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De-institutionalisation of services for children in state care in Ireland – A case study of international relevance

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In the field of child welfare, Ireland has implemented successfully a policy of de-institutionalising out-of home care for children and young people. This policy has been based on an evolving model of reformed provision that now combines heavy reliance on family placement, with some community based preventive programmes and a residual amount of residential care for very specific and tightly delineated groups of young people. This paper traces the development of this process of de-institutionalisation and explores possible lessons that may be drawn from the Irish case internationally. The author has been a participant and researcher in many of the developments over the period discussed in the article (as trainee social worker, social worker with children in care, foster carer, founder/ manager/ board member of innovative programmes etc).

Historically, Ireland has had a notable tendency to rely on institutional provision to serve various vulnerable, troubled or troubling populations of all ages, a trend still very evident well into the mid twentieth century. O'Sullivan and O'Donnell (2007) report, for example, that in 1951 'one per cent of the [Irish] population was behind closed doors in prisons, borstal, reformatory and industrial schools, psychiatric institutions (as involuntary patients) and homes for unmarried mothers', a rate which they note was *eight times* greater than was to be found in the equivalent settings fifty or so years later in 2002.

How was such a major change achieved? How was the aggregate rate of institutionalisation reduced so dramatically since the 1950s? Inevitably, there are likely to be many contributory factors that may help account for the change that has been achieved. These factors may be linked to favourable shifts in background conditions, as well as to specific active policy measures related more directly to actual provision. While social and economic conditions undoubtedly improved over the second half of the twentieth century in Ireland, this improvement alone does not account for the extent of de-institutionalisation achieved. Indeed, improving conditions also led to a *fall* in emigration from the country, a side effect of which might have been expected to *increase* pressures to institutionalise 'problem cases' previously diverted abroad through emigration. While emigration was most linked to general economic pressures, sometimes social problems were also at the heart of individual choices to leave the country. In the relevant period, candidates who saw themselves as at high risk for possible admission to institutions sometimes chose to leave the country to avoid any prospect of being placed in, or committed to, an institution. This was, of course, most relevant to adults, but older teenagers and parents might occasionally have chosen emigration as an alternative to being caught up directly, or indirectly, with institutionalisation. The overall point here is that achieving such a dramatic fall in populations accommodated in institutions since the later decades of the twentieth century is all the more remarkable in a period in which emigration

rates had also fallen substantially. According to previous experience, the expectation would have been the opposite, that without the 'safety valve' of emigration, the 'demand' for institutional care would have grown, yet the opposite proved the case.

This record of very substantial de-institutionalisation makes Ireland an interesting 'case' for study in relation to the promotion of de-institutionalisation internationally. What conditions and what policy measures and actions account for the levels of de-institutionalisation in the Irish case? While each national context is different, policy lessons may be available to be drawn discerningly from one country to another. This article is written in that spirit. It examines the Irish experience of de-institutionalisation through a focus on relevant developments in the field of child welfare, and seeks to offer insights that may be of value to child welfare and other personnel grappling with the challenges of de-institutionalisation.

Child welfare represents an appropriate choice of focus for this case study for a number of reasons. There is a variety of evidence, internationally, that suggests that institutionalisation in childhood may prove a 'gateway' experience to further institutionalisation in one or more sectors in adult life. Therefore achieving de-institutionalisation in children's services is, arguably, of wider systemic importance, beyond the benefits it confers immediately on children directly. In principle, therefore, child welfare makes a good case for study. There are also specific features of the Irish case that make it additionally relevant. De-institutionalisation has been achieved in Ireland in a period that has also seen a relative and absolute increase in numbers of children in public care and in touch with the broader child protection and welfare system. At the end of 2009, there were 5674 children in the care of the Irish state. This compared to a total of 4200 children in its care at the end of the 1960s, then comprised of an estimated 3000 children who were in residential care (71 %) and 1200 in foster care (29 %) (O'Sullivan and Breen 2008). By 2009, the equivalent proportions in the two types of care had been reversed quite dramatically: 5100 (90 %) were now in foster family care (including relative care) and 395 (7 %) were in residential care (with the balance in a variety of miscellaneous arrangements – pre-adoption etc) (Dept. of Health 2011). Over the forty year period that marks conscious efforts at de-institutionalisation, the following trends have been noted:

- a decline in numbers in care until the mid 1980s from which time, there has been a steady upward trend in annual numbers of children in care (O'Sullivan and Breen 2008)
- A fall in number in residential (institutional) care from 3000 to 300 or so, or from a share of the total from 71 % to 7 % (O'Sullivan and Breen 2008; Dept. of Health 2011)
- A corresponding rise in the numbers in foster family care (including relative care) from 1200 to 5100, or from 29 % to 90 % (O'Sullivan and Breen 2008; Dept. of Health 2011).

This reduction in numbers of children cared for in institutions has been secured on the back of a huge increase in the number of foster families, implied by an almost 4000 increase in children placed in foster care on a given day. Extrapolating from 1994 data (Gilligan 1998) which reported that there were 1839 foster families in the state, (yielding an average of 1.24 children placed per foster family), it is estimated that there were approximately 4000 foster

families active in 2009, representing a more than doubling of the number of foster families in a period of 15 years. Taking account of these achievements, it is argued that the Irish case, in the area of child welfare, may hold relevant insights for countries now embarking on a policy of de-institutionalisation in fields such as child welfare, disability and mental health.

While there has been major progress in achieving de-institutionalisation in the child welfare field in Ireland, it is also important to stress that in some respects the process is still a work in progress. There have been major achievements: the closure of many institutions (and, often, of their successor institutions), the recruitment of many foster carers, the recruitment of many social workers who have effectively driven the process of de-institutionalisation from the front line. But there are still gaps to be closed in terms of achieving a wholly satisfactory and sustainable set of de-institutionalised provision. Inevitably, the process can be discerned more sharply in retrospect than in prospect. There were various policy moves along the way that have proved important; some of these were less expected or predictable than others. These will be referred to at relevant points but include in the very earliest stages official policy encouraging the use of foster placements instead of institutional placements, and later the Kennedy Committee report (Commission of Inquiry into the Reformatory and Industrial School System, 1970) that proved a watershed in shifting mindsets away from the large scale institutional model. There was then the gradual but widespread appointment of child welfare social workers who proved decisive in achieving a major shift to foster family care, and the unforeseen (in the early stages) emergence of placement with relatives as a significant form of care.

De-institutionalisation in child welfare has been largely implemented successfully in the Irish case, but there remain some challenges. One example relates to hard to serve sub- populations, for example meeting effectively the needs of children and young people with very challenging behaviour. A second example relates to ensuring adequate information about the overall operation and performance of the care system. Two examples will help to illustrate this information issue. The first is about the need to know more about the *foster carer* population, – their age profile, morale, intentions, motivation etc. A sufficient number of high quality foster carers is clearly crucial to sustaining a child welfare system that operates largely without institutions. Retaining the commitment and morale of foster carers depends on well tailored training and support, a set of activity in which social workers are key. Having a sufficient number of committed and high quality foster carers cannot be taken for granted. The supply of new carers is likely to be subject to many influences. Attracting good people is one thing, holding on to them is another. Crucially, carers must become – and stay – involved for something more than the money that being a carer may bring. The children in their care need their carers to have strong morale and motivation. Evidence on key trends in relation to recruitment and retention, morale and motivation are clearly important to planning for a stable and secure foster care system.

The Irish case of de-institutionalisation in the area of child welfare would suggest that while a clear vision or understanding of an outline template for developments at the outset is neccessary, it is also important to have this momentum for change sustained by various policy measures along the way. These may reflect and adapt to policy issues that emerge or

are understood more clearly over time. From the Irish experience, it would also seem that various groups and interests may be recruited to, or join, the cause of de-institutionalisation, often for a diverse range of reasons and motivations that may be linked as much to their own narrower agenda or interest as to the broader ambition of de- institutionalisation. One such example would be the gradual withdrawal of virtually all Catholic religious congregations from direct provision of institutional care, a role that previously they had more or less completely dominated. Their choice to withdraw was linked to shrinking recruitment and an ageing profile in their own ranks, as well as to their anxiety about the increasing complexity of running such institutions in line with modern standards and expectations, and in response to the needs of more troubled children, – the less troubled children being increasingly served in community based programmes (Gilligan 2009a).

How does the Irish Care system now operate?

Children and young people in public care for their own protection and welfare under the Child Care Act 1991 are the responsibility of the Health Service Executive (HSE). The HSE arranges placements for children received into its care and undertakes various measures regarding practical arrangements, planning and monitoring of the child's progress in the care placement. Children enter public care in two ways. They may do so on the authority of their parents who give consent to their child entering care. Or the child may enter care on the authorisation of the courts following a hearing. Such a hearing would deal with an application to the court by the HSE to protect the child by removing the child from his / her family and admitting him/her to HSE care, with a view to placement in a family or a residential care setting. The upper legal age limit for care is eighteen years, unless the young person remains in full time education when care *may* be extended until the course of education or training is completed.

As of 2009, there are almost 6000 children in care at any one time (Department of Health 2011). The great majority (90 %) of placements for children in care are with families, just over half (60 %) of all children in care are placed with non-relative foster carers These foster carers have been formally assessed and approved by HSE social work staff, with the support of assessment panels who review evidence and approve or amend recommendations submitted by social workers and their supervisors. In some limited number of cases, assessment of suitability may be undertaken by an independent agency approved by the HSE. The balance of children placed with families (30 % are placed with relatives, in arrangements that may sometimes be initiated by relatives themselves who then seek subsequent HSE recognition). Alternatively, HSE social workers may approach relatives to undertake the care of a child who has come to HSE attention as a child needing placement. Of the remaining balance of children in care (10 %), the majority (7 %) are placed in residential care settings (group homes, hostels, special care units etc) operated directly by the HSE or approved not-for-profit or for-profit providers. Generally, most or all care staff in these settings will be educated to third level (post secondary school / college / university levels) and/or be formally qualified as professional social care workers.

While children are formally in the care of the corporate body, the HSE, in practice, operational responsibility for all aspects of placement falls to social workers employed by the HSE

or, in a small number of cases, by approved independent agencies. In principle, every child has a social worker responsible for planning, arranging and monitoring care. Their work is to be complemented by a care planning process involving those persons with a relevant interest and stake in the child's progress. The daily care and control of a child in care is generally devolved to the carer or carers who has custody of the child. The carer would liaise regularly with the child's social worker and, in the case of family placement, with the link social worker appointed to provide a direct support and monitoring service to the carer family. This arrangement is a relatively recent development and may not yet be rolled out fully in all areas. Similarly, staff shortages may mean that not every child has their own social worker. While public finances have been severely constrained in recent years (2008–2012) due to national and international economic difficulties, the Irish government has remained committed to expanding the number of social work posts as part of its response to the recommendation of the Ryan Commission investigation of historical child abuse (Office of the Minister for Children and Youth Affairs 2009) . The Commission took the view strongly that while it may not be possible to reverse policy failures of the past, the way for the government to show true remorse was to commit to avoiding equivalent policy lapses in the present and future. This argument had a lot of political force with an electorate that had been shocked and appalled by the revelations of past abuse of children in institutions stretching over many decades.

In many senses, the social work role in relation to children in care in the Irish system is one of *gate-keeping*, ensuring that only the 'right' children (for whom the move away from home is absolutely necessary for their own safety and well being) get inside the 'gate' of the care system, and that once inside the gate they remain inside only as long as necessary. This is an important point: care in the Irish system is not necessarily a long-term arrangement. Coming through the gate does not necessarily mean remaining in care until the age of 18. A child may come for a much shorter period, from a number of weeks or months to longer. The assumption generally guiding practice is that if the family circumstances improve dramatically (a parent demonstrates, for example, a verified and enduring cessation of chronic drug use) then the decision to have the child remain in care may be re-visited and possibly be reversed. Social workers work to protect children, which may mean working to have a child move through the gate into care. But social workers generally take that step seriously and where it is taken they also remain open to the child leaving care to return home. Decisions are based on two presumptions: that it is generally best for children to live with their parents, and that it is difficult for the care system to be successful in raising children to happy adulthood. This does not mean that children are not taken into care, nor that they do not sometimes remain in care, but it does mean there must be strong justification for either option. In recent years, there has been criticism of the management of certain cases where it has emerged that social workers and fellow professionals failed to gather and share information crucial to the protection of children and to necessary decisions to remove them from very abusive or neglectful home circumstances (Health Service Executive 2011, pp. 160–163). In these cases, what was in effect intimidation of social workers by clients, failure by social workers and other professionals t appreciate the significance of the evidence confronting them, and failures to share critical

information across different service systems (family doctors, schools) added to the effect of the prevailing assumptions mentioned above in preventing or delaying decisive action.

The regulatory framework for the care of children currently in the care of the HSE is governed by the Child Care Act 1991 and subsequent legislation and by related Regulations (1995). In addition, there are National Standards in the process of being developed by the Health Information and Quality Authority (2010) to help it discharge its responsibility to inspect services. The inspection of residential centres is well developed. While standards against which to inspect foster care provision have been developed, the full operational roll--out of the inspection process is for foster care is still in its early stages.

What were the most critical policy developments relevant to successful de-institutionalisation?

The recruitment of social workers

From the early 1950s, there had been a formal policy favouring foster care over residential care. Placement of a child in institutional care by the health services was not to occur unless the child could not 'be suitably and adequately assisted by being boarded out'(Department of Health 1954). 'Boarding out' was then the administrative term used for foster care. Despite internal criticism by Mary Murray and Fidelma Clandillon, long-serving Inspectors for Boarded out Children in the Department of Health, little changed for a long time in terms of prioritizing foster care despite the requirement in the 1954 Regulations (McCabe 2003; O'Sullivan 2009). By the early 1970s, a confluence of pressures gradually led to change. In addition to the internal pressure mentioned [reflected presumably in the contents of the related Ministerial circular (Department of Health 1970)] , there was the influence of the recommendations of the Commission of Inquiry into the Reformatories and Industrial School System (Kennedy Report), the *CARE Memorandum* – a call for system change by an organization of children's activists (CARE – The Campaign for the Care of Deprived Children, 1972), and probably most decisively, in practice, the establishment of regional health boards under the Health Act 1970 (Gilligan 2009a). Charged with delivering health care to the population, the health boards aimed to provide community-based services where possible, and began to recruit social workers and other professionals to that end. Until there was a sufficient number of actual social workers available to do the hard work to 'put meat on the bones' of the policy of shifting away from institutional care, that policy remained as mere hollow rhetoric. The Irish experience serves to underline that a critical ingredient for success in de-institutionalisation , therefore, is having sufficient numbers of professional staff, especially social workers. Elsewhere, I have argued the importance of the role of social workers in securing the well-being of children in care (Gilligan 2000). Social workers are, of course, a necessary but not sufficient part of an overall approach to serving the needs of children in care. Other ingredients include recruitment and support of carers and good quality care planning.

In Ireland, social workers play three key roles in relation to children in family placement: in ensuring a supply of quality carers, in supporting those carers, and in supporting the foster children in the care of those carers. Social workers play a key role in relation to the

recruitment, assessment and selection of foster carers. They also serve as link social workers liaising on behalf of the agency with the carer who is caring for one or more foster children. This link role involves offering advice and support to the carer and also monitoring their overall performance of their role over time with different children. Each child in care, in turn, has an allocated social worker who is responsible for establishing a personal relationship with the child, monitoring the child's progress, managing the overall care planning process for the child, liaising with the carer about this specific child, liaising with the child's biological family, managing access arrangements for the child's family, organising placement beginnings and endings. Generally, the hope would be that long-term placements would be intended to last until the young person reaches 18 years of age, the official cut-off point for being in care. But in some circumstances the social worker may determine in consultation with their supervisor and other relevant stakeholders that the present placement is deficient in some critical ways. In such cases, and assuming there is no 'life and death' type urgency the social worker would be expected to arrange over time to move the young person to another placement, having done the necessary consultative and preparatory work with the child.

The rise of foster care an its wider significance

There had been, as has been discussed a policy on paper of favouring foster care since the early 1950s, but this only began to emerge gradually as a reality when various conditions to sustain the change began to fall into place, especially the appointment of social workers in sufficient numbers, a policy that has been rolled out steadily over almost 40 years. Achieving widespread use of family based care (including significant use of relative care) produces a number of social gains. It avoids the potential stigma and isolation of institutional care and generates greater community awareness of the needs of children in care through the social networks of carer families. Family based care may also help to resolve another challenge facing systems of care, providing good quality support for young people when they leave care. It is gradually being recognised that what happens to the young person beyond the care leaving age is critical to the young person's future well being and to the return on the effort invested in the child's care to that point (Gilligan 2008). The social worker is likely to play an increasingly important role in helping to identify the most helpful options according to the 'facts' of a case and the young person's wishes. A notable feature in the Irish case is the considerable proportion of family placements where the young person continues to live informally with the family as a *de facto* family member beyond the official care leaving age of 18 years, a pattern also reported recently in a study from Norway (Christiansen et al 2012). Indeed, I have argued elsewhere, for the importance of adapting formal leaving care policy to reflect this pattern and of exploring ways of extending the young person's stay with their carer, as might be the case of a 'normal' young person (not in care) in their own biological family (Gilligan 2011). Hook and Courtney (2011) report from a larger US study that staying in care beyond 18 influences employment outcomes favourably by affecting educational attainment. They also show how foster care seems to support more favourable employment outcomes than institutional care with 'youth exiting from group care or residential treatment [being] 63 % less likely to be employed and may earn lower wages than other youth'. There is some

initial Irish research which also points towards the positive potential of long term foster care in shaping positive outcomes for at least some young people in long term foster care (Daly and Gilligan 2010).

The closure of most institutions

As will be clear from earlier evidence, most institutional settings are now closed with only a small residue remaining with a very specific remit to service high need populations (Gilligan 2009b). If institutions are truly to close and not re-emerge in some other form, there has to be an absolute conviction and consensus on this point. There also has to be a viable alternative put in place and a feasible means of getting to that alternative from the starting point. A potential hazard on the journey of de-institutionalisation is the danger of confusing *re-configuring* institutions with de-institutionalisation. There are examples from the field of disability and child welfare where providers closed down the main institutional building having replaced it with a series of bungalow type units on the same campus, or alternatively had re-structured part of the original building into smaller separate units. While either of these approaches may have created an impression of improvement and modernisation, the underlying dynamic of institutionalisation remained largely unchallenged. A similar tendency was noted in a recent study of the care of children in southern Italy (Licursi, Marcello and Pascuzzi 2012).

The emergence of relative (kinship) care

A new development in the Irish system in recent years and one unforeseen at the outset of the de-institutionalisation process is that of relative care – a form of care first given legal recognition in the Child Care Act 1991 (O'Brien 2000). Relative care involves informal arrangements within family networks to provide care for relative children when parents are dead, missing or in difficulty are pervasive across cultures and time. In the late twentieth century, a variant of this began to emerge in certain countries based on incorporating such informal arrangements within the formal care system. This meant that the public care system would now regard approved cases of children as children in care and pay an allowance to the relative carer. In addition, social workers might also now use relatives as a first port of call when seeking out placement options for a child requiring care. There had been a long time resistance by policy makers in Ireland to paying for placement with relatives based on moral and financial grounds. The view was that relatives were obliged to care for each other and that payments would serve to erode this obligation – and cost taxpayers' money. However, as places in institutional settings began to be lost, the system was confronted with the reality that alternative placements somehow had to be found. Relative placements began to be seen as having many potential advantages, and so they soon became an important pillar of the Irish care system, now accounting for 30% of places for children in care.

The growth of community programmes

A range of community based preventive programmes have emerged following on from the recommendations of the Task Force on Child Care Services (1981) and the impact of the Child

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Care Act 1991 which required among other things the provision of preventive measures aimed at supporting vulnerable families in caring for their own children (Gilligan 1995). These measures included projects aimed at serving young or isolated parents at home (Johnson, Howell and Molloy 1993), centre based projects aimed at parents and families (McKeown, Haase and Pratschke 2001), and neighbourhood projects serving local young people at risk of requiring admission to care or other serious intervention (Pinkerton and Dolan 2007; Dolan and Kane 2005). There was also on a very restricted basis time the option of limited placement in local neighbourhood based residential units (in Dublin inner city) (Gilligan 1982, 1984). By retaining children in their local schools and in their local networks, these units aimed to reduce the stigma and disruptions normally associated with admission to care.

Scandals about institutional care

Like a number of other countries (for example, Australia, Canada, Netherlands), Ireland has experienced a wave of serious allegations about of children in the care of religious-run childcare institutions. The Irish child welfare system has been convulsed as these allegations, following comprehensive investigation, largely turned into revelations about seriously abusive and neglectful practices in earlier years (Commission to Inquire in Child Abuse [Ryan Commission], 2009). While most of this malpractice can be traced to periods before the explicit commitment to de-institutionalise, there were also quite a number of more recent examples, which is a salutary lesson that progress will not always be smooth and linear. It has also been argued that blame for this level of abuse in institutions lies not just with staff and management but also with the wider society which permitted the conditions conducive to such abuse (Powell et al 2012).

'New' voices in the child welfare system

The UN Convention on the Rights of the Child and Ireland's ratification served to highlight the issue of children's rights in Irish children's services and policies, and prompted the development of a highly influential cross-governmental National Children's Strategy (Government of Ireland 2000). This helped to increase sensitivity among policy makers and professionals to the importance of children as active stakeholders in children's services at different levels. One expression of this status for children was the emergence of the Irish Association of Young People in Care which was founded in 1999. Recently re-named EPIC (Empowering People in Care), the organisation sets itself the following tasks: to give a voice to what young people with care experience are saying; to explain the rights of young people in care; to give information, advice and support to young people with care experience, and to help people who work with young people in care to involve them more when decisions are being made about them (EPIC 2012). In the field of Irish child welfare research, one example of involving young people in residential care in research about their care experiences and in the attempted wider dissemination of the findings is reported in Emond and Gilligan (2007). Other stakeholder groups have also been organising to become more influential in the child welfare field. One example is the Irish Foster Care Association (IFCA) which was founded in 1981. It has a mission to promote foster family care and to represent the interests and concerns

of those working in, or depending on, the foster care system. A very important new player on the child welfare stage is the Health Information Quality Authority, whose regulatory remit extends more broadly but has been and will be influential in shaping development in out-of-home care (Gilligan 2009b).

Conclusion

A lot has been achieved in de-institutionalising provision in child welfare in Ireland. The current economic crisis poses challenges in terms of resources. Many of the changes are well embedded but others in the areas of strengthening care planning and information systems may now take longer to roll out fully. While there is still no room for complacency about the Irish achievements, this paper has argued that the experience of de-institutionalisation efforts in Ireland can offer some useful lessons to discerning onlookers from abroad who are facing into a similar journey.

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