 1988: A statistical analysis of cases known to the community care teams and open at any time in 1988*, Dublin, Eastern Health Board.

Mallon, D. and White, C. (1995) "The Social Worker in Court", in White, C. (ed) *Law for Northern Ireland Social Workers*, Dublin: Gill & Macmillan.

Masson, J. (1997) "Introducing non-punitive approaches into child protection", in Parton, N. (ed) *Child Protection and Family Support - Tensions, contradictions and possibilities*, London: Routledge.

National Association for the Prevention of Cruelty to Children (1990) *Child Witness Pack*, London: NSPCC.

O'Brien, V. (1997) "A Perspective on Fostering - Relatively Speaking". Unpublished paper given at the Irish Foster Care Association conference on fostering, Dublin. (June).

Parton, N. (1997a)*Child Protection and Family Support: Tensions, Contradictions and Possibilities*, London: Routledge.

Parton, N. (1997b) "The Nature of Contemporary Social Work". Unpublished paper given to the Annual Conference of the Irish Association of Social Workers, Renvyle, Co Galway (May).

Roantree, M. (1994) "The Emotional Impact on children: Care Proceedings". Unpublished paper given to the 6th Joint St Louise & St Clare Units Annual Conference, Dublin. (20.5.'94).

Spencer, J. and Flin, R. (1993) *The Evidence of Children*, 2nd edition, London: Blackstone Press.

Veldkamp, T. (1997) Raad voor Kinderscherming, Landelijk Bureau, Utrecht: (Personal communication).

Ward, P. (1997) "The Irish Law of Children's Evidence - Protecting Parents". Unpublished paper given to Bar Council of Ireland Conference on the Evidence of Children, Dublin. (June).

Weinstein, J. (1997) "And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System", in *University of Miami Law Review*, Vol. 52 No. 79, pp 79-175.

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[1] In discussing the privacy of Dutch family life with Lamers-Winkelman, it is clear that the basis for this is different in The Netherlands than in Ireland and stems from the tradition of tolerance, rather than religious respect for the family, as was the case in Ireland.

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PLANNING AND IMPLEMENTING SERVICES TO PROMOTE THE WELFARE OF CHILDREN

by Norman Tutt

ABSTRACT

This paper describes work undertaken by Social Information Systems (SIS) in Ireland, England and Wales to identify and quantify those children defined in legislation as "not receiving adequate care".

The work attempted to link Agencies' policy statements and operational definitions with assessment practices and resource allocation. In doing so it has become evident that the information held in agencies is limited and unable to identify:

- Current expenditure on activities aimed at promoting the welfare of children.
- The impact of expenditure on promotional activities in terms of demand and expenditure on safeguarding activities.
- Whether expenditure is correlated with need.

Keywords: Child Welfare; Management and Planning of Services.

INTRODUCTION

The past decade has seen attempts by governments and administrations in the Republic of Ireland, England and Wales and Northern Ireland to undertake radical reforms of their child care systems. These reforms are based on the general principles that:

- Parents should be enabled and supported to exercise their responsibilities for their children.
- The statutory services have a responsibility to promote the welfare of children who are not receiving adequate care or are in need.
- Children have a right to be protected from substantial risk or abuse.

It is the second of these principles which has proved problematic for statutory services since it requires a consensus amongst a complex set of organisations and parties on the concepts of "adequate care" or "in need".

In England and Wales the Children Act 1989 introduces the concept of children in need. The legal definition as stated in S.17 of the Act is broad. A child is "in need" if:

a) he (sic) is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by an authority under this Part;

b) his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services; or

c) he is disabled.

In the Republic of Ireland the Child Care Act 1991 defines under Section 3 the responsibilities of the Health Boards:

3 (1) It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.

(2) In the performance of this function, a health board shall:

a) take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area;

b) having regard to the rights and duties of parents, whether under the Constitution or otherwise:

i) regard the welfare of the child as the first and paramount consideration

ii) in so far as is practicable, given due consideration, having regard to his age and understanding, to the wishes of the child.

c) have regard to the principle that it is generally in the best interests of a child to be brought up in his own family.

The Act does not clearly define which children are to be determined by the phrase: "not receiving adequate care and protection". However, under Section 8 of the Act Health Boards are required to produce annually a report on the "adequacy of childcare and family support services available in its area". Section 8 (2) states:

> "a health board in preparing a report under this section shall have regard to the needs of children who are not receiving adequate care and protection and, in particular:
>
> a) children whose parents are dead or missing
>
> b) children whose parents have deserted or abandoned them

c) children who are in the care of the board
d) children who are homeless
e) children who are at risk of being neglected or ill treated
f) children whose parents are unable to care for them due to ill health or for any other reason."

In listing these six particular categories of children the legislation goes some way towards defining the children to whom the board has a statutory responsibility.

In the North of Ireland the Children Order 1995 was implemented in November 1996 and similarly introduced into legislation the concept of children in need. Whilst the legislation defines children in need the legal definition requires local interpretation. The concept is, however, critical to ensuring a new era of support to children and their families since, the Children Order required Health and Social Services Boards to promote and safeguard the welfare of children. They must intervene as necessary to keep children safe from significant harm and to promote their well-being to ensure that they have a reasonable standard of health and development.

One of the complications to implementing the Order has proved to be its derivation from legislation developed for England and Wales. In England and Wales statutory health and social services are structurally separated, social services provided by local government, health services by central government through the National Health Service. However in the North of Ireland, Health and Social Services are provided under the same structure through joint Boards similar in some respects to the provision of child care services by Health Boards in the Republic of Ireland. The application of legislation based on England and Wales has led to substantial difficulties in defining children in need. The order states a child is in need if:

> *"he is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by an authority under* **this part** *(i.e. Part IV)".*

As this definition is stated it would immediately appear to relate to an authority i.e. Board which provides both health and social services, especially since the substance of the definition refers to **standard of health or development**. However when Part IV is examined it refers specifically to the following services:

> *"Provision of* ***personal services for children in need***
> *Day-care for pre-school and other children*
> *Childminding*
> *Accommodation for children*
> *Parental responsibility*
> *Accommodation for children in police protection"*

Thus, three different legislative enactments operating in three different organisational structures are attempting to implement improved services to a group of children who are variously described as:

- children in need
- children not receiving adequate care

Social Information Systems (SIS) an independent research consultancy based in North West England has worked with local authorities in England and Wales and Boards in Ireland and the North of Ireland with the intention of developing position statements which:

- provide an agreed operational definition of children in need compatible with the new legislation
- identify and locate children in need and the current and projected level of demand of such children
- determine costs of the service options available to meet the needs of children operationally defined as "in need"

Through this work SIS has developed a robust methodology which is described in this paper with operational examples. The methodology described is a process through which both groups of child care managers and practitioners within an agency can contribute to the development of policy and practice. SIS staff would conduct group discussions with practitioners to identify local perceived need, local assessment practice and resources. With child care managers SIS has developed a format for reconfiguring current budgets in order to reflect the new activities envisaged in the legislation. For example, budgets which are traditionally split between residential and fieldwork services are unable to identify expenditure, which may be drawn from both services, on the activity of family support.

Having worked through a structured programme with practitioners and managers SIS produces a report which attempts to integrate Agency policies, practice and budgetary arrangements.

ASSESSMENT OF NEEDS

With the exception of the U.N. Convention on the Rights of the Child, which whilst a useful statement of principle, does not specify operational definitions, there is no agreed definition of the needs of children nor any form of common assessment process. Accordingly when Social Information Systems has worked with an agency, whatever the jurisdiction, it has adopted an approach developed and tested in many settings (see SIS, 1995). This approach has seven key elements:-

a) Development of clear policies and operational guidelines about which children are eligible for a service.

b) Estimating needs.

c) Defining priorities.

d) Development of assessment procedures to identify children not receiving adequate care.

e) Reviewing services options.

f) Defining resources for service priorities.

g) Defining and using management information datasets.

A. Development of clear policies and operational guidelines about which children are eligible for a service.

All those involved in children's services need to know the aims of the service. The written statement of policy should make these clear, indicating which needs the Authority or Board (hereafter referred to as the Agency) intends to tackle and what outcomes they wish to achieve. The policy should provide clear direction to staff at all levels and to agencies working within the area.

It is most helpful if the statements are developed with other local agencies and with families using or likely to use services. Operational guidelines should include criteria which help staff and potential users understand who is eligible to receive a service. Staff need such criteria to assist them in making a reality of the aims.

Reviews of services for children in need in Ireland, the North of Ireland and England and Wales have found that guidelines which offer illustrative categories of children and their conditions are most helpful. Such guidelines help staff to use their discretion in interpreting if a child is in need under an Act, and allow staff flexibility when new needs emerge locally, e.g.:

- Children suffering or likely to suffer significant harm as a result of their own or their family's homelessness;
- Children leaving or having left care who require after care advice, counselling and support services;
- Children who face a serious risk of family breakdown which is likely to lead to significant emotional, physical or developmental impairment.

B. Estimating need

The Agency will need to gain some idea of how many children are likely to meet the criteria for eligibility it has described. The Agency can rely on available sources of information not always easily accessible such as the child protection register in England, Wales and Northern Ireland or the numbers of children in care or supervised by the Agency. It can broaden this by looking at all referrals. The

Agency might draw on existing databases held by other agencies such as Education. It could also look at geographical areas of high need, using census information about factors known to add to the likelihood that children will need to be offered care or supervision. It might use an Information Technology based geographic information system to help them identify areas where children with priority needs cluster. (See for example Assessment of Need for Services for Children and Families in Need in Southern Health and Social Services Board (1994) C.I.R.A.C.: Belfast.) In addition, and in keeping with the above statement, **discussions should take place with child care staff who are familiar with particular needs in their area.**

A "triangulation" method can be developed in which; demographic data, register data, and child care staff data, can be aggregated to produce a comprehensive picture of need in the area. If the Agency wishes to promote the welfare of children not yet needing to be safeguarded it will look at wider information. It should audit need in sample areas. Assessment procedures for individually referred children will eventually provide aggregate data on the level of need within the eligible groups and assist decisions about priorities and response.

However, it is essential for the management of services to develop key indicators of need from existing data to ensure equity of resource distribution. What follows is an example of the key indicators which can be applied to identify location of need and variations across an authority.

a) The total population of young people under 18 years of age in each area.

b) The rate of referral per 1,000 of the population 0-18 years per area.

c) The rate of referral specifically for child protection per 1,000 of the population 0-18 years per area.

d) The rate of confirmation of child abuse per 1,000 of the population 0-18 year per area.

e) The confirmation rate of child abuse i.e. the proportion of referrals confirmed per area

f) The rate of children in care (both voluntary and statutory) per 1,000 of the population 0-18 years per area.

C. Defining priorities

Not all children who fall into the illustrative categories determined by the Agency will have equally pressing or worrying needs. Therefore, it will be helpful to have clear statements about priorities: statements about what kinds of situations will receive what kind of response.

Experience has shown that statements about priorities are most helpful if they:

- are as simple as possible;
- apply to individual cases in the same way across the agency;

- make it clear that a child in any need category may have high, medium or low priority. Consequently, children with high level needs arising from homelessness may have greater priority than children with low level needs in the child protection group;
- recognise that children's needs may vary in priority over time;
- indicate that the response should relieve the urgency of the child's need, and, over time, meet the need fully; and
- indicate how quickly responses are to be made to different needs.

D. Development of assessment procedures to identify children not receiving adequate care

Assessment procedures should help staff to implement the Agency's policy. Two main kinds of assessment are required:

- screening which clarifies if children meet the Agency's criteria for eligibility and priority. Screening should provide enough information to enable staff to judge if they should direct children and families to other agencies.
- more considered and detailed assessment to be used in priority cases. The framework should be flexible, to allow the process of assessment to reflect the nature and complexity of needs in each case.

Assessment procedures are most helpful if they:

- assist staff to gather information with minimal duplication of effort;
- are needs-based, not service-led;
- are related to desired outcomes;
- take account of the Agency's timescales for responding to referrals in accordance with urgency and priority;
- are flexible and can be adapted to presenting needs;
- include the wishes of children and families; and
- allow for collaboration between disciplines and agencies.

E. Reviewing the service options

The Agency may find it helpful to review service options for eligible children, by auditing current services and considering possible future services against two dimensions.

This may assist the Agency in identifying what its priorities have been and in determining and monitoring them for the future. Describing the activity and services of other care programmes and agencies in this way may assist agreement about complementary contributions to joint plans.

As indicated by the diagram, below, services for children can be distributed on a continuum from specific to universal. Specific services are tailored to the needs of an individual child. All children, or all those in a clearly defined group, are entitled to universal services.

Figure 1:

		ACTIVITY	
		SAFEGUARDING	PROMOTIONAL
SERVICES	SPECIFIC		
	UNIVERSAL		

Similarly, activities can be distributed on a continuum from safeguarding to promotional. Safeguarding activities are always specific to the needs of the individual child. Promotional activities may be universal or specific depending on the needs and circumstances of the child.

The chart below indicates where different groups of children in need are more likely to cluster on the two continuums. For the purposes of the diagram membership of the groups are treated as discrete. In practice they often overlap.

Figure 2:

		ACTIVITY	
		SAFEGUARDING	PROMOTIONAL
SERVICES	SPECIFIC	abused children children at risk of abuse children in statutory care children in voluntary care children with drug or alcohol use	children leaving care children at risk of offending
	UNIVERSAL	pre and post natal screening and services	children living in areas high of deprivation children living in deprived families

Services may be similarly plotted.

Figure 3:

<table>
<tr><th></th><th></th><th colspan="2">ACTIVITY</th></tr>
<tr><th></th><th></th><th>SAFEGUARDING</th><th>PROMOTIONAL</th></tr>
<tr><td rowspan="3">SERVICES</td><td rowspan="2">SPECIFIC</td><td colspan="2">referred family centre</td></tr>
<tr><td>child protection investigation
fostering
residential care
child psychiatry facilities
voluntary care
“respite care”</td><td>counselling
day nursery
after school groups
parenting group</td></tr>
<tr><td>UNIVERSAL</td><td>accident prevention programmes
health education on drugs and alcohol
child abuse protection programme</td><td>family resource centres
community mothers
nurseries</td></tr>
</table>

Some services may have different functions at different times and for different children. Thus, to be useful, the plan must examine the purposes of activities, so the Agency is clear about the balance between its safeguarding and promotional activities.

The Agency will wish to consider if the amount of promotional activity is sufficient and how it may be augmented. The Agency will wish to monitor if changes in the amount of promotional activity affect the rate and/or level of safeguarding activities.

F. Defining resources for service priorities

Having established the principles, structures, processes and procedures that should be in place for children not receiving adequate care, the Agency should examine the balance of resources available to meet needs using the safeguarding and promotional dimensions. The Agency should examine the current balance of spending and develop any realignments in expenditure it wishes to see over the planning cycle e.g. three years.

The following diagram, based on the 1996 budget illustrates the current balance of spend for one Health Board in Ireland.

TABLE I:
BALANCE OF SPEND (1996) ON
“SAFEGUARDING” AND “PROMOTIONAL” WORK IN THE CHILD CARE SERVICES IN ONE HEALTH BOARD IN IRELAND

“SAFEGUARDING”	“PROMOTIONAL”
£22,049,000 *	£4,926,000 *
Made up of:	Made up of:
Residential care	Family Centre
Fostering	Family Resources
100% of social work costs	Family Support
100% of child care worker costs	Supported Lodgings
	100% of community worker costs

* These figures account for £26.9 million, the total Board budget for childcare is £29.4 million.

The balance of spend between “safeguarding” and “promotional” activities usually shows wide variations within and between agencies regardless of legislation or organisational context. Thus, for each area or operational unit within an agency not only is it necessary to have key indicators of need (see above) but also key indicators of expenditure on services to meet these needs. This is required both to ensure equity of resources between areas but also between different groups of children with different needs. Key indicators of expenditure include:

a) The Total Child Care “spend” per area.

b) The “spend” on “promotional” child care activity per area.

c) The proportion of the “promotional spend” of the total child care spend per area.

The variations in allocation of resources between areas even within the same Agency is indicated by the figures generated from the North of Ireland where the four Health and Social Services Boards not only show variations between them, but the Trusts operating under any one Board demonstrate even greater variations.

TABLE II:
PROPORTIONATE DISTRIBUTION OF BUDGET ON "SAFEGUARDING" AND "PROMOTIONAL" ACTIVITY BY BOARDS AND CONSTITUENT TRUSTS IN NORTHERN IRELAND

	"SAFEGUARDING"	"PROMOTIONAL"
BOARD A	66.7%	27.3%
Trust I	69.0%	23.8%
Trust II	66.1%	28.3%
BOARD B	68.2%	23.7%
Trust I	62.4%	26.6%
Trust II	74.5%	21.5%
Trust III	75.0%	19.3%
BOARD C	74.2%	21.9%
Trust I	70.1%	29.5%
Trust II	87.3%	8.9%
Trust III	72.0%	22.0%
Trust IV	73.1%	19.3%
BOARD D	66.5%	30.6%
Trust I	64.1%	34.3%
Trust II	70.7%	23.9%
PROVINCE	70.8%	24.5%

The current 'balance of spend' on 'safeguarding' and 'promotional' activities both of individual Trusts and Boards in the North of Ireland should not be seen as out of line with what occurs elsewhere. The following information, generated in six SIS client sites is illustrative of the range of such 'balance of spend' exercises in England and Wales.

TABLE III:
COMPARATIVE "SAFEGUARDING" AND "PROMOTIONAL" COSTS IN A SAMPLE OF SIX ENGLISH LOCAL AUTHORITIES

LOCAL AUTHORITY	"SAFEGUARDING" COSTS	"PROMOTIONAL" COSTS
A	60.7%	29.7%
B	81.1%	16.7%
C	73.2%	16.8%
D	78.0%	13.9%
E	70.0%	15.2%
F	41.9%	43.8%

The variations between areas shown within an agency are replicated between activities within agencies. The analysis of costs undertaken by SIS in Wales illustrates this point.

TABLE IV:
RANGE AND AVERAGE OF COST HEADINGS BETWEEN WELSH AUTHORITIES' SOCIAL SERVICES AND CHILD CARE ACTIVITIES

	RANGE (%)	AVERAGE (%)
Fieldwork Costs	15.8% to 42.6%	32.2%
Residential Resource Centres	13.9% to 42.6%	28.7%
Fostering / Family Aides	12.4% to 28.7%	19.5%
Other Specialist Staffing	0.6% to 8.3%	3.6%
Admin.	1.4% to 18.5%	6.8%
Budget Sub-totals	75.0% to 99.2%	89.2%
Grants /Service Agreements	0.8% to 12.5%	6.9%
Unattributed Costs	0.1% to 12.5%	5.2%

Whilst it is not appropriate to draw direct comparisons between the three systems since the data collected not only relates to different financial years, but also relates to different stages of legislative implementation i.e. England and Wales have five years of operating the Children Act 1989, North of Ireland has experienced only one year of operating the Children (N.I.) Order 1995. However, with these reservations a comparison can be drawn.

TABLE V:
A COMPARISON OF THE BALANCE OF SPEND ON "SAFEGUARDING" AND "PROMOTIONAL" ACTIVITIES WITHIN THREE NATIONAL CHILD CARE SYSTEMS

	"SAFEGUARDING" COSTS AS % OF CHILD CARE EXPENDITURE	"PROMOTIONAL" COSTS AS % OF CHILD CARE EXPENDITURE
Ireland	81	19
North of Ireland	70.8	24.5
England and Wales (Sample authorities N = 6)	77.4	22.6

The very high proportion of costs allocation to Safeguarding activity reflects the emphasis in all three systems on maintaining child protection services, as a response major public enquiries e.g. Kilkenny Incest Investigation (McGuinness, 1993, and the major review of residential care, Utting 1991). What should be noted is that despite organisational, legislative and financial arrangements within the three jurisdictions there is a surprisingly high degree of similarity on one outcome measure, namely the proportion of the child population placed in statutory care.

TABLE VI:
THE PROPORTION OF CHILDREN IN STATUTORY CARE PER 1,000 POPULATION UNDER 18 YEARS OF AGE IN THREE NATIONAL CHILD CARE SYSTEMS

	PROPORTION OF CHILDREN IN STATUTORY CARE PER 1,000 POPULATION UNDER 18 YEARS OF AGE
England (1995)	4.4
North of Ireland	5.6
Ireland (sample 1.2 million i.e. 1/3 population)	4.49

While the overall balance of budgets on 'safeguarding' and 'promotional' activity are a useful summary statement from which to develop a budget strategy, it is important to realise that within these categories there are significant variations. The following Table shows the range of budget allocation within the 'safeguarding' and 'promotional' heads within authorities in Wales.

TABLE VII:
THE RANGE OF PROPORTIONS OF CHILD CARE BUDGETS ALLOCATED TO SPECIFIC CHILD CARE ACTIVITIES WITH LOCAL AUTHORITIES IN WALES

SECTOR	HIGHEST	LOWEST
Children in Statutory Care	59.6%	30.9%
Children in Voluntary Care	17.8%	8.7%
Child Protection	23.5%	11.5%
Family Support	27.2%	5.2%
Children with Disabilities	10.6%	1.4%
Leaving Care Services	6.8%	0.6%

The information provided in these Tables, although a 'best estimate' of disaggregated budgets, does enable Agencies to begin to examine the implications of changing the current 'balance of spend' in children services, particularly in relation to provision for children in need. Four options clearly present themselves when considering implementation of the Legislation:

i) Ensuring that the balance of expenditure between 'safeguarding' and 'promotional' services is in line with policy objectives under the legislation.

ii) Ensuring that any additional allocation for 'promotional' budgets is distributed in order to reduce unintended historic variations within categories of children in need.

iii) Ensuring that any additional allocation for 'promotional' budgets reflects the range of the operational indicators of children in need (see above).

iv) A combination of the above.

G. *Defining and using management information datasets*

The Agency will need a system for monitoring and evaluating child care activity at regular intervals. It will need to know:

- what needs are being presented;
- what is the response to those needs;
- what are the outcomes of the responses; and
- if any of these change over time.

Clearly there is an urgent need to develop an information strategy to meet the requirements of the legislation. This strategy should develop a common dataset, related to the agreed definition for children not receiving adequate care or in need. The dataset will need to draw on case file and workload data, as well as resource and financial data. By drawing together aspects of this information on needs and services, the common dataset will provide the Agency with a position statement on child care activity.

These position statements can be used by the Agency to assess how far it is doing what it intended. The Agency can use its position statement to review the viability and appropriateness of the policies and strategies outlined in their children's services plan and revise their plan as necessary. This should form the basis of the annual report to the Department of Health.

The annual monitoring of activities and cost is essential to an understanding of the interaction between spending on promotional and safeguarding services. It would be predicted, but needs to be confirmed, that those areas spending the higher amounts on promotional services in doing so to reduce the numbers of children entering the safeguarding services. If this interaction is not found or contradicted in future examinations of the data then management action would be required.

CONCLUSION

The child care legislation in Ireland and England and Wales demands that Agencies refocus their services from the statutory care and protection of children to the promotion of the welfare of children. To meet the objectives of the legislation Agencies must firstly be clear through both policies and practice who are the groups of children whose welfare will be promoted since it is clearly unrealistic for any agency to believe it can promote the needs of all children. Within the defined target group priorities will need to be set since some children's needs are more pressing and failure to meet those needs has greater implications than for some other groups.

To ensure equity of access to services it is essential that child care practitioners devise and apply common forms of: screening of referrals, assessment of children and application of eligibility criteria.

However, equally for child care service managers there are major challenges in implementing the spirit of the legislation. Managers are required to develop ways of:

- measuring the needs within and between operational areas
- measuring the priorities within and between groups of children with differing needs
- allocating resources to ensure equity of access to services between areas
- allocating resources to ensure equity of access to services for children with differing needs
- monitoring the allocation of resources to ensure that investment in promotional activity produces reduced demands for safeguarding activities.

Social Information Systems, working in three different contexts, have developed a robust methodology for assisting in this process of assessing the social needs of children and matching the results against current expenditure patterns.

In carrying out this work it has become all too evident that the information held in agencies is limited, and, perhaps more importantly, the financial systems operating have not kept pace with changes in legislation and do not allow managers to budget in ways required to achieve operational goals. Thus, few agencies are able to identify:

- Current expenditure on promotional activities.
- Impact of expenditure on promotional activities in terms of demand and expenditure on safeguarding activities.
- Whether expenditure is correlated with need.

Clearly financial and planning systems need to be integrated to ensure the philosophy of recent childcare legislation is put into operation otherwise the aspirations of well intended legislation aimed at improving the lives of children will once again be frustrated.

REFERENCES

Social Information Services (1995) *Defining and Managing Children in Need.* Knutsford: SIS Ltd.

C.I.R.A.C. (1994) *Assessment of Need for Services for Children and Families in Need in Southern Health & Social Services Board.* Belfast: C.I.R.A.C.

Kilkenny Incest Investigation (May 1993). Dublin: Stationery Office.

Utting, W. (1991) *Children in the Public Care - A Review of Residential Child Care.* London: Department of Health.

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BOOK REVIEW

***Lives in Care - Issues for Policy and Practice in Children's Homes*, by Michele Clarke (1998) Mercy Congregation and the Children's Research Centre, TCD**

In recent years, the Irish Residential Care system has been subjected to much needed attention and debate. An emerging negative image of care services inadvertently may have led some (if not many) childcare workers towards feelings of being undervalued professionally and under-skilled in their work. The recent introduction of Regulations for Residential Care Centres, under the Child Care Act, 1991 although welcome, without specific guides to good practice may prove worthless. In this context, *Lives in Care: Issues for Policy and Practice in Children's Homes* provides some real assistance for practitioners. This book gives a comprehensive review of care provision in 17 residential childcare centres under the direction of the Sisters of Mercy congregation. The book focuses on childcare policy and practice in four specific ways. Firstly it considers the performance of the centres as viewed by the most important people in the care system, namely children/adolescents living in residential homes. Secondly, it explores key factors regarding the professional practice of staff, including issues of their own safety. Thirdly, the author considers each of the child care regulations and offers advice on best policy and practice in this regard. Finally, and maybe most importantly Ms Clarke sensitively highlights faults and failings in the centres under review, as well as affirming good practice. The author also offers clear recommendations for improvement, grounded in the real world of working with children in care.

This book will act as a very handy guide to childcare students, practitioners and managers of residential centres, apart from having value for other related professionals and childcare researchers. In many ways this publication can be viewed as a blueprint to good practice in childcare for the coming millennium. Importantly, this publication is a beacon of hope for honourable care workers interested in developing residential care as a safe and effective site for the welfare of children in the care of the state. Michele Clarke, Trinity Children's Research Centre and the Mercy Congregation are to be commended for producing a volume that, in the opinion of this reviewer, should be compulsory reading for all child care professionals.

Pat Dolan

Pat Dolan M. Litt., is Regional Co-ordinator of Adolescent and Family Support Services in the Western Health Board and with Mr John Canavan and Dr John Pinkerton he is currently co-editor of the forthcoming publication *Family Support: International Directions for Theory and Practice.*

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