



Towards a
Standardised Framework for
Inter-Country Adoption
Assessment Procedures

*A Study of
Assessment Procedures
in Inter-Country Adoption*

*for
Department of Health and Children*

*by
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19 April 1999

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Declaration

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The project team are independent researchers who have no connections or interests to declare in relation to any organisation or issue connected with the matters under consideration in this report, save as detailed below.

The Project Manager on this study, Dr. Valerie O'Brien, Dept of Social Policy and Social Work, University College Dublin, was appointed a member of the Adoption Board referred to in this report in February 1998. The attention of the Department of Health and Children, and the Adoption Board was drawn to this issue before the project was awarded to UCD. Dr O'Brien has absented herself from the meetings of the Adoption Board since the project commenced in December 1998.

Dr. O'Brien was a staff member of the Eastern Health Board's Fostering Resource Group (FRG) referred to in this report from 1991 to 1995.

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Mr Paul Harrison, Regional Director, Child Care Services, Eastern Health Board;
Ms Cora Hickey, Senior Social Worker, Midland Health Board;
Mr Peter Kiernan, Regional Director, Child Care Services, South-Eastern Health Board;
Ms Marie Lynch, Senior Social Worker, North-Eastern Health Board;
Ms Ita O'Brien, A/Regional Director, Child Care Services, Mid-Western Health Board;
Ms Mary Murphy, General Manager, Southern Health Board;
Ms Val O'Kelly, Regional Director, Child Care Services, North-Western Health Board.
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some profiles included in this report. They also undertook to send out letters/questionnaires to the selected adopters on our behalf.

The Project Advisory Group established to agree the terms of reference of the consultancy, to assist in the selection of the contractor to carry out the consultancy and to consider the draft report prior to its finalisation.

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Ms Pat Smith, Senior Social Worker, The Adoption Board
Ms Elaine DeLoughrey, Adoptive Parent, Romanian Support Group, Cork
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Ms Ingrid Stjerna, Ms Eva Kahn, Social Workers, Stockholm.
Ms Gunilla Andersson, The Adoption Centre, Sweden.

Table of Abbreviations

BAAF	British Association for Adoption and Fostering
CEO	Chief Executive Officer
Clann	The Regional Adoption Service of the Western Health Board
DoH&C	Department of Health and Children
EHB	Eastern Health Board
FRG	Fostering Resource Group
HB	Health Board
ICA	Inter-Country Adoption
IFAG	Irish Foreign Adoption Group
IVF	In-Vitro Fertilisation
MHB	Midland Health Board
MIS	Management Information Systems
MWHB	Mid-Western Health Board
NEHB	North-Eastern Health Board
NIA	National Board for Inter-Country Adoption, Sweden
NWHB	North-Western Health Board
ODA	Overseas Development Aid
OMPI	Output Measure and Performance Indicators
PACT	Protestant Adoption Society
PARC	Parents of Adoptive Romanian Children
PNPIC	Parent Network for Post-Institutional Children
SEEK	The Regional Adoption Service of the South-Eastern Health Board
SEHB	South-Eastern Health Board
SHB	Southern Health Board
SMI	Strategic Management Initiative
SSW	Senior Social Worker
SW	Social Worker
WHB	Western Health Board

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CHAPTER 1

Introduction

1.1 Terms of Reference

This report on Inter-Country Adoption was commissioned by the Department of Health and Children in November 1998, with Terms of Reference as set out below.

(i) the current assessment procedures in health boards to be reviewed in consultation with the relevant interests (this review should encompass both social work practice and service management)

(ii) an overview of current assessment procedures in health boards which identifies any particular issues which need to be addressed to be provided;

(iii) a standardised framework for carrying out of future assessments which accords with best practice in the field and delivers the service in the most efficient and sensitive manner possible to be proposed. Within this standardised framework, health boards should be able to exercise a degree of flexibility in the management of the service and in the detail of its delivery so that they can adapt it to the particular circumstances prevailing in their functional area.

(iv) the resource implications (on current application rates for assessment) of this proposed standardised framework to be estimated (this estimate to include staffing levels, management and administrative requirements etc.). The feasibility of introducing charges for assessments should also be considered in this context.

(v) any areas in which legislative or administrative change would improve the quality of the assessment process to be highlighted

Since the report was commissioned, there has been considerable media (print, radio and television) coverage of the subject of assessment for inter-country adoption, where prospective adopters have detailed objections to their experience of the assessment process. It was not part of our terms of reference to investigate individual complaints. However the views expressed have, in the general sense, formed part of the underlying enquiry. In our field work we have had the opportunity to hear many views of the issues involved. We have taken a systemic view of the issue, and made positive recommendations to improve the service.

The report was commissioned at a time when the Government's Strategic Management Initiative, which focuses on quality, efficiency and openness of public services delivery, is being implemented. We believe this is an opportune frame through which to review the ICA service and to make recommendations. The report contains discussion of aspects of the process. However, it also contains clear guidelines and recommendations which are our view of how this service can best be progressed into the future.

1.2 Report Structure

This report is structured in three parts.

In the first part the background on inter-country adoption and assessment of prospective adopters are considered in general terms in Chapters Two and Three respectively. The second chapter places the objectives of the research into context. Due to the declining numbers of children being put forward for domestic adoption, there is increasing recourse to inter-country adoption. An overview

of the situation is outlined. The legislation section outlines both Irish legislation and the pivotal international agreement relevant to inter-country adoption, namely the Hague Convention. The implications for inter-country adoption processes are described.

The third chapter provides an overview of assessment. A summary of the shifts in theoretical perspectives on adoption assessment indicates the movement from earlier vetting and investigative procedures to a current model of self-assessment. The assessment process itself has come under severe criticism for its duration, intensity, insensitivity and bureaucracy. The issues surrounding the content and the process of the assessment are outlined. The research undertaken for the purpose of the report indicates the absence of a comprehensive body of research on inter-country adoption assessment procedures.

In the second part of the report, details are given in Chapters Four and Five of the current health board procedures and practices for dealing with applications for inter-country adoption assessments. The similarities and differences which presently exist in each board's inter-country adoption assessment procedures are identified.

In the third part of the report, the current procedures and practices are analysed, with a view to recommending contextual and organisational improvements, as well as proposing a standardised framework of procedures and practices for the assessment of prospective adopters. An assessment scheme that is appropriate, fair, efficient and consistent across all health boards is required. The implications and implementation of this new framework, in terms of resources, management, administration and legislation are addressed in the final chapter.

1.3 Research Methodology

In this section the methods used to collect and analyse data for the report are explained. Data was obtained from a number of sources, and using a variety of research methods.

1.3.1 Literature:

The current literature and research on inter-country adoption and assessment was reviewed. A bibliography of the more important literature is given at the end of the report.

1.3.2 Quantitative Data:

The quantitative data used in the report is based on a number of sources. The principal sources of quantitative information were the health boards. Questionnaires were sent to each of the health boards at the earliest stage of the project. All health boards co-operated fully and provided the required information in very short time-scales. Each agency was asked to compile a profile for each case presented to their adoption committee in 1998, tracking the process from application to submission to adoption committee. Information was provided on all assessments completed during 1998, and a profile was provided of the social workers who carried out the assessments

In addition to the health board information, the Adoption Board provided access for the researchers to its files on inter-country adoption assessments in 1998. A biographical profile of applicants drawn from all home studies reports submitted to Adoption Board in 1998 (N = 166, which comprised 163 couples and 3 single applicants) provides baseline data on this population (presented in Chapter Two). In order to maintain confidentiality all identifying information was removed from the record before access was granted. The full total of home study reports processed by the Adoption Board in 1998 were examined.

A biographical profile of children entered into the Register of Foreign Adoption from 1991 to 1998 was compiled during the research and is used to provide baseline data (presented in Chapter Two).

1.3.3 Documentary Sources

A number of sources of documentary data were also examined during the project. These included:

Written documentation and training course material provided by each agency, which provided valuable background material prior to the agency visit.

One home study report was examined for each social worker who submitted reports to the Adoption Board in 1998. This was designed to familiarise the researchers with the style and content of reports and with practice issues prior to the agency visits.

In each agency the last three files presented to the adoption committee were examined at the time of the agency visit. The purpose was to review the content and length of case notes, and the styles of file-keeping.

Each of these data sources were used as background material to familiarise the researchers with individual agency practice. The description presented in Chapter Five is drawn in part from this source, and combined with the interviews conducted during the agency visits.

Material was also provided by different organisations and stakeholders involved in inter-country and domestic adoption. This documentation included previous submissions made to agencies and government departments and submissions provided for this research. Background information was also provided on certain issues in inter-country adoption.

1.3.4 Qualitative Data

There was a substantial qualitative research component to the project. Interviews were conducted in each Health Board with the following personnel:

- Social Workers
- Administrative Staff
- Team Leaders
- Senior Social Workers
- Child Care Managers
- General Managers
- Programme Managers Group
- Representatives of Placement Committees

These interviews were conducted after receipt of the initial quantitative information, which was clarified at the meetings, as well as considering process issues. This field-work was conducted primarily by Dr O'Brien and Ms Sanyal, and was for the most part tape-recorded. This material, with the documentation provided, formed the basis for the descriptions of current practice in Chapters Four and Five. The material was also examined for themes which have informed the analysis.

Meetings were held with a range of groups representing the stakeholders in the ICA process. These include:

- Parent Network for the Post-Institutional Child
- Romanian Adoption Support Group, Cork
- Adoptive Parents Association of Ireland
- Parents of Adoptive Romanian Children
- International Adoption Association (formerly Irish Foreign Adoption Group)
- Natural Parents Network of Ireland
- Adult Adoptees Association
- Adopted Peoples Association
- Council of Irish Adoption Agencies

A sample of sixty-two couples whose assessments were completed during 1998 were contacted through the Adoption Board, requesting that they provide information to the researchers on their perspective of the ICA process. This was aimed at obtaining applicants' views of most helpful aspects of the assessment process in preparing them for adoptive parenthood, the most difficult aspects, and the changes they would propose. Couples were selected from each of the Health Boards, and numbers were in proportion to the total numbers of reports completed by each Health Board during 1998. No identifying information was available to the researchers, and the questionnaire was returned anonymously. A total of 62 forms were sent out, and 51.6% (32) were returned.

Interviews were also held with individuals who had adopted a child from overseas and who contacted the researchers on their own initiative.

The research team again wish to acknowledge the help and co-operation of organisations and individuals in gathering data for this project.

1.3.5 Limitations on Data

Because of short time-scale involved in the preparation of this report, from late November 1998 to February 1999, it has not been possible to include a pilot data collection phase, as would be normal in research projects. This resulted in agencies interpreting some data requested differently. It will be seen that there are uncertainties in some of the data, which are referred to in the text of the report. These relate principally to the number of interviews, and confusion between first and second applications. Such difficulties would normally be overcome by piloting. However, the issues are relatively minor, and are not such as to affect the overall findings or proposals.

The data relating to the health boards in Chapters Four and Five has been referred back to each agency for validation purposes, and any inaccuracies noted have been amended. We would draw attention to the relatively small size of samples in the quantitative data sets, and the need to exercise caution in drawing conclusions where these are analysed across multiple variables.

1.4 Definition of Terms

The following are terms used throughout the report:

Agency

Refers to health boards and registered adoption societies, who are obliged and empowered respectively by Section 8 of the Adoption Act, 1991 to carry out assessments for Inter-Country Adoption.

Applicants

Refers to persons who have made an application to an agency under Section 8 of the Adoption Act, 1991 for an assessment. The phrase 'adopters' is also used in the report.

Assessment

Assessment is generally defined as a two-way process whereby the applicants and the agency share information and decide together if adopting a child will work for all the parties concerned, especially the potential child.

Birth Parent — Natural Parent

The use of the term 'natural parent' was requested by representatives of those who had children adopted. They saw the term 'natural parent' as a means of honouring their place in their child's life. The term 'birth parent' is preferred by many adopters and others involved in adoption, who see the use of word 'natural' as implying that adoptive parents are 'unnatural'. Because of the need for ongoing conversations about this topic, we have included both terms in this report.

Inter-Country Adoption

Inter-country adoption is the phrase used in this report to refer to the process of adopting a child from a different country. The term “foreign adoption” is used in the Irish legislation. Due to the inherent ethno-centric assumptions in this phrase, most of the literature on the topic uses the phrase ‘inter-country adoption’, and this is the terminology used in this report.

Placement Committee

The term ‘Placement Committee’ is used interchangeably with the term ‘Adoption Committee’ and ‘Case Committee’ in the health boards, and consequently also in this report.

1.5 Conclusion

During the past months, especially from September 1998 to the present, there has been increased media attention focused on the subject of inter-country adoption. Concerns regarding the propriety of inter-country adoption, the nature and duration of the assessment process of prospective adopters, the rights of natural parents, the efficiency with which the health board deals with applications and the effects of the adoption on the child(ren) involved, have been expressed vociferously by some those involved in the adoption process.

It is not our task to pass comment on the merits of the debate. However, many of the issues have, in general, been included in the scope of the research. An acknowledgement that assessment in inter-country adoption is in itself a difficult concept, due to the interplay of legislative, organisational, professional and consumer factors, is central to the report. The resolution of these difficulties should retain the “best interests of the child” as a fundamental premise. It is our belief that the recommendations in this report can provide a way forward from the difficulties which are currently experienced by participants.

CHAPTER 2

Inter-Country Adoption

2.1 Introduction

It is important to define the primary terms used in this subject. A comprehensive definition sees inter-country adoption as a world-wide phenomenon involving the migration of children over long geographical distances and from one society and culture to another very different environment (Van Loon 1990:17). Adoption has been traditionally defined as

a means of meeting the developmental needs of a child by legally transferring ongoing parental responsibility from birth parents to adoptive parents, recognising that in the process we have created a new kinship network that forever links those two families together through the child who is shared by both. This kinship network may also include significant other families, both formal and informal, that have been a part of the child's experiences (Watson 1994)

As such, inter-country adoption poses additional challenges for adoptive parents beyond those faced by biological parents and in-country adoptive parents, as it also involves cross-cultural and cross-ethnic elements.

2.2 Changes in Patterns of Adoption in Ireland

The growth of inter-country adoption represents the most significant change in adoption in Ireland since its introduction in 1952. The surge of interest in and recourse to inter-country adoption in Ireland developed in the late 1980's resulting from a number of factors, the most notable being the dramatic fall in the number of children being made available for domestic adoption. For example, in 1970 there were 1,317 non-family adoptions of Irish children approved by the Adoption Board. However by 1997 this figure had declined to 136 non-family adoptions. (Annual Reports of The Adoption Board). This decline was occurring at a time of demographic change represented by a rapid increase in the number of non-marital births from 2.7% of all births in 1970 to 26.6% in 1997 and a decrease in the rate of marriage from 7.1 per 1,000 population in 1970 to 4.3 per 1,000 population in 1997 (Report on Vital Statistics, Central Statistics Office, 1970 and 1997).

Over the same period, increasing numbers of never married mothers were choosing to parent their children rather than place their child for adoption. One study showed that between 1986 and 1990 the percentage of mothers placing their babies for adoption in one Dublin maternity hospital fell from 24.5% in 1986 to 7.1% in 1990 (Flanagan and Richardson 1993:79). This decrease can be accounted for by a number of factors such as the increasing acceptance of single parenthood in Ireland, the progress gained by the women's movement, the development of support groups for single mothers, such as *Cherish* and *Ally* and the introduction of the Unmarried Mothers's Allowance in 1973 (later to become the One Parent Family Payment) which made it more feasible to exist as a single parent family (Flanagan and Richardson 1993:77).

Mahon, Conlon and Dillon (1998) showed that about three-quarters of women who become pregnant outside marriage now become single mothers while about one quarter have abortions. They argue that the reason many women turn to abortion could be due to the fact that it enables them to conceal their sexual activity, prevents them from forming a relationship with the developing

embryo and enables them to resume their lives. Adoption on the other hand signifies a far more complicated alternative, one in which the final outcome is unpredictable.

In 1998, 100 Irish babies only were made available for adoption (Report of the Adoption Board for 1998 *in press*). This continuing trend of decline suggests that the disappearance of traditional adoption is imminent. It also indicates that prospective adopters have no alternative but to adopt children from abroad.

2.3 Increasing Interest in Inter-Country Adoption

There was extensive coverage of the plight of abandoned children residing in orphanages and residential institutions in Romania, following the overthrow of the Romanian leader in 1989. This led increasing numbers of Irish couples to travel to Romania to adopt and to provide children in orphanages with the opportunity of a family life in Ireland. However, on their return to Ireland they found that there were considerable difficulties in adopting the children under Irish law. No statutory provisions existed for the recognition of adoptions from abroad or to effect an Irish adoption of a child from outside the State. The adoptive parents grouped together and brought considerable pressure to bear on the government to legislate for the recognition of these adoptions under Irish law. As a result, the Adoption Act, 1991 was enacted providing for the recognition of orders effected outside the Irish State under Irish Law (Shatter 1997: 510-516).

Table 2.1 illustrates the significant increase in the number of inter-country adoptions in Ireland in recent years.

Table 2.1:

Number of Declarations granted and refused by Adoption Board to Applicants to apply to adopt overseas for the years 1991-1997

Year	Number Granted	Number Refused
1991	4	1
1992	40	1
1993	54	6
1994	63	3
1995	109	4
1996	117	5
1997	176	1
1998	206	3
Total	769	24

(Source: Adoption Board Annual Reports 1991-1998)

The table depicts a fifty-fold increase in the number of declarations of eligibility and suitability (approvals to apply to adopt abroad) granted by the Adoption Board to couples and in some cases, sole applicants since 1991. In view of the decline in the number of Irish children available for adoption, the trend towards inter-country adoption seems likely to continue.

Ironically, the large number of Irish couples adopting from abroad today stands in stark contrast to Ireland's role in inter-country adoption during the 1940's and 1950's. At that time many Irish children were adopted by citizens of other countries and sent abroad, mainly to the United States. The legality of some of these adoptions has subsequently been questioned (Milotte 1997).

The easy availability of Irish children for removal abroad helped paint a picture of Ireland abroad not unlike the image the Irish themselves had of Romania and China in later years. (Milotte 1997: 17)

One aspect of practice from this period has remained problematic. The poor record-keeping involved at that time has made tracing across the geographical divide difficult. This has aggravated problems for natural mothers and adoptees alike, and highlights the need for the regulation and control of inter-country adoption. Ireland has now moved from being a donor country to being a country receiving children for adoption, and the lessons of the past need to be included in the future procedures and practice of inter-country adoption.

Historically, inter-country adoption can be seen as an individual humanitarian response to war, destruction and other calamities. It has become a more organised activity in recent years. Traditionally, children placed for inter-country adoption were older and hard to place children, while now it is the most desirable children in terms of age, health and racial heritage that are being adopted while the hard to place children, many of them physically and emotionally disabled, are being left in their country of origin. Many of these children have spent years in ever changing institutional settings. (Silverman and Feigelman in *Brodzinsky and Schechter* 1990)

2.4. The Irish Legislative Framework

Provisions contained in the Adoption Acts, 1952-1998 and the Statutory Instruments (Adoption Rules) made under the primary legislation constitute the body of law governing the administration of the process of inter-country adoption. The most relevant for the purposes of this Report is the Adoption Act, 1991.

This Act provides the statutory basis for the recognition of inter-country adoptions and the procedures to be followed by Irish citizens wishing to adopt a child from another jurisdiction. The Act changed the procedures for those wishing to adopt abroad by placing a statutory duty on health boards to undertake the assessment of adoptive applicants in their area in order to establish their eligibility and suitability to adopt before they travelled to a foreign country to obtain a child. Sections 5 and 8 of the 1991 Act outline the steps which a couple or individual must go through in order to have an adoption recognised, where they are unconnected with the foreign state. Following a request for an assessment, the Health Board is required to carry this out '*as soon as is practicable to do so*' (Section 8(1)). The Act also empowers Registered Adoption Societies to carry out assessments. However they are under no obligation, and are at liberty to refuse to carry out such assessments if they choose.

The interpretation of Section 8(1) of the 1991 Act has been clarified in the Supreme Court in the case of *McC and McD v The Eastern Health Board* [1997]IFLR 33(SC);[1997]1 IRLM349 (SC) in which it was held that the phrase 'as soon as practicable' was not synonymous with 'as soon as possible'. Whether a health board is complying with its obligations under the Act must be interpreted in relation to the circumstances of the individual health board in the light of the resources available to them to carry out such assessments (Shatter 1997 p 513).

When the assessment is completed, the resulting report is submitted to the Adoption Board, who if satisfied that the couple or individual are suitable, will issue a declaration which is sent to the applicants, together with a copy of the assessment report. The applicants are then free to obtain a child, and the adoption will be recognised in Ireland. In order to be valid, an adoption must be broadly in line with the requirements applicable to Irish adoption laws. Under Section 5(5) the declaration is only valid for an adoption effected within 12 months from the date of issue, although there is provision for this to be extended by the Adoption Board.

Under Section 6 of the 1991 Act, the Adoption Board are required to maintain a Register of Foreign Adoptions. However, there is no statutory requirement on adoptive parents to inform the Adoption Board or to enter the name of children adopted on this register.

2.5 Guidelines for Inter-Country Adoption Practice

One of the principal bodies established by the Irish Adoption legislation, the Adoption Board, issued a number of guidelines following the signing into law of the Adoption Act, 1991. These are

- The Guide for Adoption Personnel, 4th July 1991;
- The Review of the Guide for Adoption Personnel, 7th October 1993;
- Guidelines for Adoption Personnel, 7th November 1993.

The 1991 Guidelines emphasised a number of points:

- The need for agencies to provide counselling and preparation for prospective adopters travelling abroad;
- Assessment reports were to be made available to those adopting abroad;
- Reasons for refusal of declarations were to be made available to couples;
- Where the placement of a first baby was to couples where one of the applicants was over forty years of age, the agency was required to specify special factors supporting the placement. This guideline was supported by the findings of an Australian report (Adoption Legislative Review Committee 1991 : 106) which recommended that the age difference between the adopters and the adoptees should be no more than forty years. This reflected practice current at the period. However, following considerable pressure, the Adoption Board modified their guidelines stating that the views on age should *'not be viewed as in anyway placing an embargo on or preventing persons over forty years availing of their entitlement to an assessment'* (Adoption Board 1993(b) : 2)

The Adoption Board guidelines did not contain specific recommendations regarding the process to be followed in the assessment. This resulted in individual Health Boards and Adoption Agencies developing their own practice and procedures. The impact of this guidance is discussed further in Chapters Five.

2.6 International Conventions

In developing policy on inter-country adoption, Ireland is bound by the international conventions to which it is a party. Ireland ratified the United Nations Convention on the Rights of the Child in 1992, and is a signatory to the Hague Convention on the Protection of Children and Co-operation in Respect of Inter-Country Adoption. However, in order to ratify the Hague Convention new legislation is required in Ireland to give effect to the procedures and provisions of the Convention.

2.6.1 The Hague Convention

The Hague Convention is the first international instrument which has the potential to regulate inter-country adoption on a global basis. It provides a framework within which states, through co-operation, may regulate the process of inter-country adoption. It is based on the assumption that neither a state of origin nor a receiving state can effectively regulate inter-country adoption by unilateral measures. Co-operation between the sending and receiving country is necessary. This involves opening up the channels of communication between them, encompassing an agreed division of responsibilities, administrative links and a shared effort to combat potential abuse.

The underlying purposes of the Convention are:

- To establish safeguards to ensure that inter-country adoptions take place in the best interests of the child and with respect for his or her fundamental rights as recognised in international law;

- To establish a system of co-operation amongst contracting states to ensure that these safeguards are respected, and thereby prevent the abduction, the sale of, or traffic in children
To secure the recognition in contracting states of adoptions made in accordance with the Convention

The Convention does not set out to establish a uniform international law on adoption. It recognises that there are diverse national laws on adoption, and it lays down minimum universal requirements. States may surpass these standards in their own implementation of the Convention. It is, therefore, flexible in that it is designed to accommodate and respect the diversities between states in their adoption procedures..

The Convention lays down a number of substantive requirements for inter-country adoption, and divides responsibility for ensuring that these are met between the state of the child's origin and the receiving state. The state of origin is responsible for ensuring that the child is adoptable, that inter-country adoption is in the child's best interests and that all the necessary consents have been obtained. The receiving state must determine that the prospective adopters are eligible and suitable to adopt, that they have been counselled if necessary, and that the child will be authorised to enter the receiving country and reside there permanently.

Each contracting state must nominate a central authority whose function will include co-operation between states and duties in respect of particular adoptions. These duties may be delegated to 'accredited bodies' which are likely to be approved adoption agencies. The Convention sets out the procedures which must be followed by both the donor state and the receiving state in relation to preparation of reports on the child and the prospective adopters, the placement process, the obtaining of consents, receiving permission for the child to enter the receiving state, the making of arrangements for the transfer of the child and the steps to be taken in the event of a breakdown in the placement. While recognising the basic right of the state of origin to make the placement decision it allows the receiving state a veto where it wishes to be involved.

General provisions in the Convention restrict contact between prospective adopters and the child's birth parents in the early stages of the adoption process in order to avoid pressuring of birth parents into giving consent to an adoption. In addition, provision is made to ensure that information concerning the child's origins, including the identity of both parents, as well as the medical history is compiled. Access to such information is only allowed to the extent permitted by the law of the state in which such information is held. Provision is also made to prevent improper financial or other gains to be made in connection with inter-country adoption.

One of the most intractable issues in early discussions at the Hague was whether the Convention should seek to outlaw so-called 'independent' adoptions, arranged between individuals, without state supervision. These are permitted in the United States, but prohibited or strictly limited by many other states which feel that agency adoption offers a better degree of protection for the interests of the child. During the course of negotiations it became apparent that the United States would not ratify a Convention which prohibited entirely the activities of independent intermediaries. The compromise eventually reached was one by which the individual states may, if they wish, insist on agency adoption in their own cases, but not insist on agency adoption between all states. Non-accredited persons or bodies may continue to operate in those states which opt for independent adoptions, subject to supervision of their activities by competent authorities.

2.7 Law Reform Commission Report on the Hague Convention 1998

Following a consultation process, in 1998 the Law Reform Commission published a report on the implementation of the Hague Convention. The purpose of the report was to make recommendations on the implementation of Convention in Ireland. Consequently, broader issues of inter-country

adoption was considered to be outside the scope of its report. However, quoting Duncan (1993:12), the Report does state:

Integral to the successful operation of the Convention on Inter-country Adoption is the task which falls on the developed countries of assisting developing countries to build and strengthen their child care services.

The Report proceeds on the basis of several core principles contained in the U.N. Convention on the Rights of the Child, 1989. It endorses the belief that the entire inter-country adoption process should be child centred, in that at all stages of the process the child's interests must be paramount. This is encapsulated in the phrase:

The aim of inter-country adoption is to find the best parents for the child and not to find the best child for adoptive parents (Law Reform Commission 1998: 2-3)

Furthermore, the Report recognises that inter-country adoption represents a subsidiary means of childcare, and that other options, such as the child being cared for by relatives, or in a family, within his or her own country should be the primary approach.

The Convention will not come into force in individual states until ratification or accession occurs. Of the states that have already put implementation measures in place, the majority have introduced detailed provisions and administrative procedures to allow for the operation of the Convention's provisions and for the recognition of adoptions made through Convention procedures.

Ireland signed the Convention in 1993. Following this the Department of Health's strategy document, *Shaping a Healthier Future*, confirmed a commitment to the introduction of changes in adoption in line with the Convention:

Changes will be introduced in adoption law and procedure to amend current legislation on the recognition of foreign adoptions to bring them into line with the recently agreed Hague Convention on the subject. (Department of Health 1994: 59)

The Department of Health and Children has completed a comprehensive consultative process with interested groups, and is currently preparing legislation to ratify the Convention.

2.8 The Assessment Process

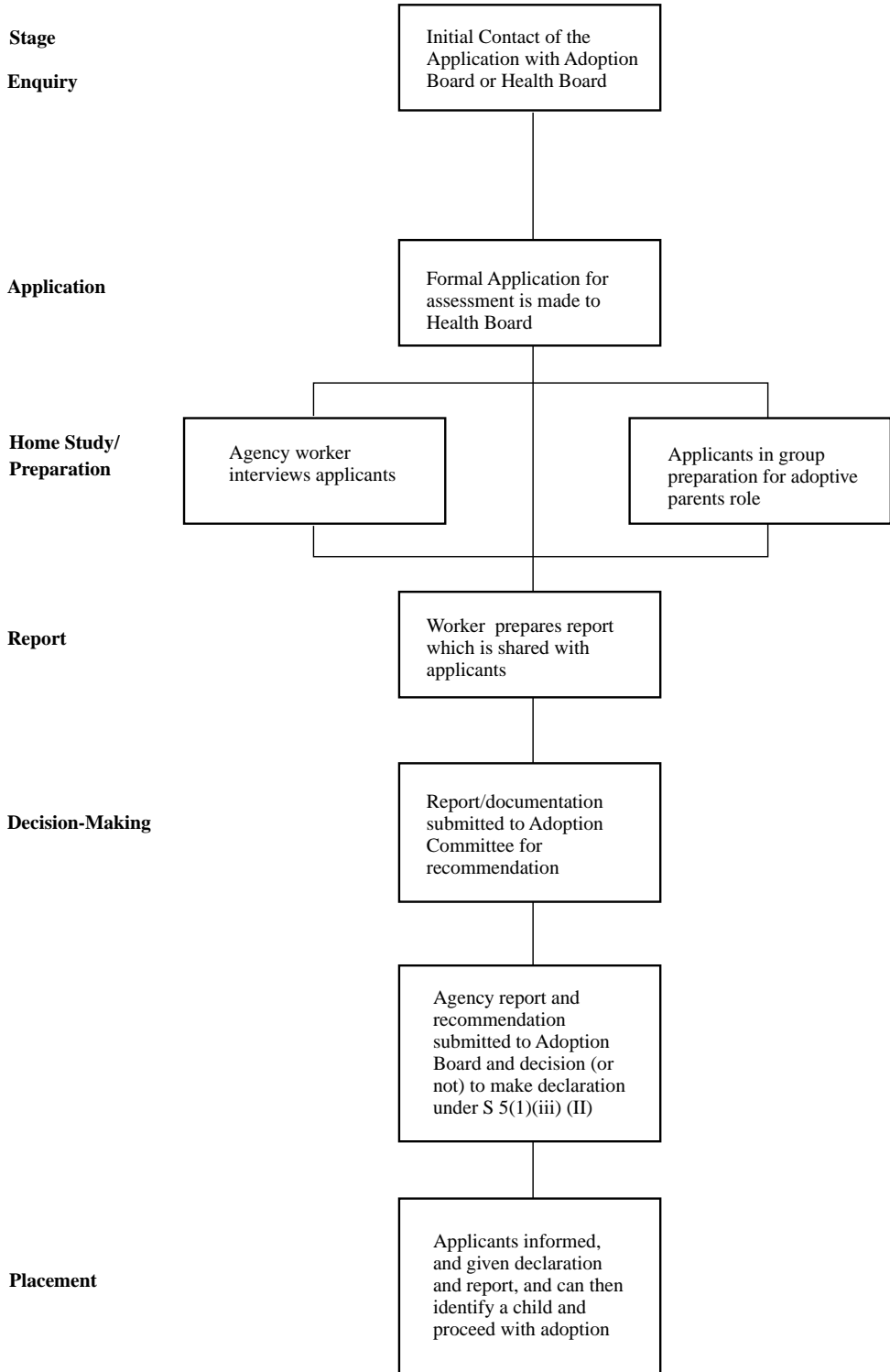
The need for assessment in adoption arises from the requirements of the Adoption Act, 1952 which is called up in the Adoption Act, 1991. Section 13 of the 1952 legislation states that:

(1) The (Adoption) Board shall not make an adoption order unless satisfied that the applicant is of good moral character, has sufficient means to support the child and is a suitable person to have parental rights and duties in respect of the child.

(2) Where the applicants are a married couple, the Board shall satisfy itself as to the moral character and suitability of each of them.

It is the requirement to establish suitability of applicants that has led to the development of assessment. The process of assessment is not regulated beyond what is stated in the primary legislation. Assessment has been practiced in domestic adoption and fostering for over forty years. As referred to in Section 2.5 above, much assessment practice has been imported into inter-country adoption from domestic adoption and fostering. The evolution of this practice-led approach in adoption assessment is described further in Chapter Three.

Figure 2.1
Current Process of Inter-country Adoption Assessment



2.8.1 Current Process of Inter-Country Adoption

As stated above there are no national standards drawn up and no regulatory policies set down for assessment. The Adoption Board Guidelines (1991, 1993a; 1993b) have been the main determinants of current practice. However, these are quite broad, leaving many aspects of the process to the discretion of the implementing agencies. As the Law Reform Commission (1998) noted, the assessment process will vary according to the particular health board concerned. While the process of inter-country adoption has evolved differently across the various health boards and adoption agencies, Figure 2.1 gives a general picture of current assessment process.

2.9 Issues Arising from Current Assessment Procedures

Since the 1991 legislation came into force, certain issues have become controversial in the delivery of the ICA assessment service. These are considered briefly here in the context of literature referring to these issues. The issues, and the participants views of them, are elaborated in more detail in Chapter Five.

The issue of long waiting periods before the assessment starts has been the source of much criticism from applicants in some health board areas. The uncertainty of the waiting period often fosters increased anxiety, confusion, feelings of helplessness and depression among prospective adoptive couples (Brodzinsky et al 1998). The Law Reform Commission noted that the average waiting time, from the time of application to the commencement of an assessment in some Health Board areas was 18 months (Law Reform Commission 1997: 18).

No guidance has been set down in relation to an appropriate duration for an inter-country adoption assessment. Duration of assessment is determined by structural issues within the organisation, availability of staff, frequency of training programmes, theoretical assumptions influencing practice and structure of case committees (O'Brien 1994). There is limited research available on the optimum duration of an assessment. Triseliotis has pointed out that '*the process of recruitment, preparation, home study, selection, matching and supervision can be long and protracted*' (1997:134).

2.10 Significant Issues in Inter-Country Adoption Assessment

Assessment is reviewed in detail in Chapter Three. A brief outline is presented in this section of the issues considered in the literature to be important to be included in ICA assessment.

2.10.1 Race and Identity

Identity development is more complicated for adoptees when an additional dimension of 'difference' such as race is added to the family system. When assessing potential inter-country adopters, research has emphasised the importance of focussing on those family factors that are more or less supportive of healthy psychological adjustment and racial group identification (Brodzinsky et al 1998). Prospective adopters would be expected to understand the need to foster their child's racial and ethnic identity within white structures, leading to a positive self-image (Triseliotis et al 1997).

2.10.2 Racism

The impact of racism on inter-country adoption has not yet been fully explored in the literature (Tizard 1991). The adoptee faces a considerable chance of being discriminated against because of the different appearance and racial distinction. Of great importance to adopted children is whether or not their parents have prepared them well enough to be able to cope with certain forms of discrimination (Hoksbergen 1997). The phenomenon of inter-country adoption has often been portrayed in the media in a negative light, and Hoksbergen (1997) has argued that some parents may unintentionally stimulate the stigmatisation of trans-racial adoptive children by giving a certain meaning to the negative publicity.

2.10.3 Family Structure

One of the most difficult tasks faced by adoptive parents is talking with their children about adoption. Triseliotis (1997:155) has highlighted the need to explore with the adoptive family their attitudes and feelings towards parents who relinquish their children and how they intend to explain to the child the circumstances of his or her adoption and origins. This is complicated in inter-racial adoption where there may be a dearth of information about the background of the child, and adoptive parents may be confronted with the philosophical dilemma about developed countries supporting under-developed countries to enhance their child care facilities, rather than adopting children outside their own culture.

The quality of the couple's relationship should be included in an appraisal, as well as how flexible and open the boundaries are to accommodate the new child. It is crucial to gauge the couple's desires with respect to the adoptive child, especially in terms of their preference for the country of origin. To some parents the outward appearance of the child is significant, for many have a preference for children that look the most European (Hoksbergen 1997).

2.10.4 Openness and Tracing

In the first half of this century, adoption practice was based on three primary principles — secrecy, anonymity and sealing of records. The emergence of the narrative accounts of those who have been adopted, and the difficulties encountered in tracing adoptees' beginnings has been very influential in changing attitudes. It is now generally recognised that adoptees' search process begins in early childhood when they begin to think about who are their birth parents and what happened that led to the adoptive placement (Brodzinsky et al 1998). Adoption has shifted decidedly towards openness as a core principle.

2.10.5 Age

Irish adoption legislation has never contained any specification on the upper age limit for adopters. This is similar to USA (CWLA 1988;) UK (DHSS 1998); but differs from Holland (Bureau VIA 1992) and Sweden (NIA 1998) which both introduced an upper age limit. However, guides to practice have consistently recommended that adopted children should be brought up by parents in the same age range as children reared by their birth parents (A Guide to Adoption Practice 1970 : 28; Standards for Adoption Service 1978: 44). The Review Committee of Adoption Services (1984 :25) while not recommending an upper age limit stated that it was important that 'children, particularly small babies, should be adopted by parents of broadly similar age to other parents of small children'. With the reduction in the numbers of babies becoming available for adoption in Ireland, adoption agencies began to use age as a screening mechanism and as a means of limiting the number of applicants. In general applicants over the age of forty years were not considered for assessment as domestic adopters by adoption agencies.

Following the Adoption Act, 1991 health boards attempted to carry out assessments on the same basis as for domestic adoptions. However, upper age limits became a contentious issue in relation to inter-country adoption, after some applicants were refused an assessment on the grounds of age. When it was pointed out that the 1991 act gave a right to all for an assessment, the Adoption Board policy on upper age limits was revised so that age should '*not be viewed as in anyway placing an embargo on or preventing persons over forty years availing of their entitlement to an assessment*' (Adoption Board Guidelines 1993(b):2). In the years 1991-1998, just under 40% of applicants to the Adoption Board for a declaration of eligibility and suitability to adopt were over the age of 39 years.

2.10.6 Infertility and Voluntary Childlessness

For many couples, the decision to adopt is made after lengthy periods of time spent undergoing infertility testing and treatment. The question arises as to whether couples should have completed such treatment before being assessed for adoption or whether the two processes can be carried out simultaneously. Some studies (Brebner et al 1985; BAAF 1983; Johnston 1984) have shown that couples may never fully come to terms with their childlessness, and the mode of resolution of infertility could have important implications for the success of the tasks of adoptive parenthood. One study (Daly 1990) found that infertility resolution and readiness to adopt were issues that could be addressed simultaneously. The practice imported from domestic adoption has been that couples should have completed infertility treatment prior to applying for adoption. However, for ICA this practice has been questioned, particularly as some couples who have applied for ICA may not be infertile but have made a conscious choice not to have birth children or to add to the family they already have.

2.11 Profile of Participants in Inter-Country Adoption

The following two sections present a profile of inter-country adopters and adoptees. The first part, the profile of applicants, is a profile constructed from data obtained from an analysis of all the home study reports (n = 166) received by the Adoption Board in 1998 in respect of first applications. The relevant tables are given in Appendix A. Information was also compiled from Tables relating to the same issues over the period 1991-1998. These tables are given in Appendix B.

Fourteen agencies carried out assessments during 1998 and submitted reports to the Adoption Board. 89.2% of all the reports were completed by the eight Health Boards with the remainder being carried out by voluntary registered adoption agencies. The Eastern Health Board completed the largest number of reports at 56, which represented 33.7% of the total.

2.11.1 Profile of Adopters

Of the 166 applications in the sample, 163 were for couples, and three were sole applicants, all of whom were women. Two of the sole applicants were assessed by the Eastern Health Board and one by the Southern Health Board.

Age:

For the couples, 76 (45.8%) of the men were aged under 39 years. The largest number of men were aged between 36 and 39 years (29.5%) and 45 (27.1%) were aged between 39 and 43 years. Eight of the men were over 50 years of age, one of whom was aged over 57 years. The female applicants tended to be younger with 92 (55.4%) being under the age of 39 years. Again, the largest number were aged between 36 and 39 years (33.3%) with 36 (21.7%) being between 39 and 43 years of age. Ten women (6%) were over the age of 50 years. Calculating for 99 couples (59.6%), the age differential between the partners was less than 3 years. Thirty-nine couples (23.5%) had between 3 and 6 years difference between their ages.

The Tables of Appendix B gives the age of applicants at time of application to the Adoption Board for a declaration of eligibility and suitability for the years 1991 to 1998. This table shows that there has been an increase in the number of applicants over the age of 39 years between 1991 and 1998. In 1991 just under 40% of applicants were over 39 years of age compared to almost 46% in 1998. In 1998 seven applicants were over the age of 50 years compared to three applicants in 1991.

Length of marriage:

The largest number of couples (74) 44.6% had been married between 5 and 10 years and 64 (38%) had been married for between 10 and 20 years.

Accommodation:

Almost all the applicants were owner occupiers (95.2%), with an equal division between urban and rural locations.

Employment:

The returns on the employment of applicants is shown in Table 2.2 below.

Table 2:2
Employment Categories of Applicants in 1998

Category	Male		Female	
	Number	%	Number	%
Professional	27	16.3	11	6.6
Managerial/Technical	62	37.3	63	38
Non-manual	22	13.3	47	28.3
Skilled Manual	25	15.1	7	4.2
Semi-skilled	24	14.5	11	6.6
Inskilled	2	1.2	0	0
Not Applicable/No available for work	1	0.6	24	14.4
Information not available	3	1.8	3	1.8
Totals	166	100	166	100

Categories based on Census of the Population social classes — list of constituent occupations (Central Statistics Office)

While applicants came from all employment groups, the highest percentage of both men and women applicants was in the managerial/ technical category.

Family Structure:

Just over a third of the couples (57) 34.3% already had children of whom 25 couples had birth children, and 34 already had one or more adopted children.

Sole Applicants:

A profile of the sole applicants showed that they were all women, who had no children previously. They were all educated to third level, lived in urban areas and were owner occupiers. The three sole applicants were classified as employed in managerial/ technical positions. One applicant was between 31 and 35, one was aged between 39 and 43 and one was aged between 43 and 47 years. Since 1991 there have been 12 sole applicants entered in the Register of Foreign Adoptions under the Adoption Act 1991 and 2 applicants processed under the Adoption Act, 1988.

Declaration:

One hundred and fifty eight (95.2%) of applicants were granted a declaration of suitability by the Adoption Board in 1998. The majority of the declarations (135) 81% were for a single child, with 23 (13.9%) being for two siblings and one for two unrelated children.

Children Placed with 1998 applicants:

Twenty one couples had adoptions completed and children placed with them in 1998. Of these children, 14 were under one year of age, five were aged between one and two years and three were aged between three and four years. Eleven of the children were girls and ten were boys. Fourteen were adopted from Russia, five from Romania one from China and the country of origin was not known for one child.

2.11.2 Profile of Children

The following statistics were obtained from the Adoption Board and provide a picture of the children adopted from abroad between the years 1991 and 1998. The information is presented in four

Tables, according to the source of the data. Tables 2.3, 2.4 and 2.5 present information on ages of children entered on the Register of Foreign Adoptions according to the legislation the adoptions were made under. The previous comment that there is no obligation on adopters to have a child's details entered on the Register is pertinent. Table 2.6 gives an aggregated picture.

Table 2.3

Age of Child at time the foreign adoption was effected in respect of entries in Register of foreign Adoptions in the Years 1991-1998

Age of Child	Total Number and Percentage
0<1 year	53.55% (377)
1>2 years	24.43% (172)
2>3 years	10.94% (77)
3>4 years	7.81% (55)
4>5 years	1.99% (14)
5>6 years	0.57% (4)
6>7 years	0.28% (2)
7 years and older	0.43% (3)
Total	100.00% (704)

The majority of children 53.55% of the total number of 704 were between 0 and 1 year when the inter-country adoption was effected. A total of 88.92% of adoptions took place when the child was between the ages of 0 to 3 years.

Table 2.4

Age of Child Adopted from Abroad at time of Placement for Applications for an Adoption Order which Have Been or Are Being Processed Under the Adoption Act, 1952 in the years 1991-1998

Age of Child	Total Number and Percentage
0<1 year	73% (73)
1>2 years	15% (15)
2>3 years	7% (7)
3>4 years	3% (3)
4>5 years	0% (0)
5>6 years	0% (0)
6>7 years	0% (0)
7 years and older	2% (2)
Total	100% (100)

In 21 of these cases an adoption order had not yet been made under the Adoption Act 1952 at end of 1998.

73% of inter-country adoptions were effected before the child was 1 year old.

Table 2.5

Age of Child Adopted from Abroad at time of Placement for Applications for an Adoption Order which have been or are being processed under the Adoption Act 1988 in the years 1991-1998

Age of Child	Total Number and Percentage
0<1 year	70% (7)
1>2 years	20% (2)
2>3 years	10% (1)
3>4 years	0% (0)
4>5 years	0% (0)
5>6 years	0% (0)
6>7 years	0% (0)
7 years and older	0% (0)
Total	100% (10)

In 5 of these cases an adoption order had not yet been made under the Adoption Act, 1988 at end of 1998

All inter-country adoptions, in the years 1991-1998, which have been or are being processed under the Adoption Act 1988 were effected within the age range of 0 to 3 years.

Table 2.6

Summary — Age of Children Adopted Abroad At Time Foreign Adoption Was Effected in Respect Of Adoptions Entered in the Register of Foreign Adoptions and In Respect Of Applications For An Adoption Order Under the Adoption Acts 1952, 1988

Age of Child	Total	% of Total
0<1 year	457	56.14%
1>2 years	189	23.22%
2>3 years	85	10.44%
3>4 years	58	7.13%
4>5 years	14	1.72%
5>6 years	4	0.49%
6>7 years	2	0.25%
7 years +	5	0.61%
Total	814	100.00%

In total 79.36% (646) of all children adopted and whose names were entered on the Register for foreign adoption, were 2 years and under. 17.57% (143) were aged between 2 years and 4 years, and the remaining 3.07 % (25) were aged 4 years or over 1991 and 1998

Country of Origin of Children

In Table 2.7, information on the country of origin of children adopted are presented. 72% of the children came from Romania, 9.58% from Guatemala and 7.25% from Russia.

Table 2.7
Number of Children Adopted by Country from 1991 and 1998

Country	Number of Children	%
Romania	588	72.24%
Guatemala	78	9.58%
Russia	59	7.25%
China	15	1.84%
Brazil	13	1.60%
India	12	1.47%
Colombia	9	1.11%
Paraguay	6	0.74%
Peru	5	0.61 %
Thailand	5	0.61%
Ethiopia	3	0.37%
Texas, USA	3	0.37%
Vietnam	3	0.37%
Uganda	2	0.25%
Bolivia	1	0.12%
Bulgaria	1	0.12%
Chile	1	0.12%
El Salvador	1	0.12%
Israel	1	0.12%
Japan	1	0.12%
Lebanon	1	0.12%
Massachusetts, USA	1	0.12%
Mexico	1	0.12%
Sri Lanka	1	0.12%
Taiwan	1	0.12%
Venezuela	1	0.12%
Zambia	1	0.12%
Total	814	100.00%

CHAPTER THREE

Background on Assessment

3.1 Introduction to Assessment

The legislative framework governing adoption was discussed in Chapter Two, and the need for assessment in adoption was seen to arise from the requirements of the Adoption Act, 1952 which is called up in the Adoption Act, 1991. It is the requirement to establish suitability of applicants that has led to the development of assessment. The practice of assessment is not regulated beyond what is stated in the primary legislation. This situation has allowed a “good practice” approach to be used in adoption assessment. The “good practice” approach has evolved as described in the following sections. The literature relating to assessment, and the more controversial aspects of practice are also reviewed.

Assessments of alternative placements have a crucial part to play in successful placements of children unable to live with their own parents. They provide the agency with important information, and applicants come to learn about the facets of adoption and a relationship is established with the worker which will influence all future contact (Selwyn, 1994). Assessment is generally defined as a two-way process whereby the applicants and the agency share information and decide together if adopting a child will work for all the parties concerned, especially the potential child. Underpinning the assessment process are criteria and standards for selection by the agency. It is against these standards that the social worker, on behalf of the agency, must construct a methodology to elicit and provide information, to facilitate decision making, to evaluate potential and to recommend placement type (McCracken and Reilly, 1998). The general aims of assessment are to address the needs of children by identifying potentially good quality, safe homes. Quality standards determine that each child has the right to be cared for by carers who have appropriate skills, training and support. Safe care relates to the concern that children will be placed in safe, non-abusive homes (McCracken and Reilly, 1998).

Methods of assessment have changed and evolved over time. An examination of the shifts in assessment practices provides a context for understanding the premises which underpin the practice of assessment, and how the suitability of families for the adoption task is determined. It is possible to trace a gradual evolution from a psycho-dynamically oriented assessment to a task centred approach with a focus on group based training (McCracken and Reilly, 1998). A brief summary of the theoretical and practice shifts in the models of assessments used to ascertain the suitability of families for adoption, both domestic and inter-country, and fostering is presented. A description of current practice and standards in assessment as espoused by the British Agency for Adoption and Fostering (1998), the Child Welfare League of America (1988) and the Australian Adoption Legislative Review Committee (1991) is also given.

3.2 Models of Assessment

Three assessment models spanning three different time-frames 1940-1970; 1970-1985; and 1985-date, can be traced. The three time spans are referred to as the traditional model, the education/ preparation model, and the self-selection model respectively. These are relatively arbitrary time distinctions, as changes in theory and practice occur at different rates from area to area, as shown by American, Swedish, English and Irish literature (George, 1970; Hartman, 1979; Smith, 1984; Triseliotis, 1988; McCracken and Reilly, 1998; NIA, 1998). Practice models governing the assessment format, however, have followed similar trends in many countries. Prior to describing the traditional

model of assessment, it is important to consider the informal selection procedures prevalent before standards were introduced in the earlier part of this century.

3.2.1 Informal Assessments

Throughout the latter part of the nineteenth century and the initial stages of the twentieth century, child welfare was viewed as a philanthropic pursuit, not a professional one (Gill, 1997). The selection of families for abandoned children focused solely on the moral and physical characteristics of the prospective adopters. The main criterion in selection proceeded on the basis that a good Christian family was the ideal family for rescued children. At the time there was a widespread, abiding faith in the goodness of the rural, Christian home. The screening process was therefore informal, and designed to verify the character, kindness and good intentions of the applicants (Gill, 1997). The applicants rejected were those known to be cruel and those who wanted merely to exploit the children's labour.

The standards for selection that were set at the time were straightforward, easily observable and directly related to the welfare of the child. They involved physical and external standards of behaviour and economics. There was also an obsession with matching the characteristics of the child — physical, racial, intellectual, religious, and otherwise with those of the adoptive parent (Gill, 1997).

3.2.2 The Traditional Approach (1940-1970)

The traditional model of assessment is generally taken as starting around the 1940s. (Dubois 1987; Smith 1984; Hartman 1979). At this time, adoption professionals were only beginning to establish common standards and practices, as social work began to shift from a philanthropic orientation to a professional career (Gill, 1997). The focus of concern surrounded vetting people as to their suitability to adopt. The model was built on the premise that “applicants either have or do not have the necessary characteristics and qualities to make successful adoptive parents and that skilled social work investigation can select those who have whatever it is the social worker is looking for, to a sufficient degree to pass the test” (Smith, 1984: 15). In this approach the social worker makes the choice. As Gill (1997) points out, the adoption agencies were confident in their right and competence to select the “best” adoptive parents. Their conflation of “best” with “normal”, however led to the enforcement of a singular vision of the ideal family (Gill, 1997). The quest for the pursuit of ideal families, however demanded an intrusive inquiry into the most intimate aspects of applicants' lives. This model was dominant up to 1970.

There were many critics of this model of assessment. Shaw argued against the social worker's role as inquisitor, detached from and superior to the applicants, probing and waiting to catch them out in a wrong answer (Shaw, 1988). Smith argued increasingly against the traditional model, with the contention that the investigative method was flawed and lacking in agreed criteria surrounding measures of acceptability. It was argued that all the power was located with the worker, thus the relationship between the worker and the applicant proceeded on the basis of a closed style of communication (Selwyn, 1994). Hartman (1979) questioned the myth that the worker could gather information about as complex a system as the human family and make reliable judgements and predictions about that system's capacity to rear a child. Smith and Kirk both urged instead that “assessment and selection should be discarded in favour of an approach which prepares prospective substitute parents for their distinctive role” (1984: 30).

3.2.3 The Educational/Preparation Approach (1970-1985)

The second broad time frame, from the early 1970's to the mid 1980's, was largely concerned with exploring an assessment model based on both education and preparation. The model favours an empowering approach, where if people are given adequate information regarding role and agency

expectations, they can then choose whether they have the resources to undertake the task. Applicants were to be enabled through training to make their own decisions about their suitability as adopters (Selwyn, 1994).

Within this model the emphasis on an assessment role for social workers remains important. The social work role as assessor co-exists with an educational and facilitator role (Hartman 1979; Triseliotis 1988; Davis and Morris 1984). As a response to this developing trend, courses to train prospective parents were developed, predominantly on an agency to agency basis. Professional practice in agencies was altered by the shift in emphasis, and different practices emerged. In some agencies different workers were allocated to fulfill the assessment and educational roles while in others the same worker did both (Rhodes 1992).

3.2.4 Self-Selection 1985 — to Date

The model of practice which has been developing from the mid-1980's to the present is known as self-selection (Ryburn 1991; Cain 1993; Laird and Hartman 1985). The shift in title to "self-selection" arises from a questioning of the assessment process by social workers and applicants, and a developing empowerment of applicants in the educational/ preparation approach. In tracing this development, Ryburn argues that the more traditional assessment practice was deeply disempowering and a weakness-based approach. Drawing on his own experience of assessment, he recalled that there was more emphasis on "my potential failings, not my capacity to change, to modify and to grow into the job" (Ryburn 1995: 38). Ryburn references social constructionist premises as influential in questioning if "through some skill assessment process professionals can decide who is and who's not suitable to become a ... carer" (Ryburn 1995: 37). According to Ryburn, the central issue to be addressed is the belief that "there is an independent objective reality against which, through a process of enquiry, prospective adopters can be measured and appropriate placements can be made" (1991: 20). Ryburn (1991) suggests that such a belief accords to recruitment and placement, a scientific base that is removed from the hit and miss process which he really thinks it is. He vociferously argues that the belief that social workers know best is in fact spurious. According to Ryburn (1991) objective assessment is akin to a myth.

The social work role in the self-selection model is one of facilitator. The ramifications of this include a more balanced power relationship between applicant and worker and more openness and honesty expressed by the potential adopters (Stevenson, 1991). The approach is based on the principle of self-determination, and the applicants play a major role in evaluating their own families as resources in the decision-making process. Empowerment is not achieved solely by giving information or by training but by helping applicants redefine themselves as adoptive parents. Workers should be clear about their role, their use of power and their goals in empowerment-oriented practice (Selwyn, 1994). However, the agency continues to play a central role in ensuring that the major emphasis is firmly kept on the child's needs.

3.2.5 Group Work in Assessment

There has also been a developing trend towards preparing and assessing people within groups. With the traditional method, it is much easier for couples to have "played the game" and tried to impress the social worker during the home visits, but within the group they are prevented from doing so (Stevenson, 1991). The main exponent of the use of groups in the preparation of adoptive parents was Kirk (1964), however his ideas were not widely taken up for another 10-15 years. Through the group, applicants are subjected to an educational process in which they can learn enough about themselves, their motives and needs to bring them to the stage of deciding for themselves whether they should adopt or not (Triseliotis, 1997). The group provides a less formal setting for exploring ideas and feelings, moreover participants are more receptive to observations and suggestions made by peers (Triseliotis, 1997). Furthermore, their motivation can be examined in a climate of safety and mutual support.

3.2.6 Conclusion on Historical Evolution of Assessment

In summary, the emergence of the self-selection approach has far reaching consequences, connected with power, partnership, empowerment, marginalisation and normalisation. The practice activities in the self-selection approach to assessment are not greatly different from the techniques discussed in the education/preparation model. The distinction between the two models is the increased emphasis placed in self-selection on enabling applicants understand the process they have entered into. However, despite the references to the development of a self-selection approach to assessment in the literature, the educational/preparation approach is still more dominant in practice (Rhodes 1991, Ryburn, 1991) and there is ample evidence that vetting and motivation associated with the psycho-analytical approach is still evident (O'Brien, 1997). Furthermore, it may be argued that there has been confusion between the ideas underpinning group assessment and the education/preparation and self selection approaches, which has led to lack of clarity in assessment practice (O'Brien 1997).

3.3 A Systemic Approach to Assessment

A growing frustration with traditional family assessment which focused on past history, coupled with a belief that it was more important to look at a family's current functioning led to the introduction of a systemic approach to family assessment (BAAF, 1996). Hartman's (1979) seminal work represents the beginning of this approach. According to systemic theory, individuals do not function in isolation but rather as part of highly organised systems, often with consistent behavioural patterns and beliefs (McCracken and Reilly, 1998).

A systemic assessment model is based on the premise that the adoptive family as a whole serves as the context for any placement. The approach gives due attention to the need to achieve a fuller understanding of family relationships and possible points of strain and tension, as every member of a household will both affect and be affected by the presence of an adopted child (McCracken and Reilly, 1998). The systemic framework brings into focus the "who's who" in the adoptive family configuration and provides a collaborative and co-operative milieu for the assessment process (McCracken and Reilly, 1998). Therefore it goes some way to make the assessment process "more open and objective and less dependent on the judgement and intuitive flair of the individual worker" (McCracken and Reilly, 1998:20). The richness of working with what happens, not just what is said, provides another level of evidence for assessment (BAAF, 1996). Most importantly by understanding family networks and the systems which impinge on them, the systemic approach values and empowers adults and children alike, giving voice to all the significant family members. (McCracken and Reilly, 1998).

The use of a systemic approach in assessment includes reflecting on material from the applicant's own life experience and how this has influenced them as adults. However, the focus is more firmly on the present and future than on the past. By identifying the systems and sub-systems which make up the day to day lives of potential carers, the applicants, together with the social worker are freed to explore behaviours and relationships, the routines and rituals, the family rules and boundaries, the support networks and stresses. Terminology in systemic theory such as recursiveness, circularity or reflexivity all capture the dynamic and evolving process whereby new information is absorbed, reflected upon and shapes future ideas and actions (McCracken and Reilly, 1998). Equally, the emphasis on context, language and how meaning is constructed are important premises on which this approach is based.

3.4 Guidelines for Assessment Practice

The British Agency for Adoption and Fostering (BAAF) (1998), the Child Welfare League of America (CWLA) (1988), the National Association for International Adoptions in Sweden (NIA) (1998) and the Adoption Legislative Review Committee in Western Australia (1991) are the main bodies who have documented guidelines for assessment practice in the English speaking world. All

embrace to some extent the current focus surrounding the systemic perspective. These frameworks provide a guide for understanding the assessment process and represent a reflection of current practice in adoption assessment.

The central aim of assessment, as outlined by BAAF (1998), is to help families understand how children's emotional well-being and behaviour will be affected by their early experiences. Thus, according to the CWLA (1988) a realistic understanding of the needs and behaviour of children who need adoption and of the adoption relationship's impact on them can be formed. A parallel objective is to help families understand what parenting another person's child will be like for all members of the family. BAAF's information guide advocates the need for openness throughout the assessment process. Particular attention is paid to the need for applicants to be open and honest in terms of how flexible they are prepared to be about the sort of child they would consider for adoption. Openness is also recommended in terms of divulging information regarding family.

3.5 Criteria of Capacity for Adoptive Parenthood

The literature identifies general areas that need to be addressed when interviewing potential adopters. These include total personality functioning and emotional maturity; a stable mutually satisfying marital relationship (where applicable), motivation for adoption which reflects a healthy desire for a child and an understanding of the differences between adoptive and biological parenthood; the quality of relationships experienced in the adopting parent's own family of origin; transition to adoptive parenthood; attitudes about and experience with birth parents; adoption revelation and child's curiosity about his/her origins; and the family's social support for adoption (Brodzinsky et al 1998, CWLA, 1988, Western Australia, 1991). On the basis of present knowledge, these criteria provide the best indication of capacity for adoptive parenthood (CWLA, 1988). These criteria, while embraced by most agencies, are given different weight in different contexts but all are viewed as important.

In current practice the primary responsibility of the agency is to safeguard the best interests of the individual child (CWLA 1988). Indeed Article 21 of the United Nations Convention on the Rights of the Child 1989 emphasises that in adoption, the best interests of the child are paramount (Western Australia, 1991). When adoption is viewed in the best interests and welfare of the child, adoptive parents can be recruited to meet the specific needs of the individual children (Western Australia, 1991). In the selection process for suitable adoptive parents, the agency looks for families who will understand the importance of the child's early life experiences and the way this may affect their general behaviour and development. Furthermore the family must be able to deal with difficult behaviour and fully accept the child's family background. Attitudes towards birth parents and children born out of wedlock, feelings about inherited traits and parents who will be no longer responsible for their children, all need to be taken into consideration. These reactions may affect the prospective adopter's attitudes toward a child (CWLA, 1988).

A willingness to provide linkages to the child's birth family, when appropriate, is pivotal to the success of the placement (CWLA, 1988 and Western Australia, 1991). In the past, the opposite was thought to be true, adoption represented a complete severance of all ties with the child's natural family in the interests of creating a "normal" family. More often than not the interests of the adopting parents were served over the adopted child (Western Australia, 1991). Currently it is considered ideal that the adoptive family share as well as promote the child's background and heritage (BAAF, 1998). This is more difficult in inter-country adoption, where linkages with the past generally involves connections with ethnicity and race and the child's country of origin. This knowledge is important to the child's developing identity as discussed in chapter two.

3.6 The Home Study

The assessment process is commonly called a “home study”. It aims to offer a full, honest and open assessment. The applicant and social worker are expected to work in partnership through a series of interviews and group meetings (CWLA, 1988). Applicants must be able to recognise their own needs, strengths and limitations and it is hoped that through the assessment process the applicant will come to evaluate his/her existing understanding and skills as well as the potential for learning and development over time (BAAF, 1998). Current practice favours an empowering approach, in which, all applicants have an equal opportunity to apply for the adoption of children and receive equal treatment and consideration of their qualifications as adoptive parents under applicable law (CWLA, 1988).

BAAF’s Form F1 is commonly used in Ireland and England as a framework aimed at gathering information about prospective substitute parents. The areas covered are related to legal and medical information and to areas of the applicant’s life experience and what that has to offer the children. According to BAAF (1998) the report should give a real picture of the prospective applicants and their family. The potential adopters should be afforded the opportunity to be involved in producing it. This adds to the sense of partnership and empowerment which current practice aspires to convey to the applicants.

3.7 Criteria: Current Practice and Professional Focus

It is important to highlight that while criteria, like age, health, income, housing and marital status, are an integral part of the agency’s consideration of whether the applicants meet minimum standards for parenting, no single factor should be decisive in and of itself (CWLA, 1988). Current practice advocates an assessment approach which is underpinned by the principles of equity and justice. All applicants should be fairly assessed on their abilities to successfully parent a child and not on their appearance, differing life style or sexual preference (CWLA, 1988).

An important part of the agency’s focus surrounds the fact that many of the children needing families will have lost important people in their past. Thus, during the assessment the agency will want to ensure that as far as possible children will be provided with security and care throughout childhood into adulthood. Therefore contingencies such as the age of the applicant, the existence of potentially serious or life-threatening illnesses and medical conditions are considered in light of this (BAAF, 1998). Having older parents can in itself represent a significant life stressor for children (Morris, 1987). Areas of concern include the loneliness of being an only child, embarrassment that one’s parents look like grandparents and that they were different from other mothers and fathers, regret that fathers were too old to play active games, fears of the illness or death of their parents, the worry while still in their twenties of having to care for elderly and infirm parents much earlier than is the norm. All these difficulties suggest that a higher than average age difference between the adoptee and his/her adoptive parents can be seen as an additional stressor for the adopted child at different life stages (Western Australia, 1991).

The purpose of exploring the prospective adopter’s background is to help examine how life experiences may have an impact on the ability to parent an emotionally damaged child in terms of expectations, understanding and acceptance. Factors such as applicants’ infertility, previous significant relationships, sexual habits and conformance to gender roles can be examined. Such examinations are useful in terms of illuminating lessons learned from the past and in terms of gaining ideas for the future (BAAF, 1998). Experience has shown that the manner in which individuals deal with previous life situations, the manner in which they get along with their own family, their work adjustments, relationships with friends, activities in the community and the satisfactions they have experienced all have a bearing on their capacity to meet the needs of an adopted child (CWLA, 1988). However, there are some rebuttals. According to Gill (1997) inquiry into such questions may be useful for psycho-analytic purposes but their relationship to the future welfare of an adopted child

seems tenuous. Kirk (1988), argues that adoption agencies fail to notice that the concepts they borrow from psychiatry are therapeutic rather than predictive. He contends that personal history appropriately explored on the analyst's couch is not necessarily diagnostic of parental competence.

Infertility is a significant issue in adoption. In the past adoption was regarded as a way of providing healthy babies for childless couples thus adoption became entrenched in Western society as a solution to infertility (Western Australia, 1991). Nowadays the focus of infertility in adoption surrounds the potential impact of childlessness on the prospective adopters and the possible implications this could have on the successful placement of a child within that family. The role of children in adult's ideas about themselves as individuals and as a married couple represents an important but sometimes overlooked area of inquiry. For many adults, the capacity to have a biological child is at the core of their identity. Therefore infertility can create great personal and inter-personal conflict, making it difficult for a couple to reach a mutual understanding of themselves as "infertile", let alone a mutual agreement about whether or not to pursue adoption. Infertility may also impact on the couple's feelings about masculinity and femininity or it may lead to feelings of guilt towards the spouse (CWLA, 1988). Inadequate resolution of infertility issues can adversely affect the creation of a supportive post adoption child-rearing environment, and it is thus important for social workers to explore how parents have handled the stress and strain of infertility and whether the decision to adopt was by mutual agreement or primarily a reflection of one parent's need (BAAF, 1998). The desire to adopt should be based on emotionally healthy needs, such as the desire to experience another dimension of life, to undertake parental responsibility and to contribute to the development of another human being. Adoption is not desirable when it is sought only as a means of acquiring an heir or of overcoming the loss of a child (CWLA, 1988).

Ryburn (1991) challenges the current philosophical belief in adoption that infertility must successfully be grieved and resolved before someone is "ready" to adopt. This belief, as well as not recognising that infertility is a living grief that cannot be grieved like a bereavement, is supposed to ensure that adopters can manage the impossible. The other side of the coin involves the inclusion or exclusion from assessment of those applicants who can conceive. According to CWLA (1988), the ability to conceive should not preclude consideration of applicants for the placement of a child.

In assessment, the quality of the spousal relationship is of critical importance. In two-parent families, it is argued that the relationship should be one that could continue successfully without a child. Moreover the emotional climate should be satisfying for the parents as well as the child. Each partner should have respect for the other (CWLA, 1988). It is important in assessment to appraise not only the quality of the couple's relationship, but how far the boundaries are flexible and open to accommodate the new child. It is also crucial to gauge the couple's desires with respect to the adoptive child, especially in terms of their preference for the country of origin. To some parents, the outward appearance of the child is significant, many have a preference for children that look the most European (Hoksbergen, 1997).

It is also considered essential to seek references. The purpose of seeking references is not only to secure the safety and well-being of the child who might come into the family, but also to explore skills and strengths the applicants have to offer, as well as what might be too stressful for them. Personal support networks are advocated as indispensable and the referees are in a position to speak to the networks of the applicants.

3.8 Conclusion

In conclusion, current views on assessment regard the home study process as adductive and supportive. The basic concept is one of preparation through partnership, and the approach is more or less task-centred (Triseliotis, 1997). However many prospective adopters continue to feel the historical,

evaluative legacy of practice, which often increases their anxiety and undermines their self-confidence (Brodzinsky et al, 1998). Power is a central issue in inter-country adoption assessment. Assessment is a two way process, however, the balance of power in this process is nevertheless unequal since the agency ultimately makes the decision (McCracken and Reilly, 1998).

There are high stakes involved in the selection of adoptive parents. The chance to become a parent, for many applicants, lies in the hands of the evaluating agency. Honesty and openness are more difficult to achieve, and refusal of an application carries huge emotional costs. Therefore, due to the high stakes involved it is imperative that the state should go to great lengths to ensure that the screening process is fair (Gill, 1997).

It is our view that systemic theory and practice has a significant contribution to make to ICA assessment. The systemic model provides a ready made and comprehensive framework for understanding families and the systems which impinge on them (McCracken and Reilly, 1998). Equally it provides a framework in which social workers can examine the impact of their own attitudes and values on practice. However, a systemic application does not rule out the fact that social workers can never with absolute certainty determine risk, rule out the possibility of abuse by adoptive parents, or predict successful outcomes (McCracken and Reilly, 1998).

Assessment may be criticised for its lack of a coherent theoretical base and its susceptibility to the orthodoxies currently in fashion. It also highlights how the values of partnership and empowerment, on which current assessment practice is built, are somewhat at variance with practices and values underlying the social control function of child protection practice. This in turn results in a paradoxical situation for both worker and applicant. It is apparent that the drive to empower prospective adopters as well as the need to ensure safe and positive care for children has resulted in an assessment process which, in practice, is in many senses a hybrid, comprising elements of previous models in terms of preparation and training, self-assessment, group assessment and vetting (McCracken and Reilly, 1998). Perhaps there will always be tension in assessment as the state and its agencies, social workers, applicants and birth parents strive to find a way of ensuring that children will be cared for in safe and loving families.

CHAPTER 4

Inter-Country Adoption Service Management

4.1 Introduction

This chapter describes current organisational and staffing arrangements for the ICA assessment service within the eight regional health boards. It also provides quantitative information on current inter-country adoption assessment activity. The following aspects of the inter-country adoption service are described:

- Positioning of the ICA service within Health Boards;
- Staffing of the ICA service;
- Demand levels for ICA assessment;
- The levels of applications processed and work undertaken;
- Length of the assessment process;
- Number of interviews involved in the assessment process;
- Data concerning second assessments;
- Costs of the inter-country adoption service per Health Board.

Eleven agencies carried out assessments during 1998 and submitted reports to the Adoption Board. 94% of the reports were completed by the eight health boards, with the remainder being carried out by three registered adoption societies (voluntary sector). The Eastern Health Board (EHB) completed 35.3% of the total.

The voluntary sector accounted for 6% of total assessments carried out. In the case of two of the societies St. Mura's (Donegal) and St. Catherine's (Ennis), arrangements are in place with the NWHB and the MWHB respectively to provide a service for a specified geographical area of Donegal and Clare. In Sligo the service is provided by a health board social worker assigned responsibility for tracing and assessment work. This arrangement came into place in 1998. Prior to this date, the ICA service in Sligo was provided by St. Attracta's Adoption Society. The data in this report for the NWHB is drawn predominantly from St. Mura's as the health board did not have access to the data from St Attracta's. The assessment practices described in Chapter Five refers to the community care practice in the NWHB, and St. Mura's is referenced separately.

Likewise in the case of the Mid-Western Health Board, St. Catherine's Society provides the service in Co. Clare. Up until 1998 this was an informal arrangement. The arrangement is currently under negotiation and some changes have occurred i.e. St Catherine's now presents completed assessment reports to the health board's regional adoption committee. The PACT Adoption Society have no geographical area and provide a small inter-country adoption assessment service on a national basis.

4.2 Positioning of the ICA Service within Health Boards

4.2.1 Structure of teams

The service is structured and delivered in different ways across the Health Boards. There are some variations in service delivery between community care teams in the same board. The service is recognised as being predominantly specialist, in that ICA workers are not involved in regular family support and child protection work. Health Boards provide adoption services through a number of

specialist teams that have responsibility for different functions and tasks within that brief. The range of teams include those that:

predominantly focus on carrying out **inter-country adoption assessments**, inclusive of related tasks i.e. taking general enquiries, providing information and hosting meetings, preparation courses, post-placement reports and support and tracing (EHB);

provide a **broad based adoption service**, which includes domestic¹ and inter-country assessments, and child placement associated with adoption, and tracing² services (MWHB; NEHB, NWHB, SHB)

provide a **broad based adoption service** which includes domestic, inter-country assessments, and tracing in addition to adoption counselling /child placement and may also be **combined with conducting foster care assessments** and associated child placement work (WHB; MHB, and SEHB)

4.2.2 Service Delivery

The teams involved are also organised in a number of different ways, either on a regional basis, a community care basis, or a combination basis, along the lines of the following descriptions:

Regional team, headed by a senior social worker, where the social workers operate from a central location, and all social workers are accountable to the specialist senior social worker only (i.e. NEHB; EHB);

Regional team, headed by a senior social worker. All social workers are centrally based with the exception of a social workers who is based in Kerry but works as part of the Regional team. All social workers accountable to the specialist senior social worker for adoption in the region (i.e. SHB);

Regional team, where the social workers operate from a central location and are accountable to one community care team leader/social worker who has responsibility for general social work services delivered by Health Board (i.e. MWHB). Part of the responsibility for ICA work in the MWHB is carried by the voluntary sector (St Catherine's Adoption Society);

Community Care based service, but headed by a regional senior social worker who has primary responsibility for development and co-ordination of the adoption service. Social workers prime identification is as part of local community care team, and there is limited opportunity for formal co-operation across community care boundaries. Social workers carry a mixed caseload i.e. family placement in adoption, foster care and tracing. Social workers have dual accountability to adoption senior social worker for adoption work, and community care senior social worker /team leader for other related work i.e. foster care (i.e. MHB; SEHB)

Community Care based Adoption service, headed by a regional senior social worker who has major role for development and co-ordination for service. Local arrangements are in place at community care level to meet adoption service needs. Within the region, there is variation in that a worker may carry only adoption work in one area, while in other areas adoption work is carried out alongside foster care. In exceptional circumstances, general team members carry out assessments if the need arises, or if workers show an interest. Social workers prime identification is as part of local community care team, but there is limited opportunity for formal co-operation across community care teams. Social workers have dual accountability to adoption senior social worker for adoption work and community care senior social worker /team leader for other related work i.e. foster care (i.e. WHB)

¹All agencies provided a domestic adoption service but the numbers of domestic adoptions are decreasing and this represented only a small aspect of the health boards' work. Registered adoption societies in the voluntary sector are placing the larger number of children in this country in this category.

²The demand for tracing service is steadily growing. No statutory basis exists for this service though the demand is increasing. Social workers expressed a view that they are ethically obliged to provide such a service, despite the absence of statutory basis.

Community Care /voluntary sector, Community care team provides part of the service in geographical area and has informal arrangements with voluntary sector to conduct assessments also. In the NWHB, an arrangement is in place between the NWHB and St. Mura's Adoption Society, whereas in Sligo the service is provided by a health board social worker assigned responsibility for tracing and assessment work, (i.e. NWHB). This arrangement came into place in 1998.³

Table 4.1
Position of ICA within Health Boards

Health Board	Structure of team	Specialist senior social worker	Areas of work covered
EHB	Regional team headed by a senior social worker. Social workers all operate from a central location. All social workers accountable only to the senior social worker.	Headed by Senior Social Worker with responsibility also for foster care team.	Inter-country adoption service, inclusive of assessments, related tasks and tracing.
MHB	Social workers based in community care teams. Social workers prime identification is as part of local community care team and limited opportunity for formal co-operation across community care boundaries. Dual accountability to adoption senior social worker and community care senior social worker /team leader	Headed by Senior Social Worker with primary responsibility for development and co-ordination of the adoption & fostering service. (one area)	A broad based adoption service which includes domestic, inter-country assessments, and tracing in addition to adoption counselling /child placement combined with conducting foster care assessments and associated child placement work.
MWHB	Regional team at a central location. Accountable to one community care team leader/senior social worker. St. Catherine's Adoption Society provides service in Clare Community Care area	No	A broad based adoption service which includes counselling, domestic & inter-country assessments, and tracing.
St. Cath's, Ennis	Registered Adoption Agency in voluntary sector. Arrangement with Mid Western Health Board in relation to Clare community care area. ICA is a small component of agency work.	No senior post	A broad based adoption service as part of community service, /adoption service includes counselling, domestic, inter-country assessments, and tracing. Mediation in open adoption
NEHB	Regional team, headed by a senior social worker. Social workers all operate from a central location. Social workers accountable only to the senior social worker	Headed by Senior Social Worker	A broad based adoption service domestic, and inter-country assessments, and tracing Child placement associated with domestic adoption
NWHB	Arrangements differ according to Individual community care areas (see St Mura's) In Sligo one worker employed in specialist adoption post	No	A broad based adoption service domestic, and inter-country assessments, and tracing (See St. Mura's)

³The service for ICA in Sligo was provided up to the end of 1998? by St Attracta's Adoption Society. The data in this report for the NWHB is data from the two accredited Adoption Societies who provided services in the region. The assessment practices of St Attracta's is not included in the report however, as the Agency has withdrawn from this work. Where a description is included, it is for the new arrangements now put in place by the NWHB in Sligo. St Mura's Adoption Society continues to provide the ICA service in Donegal.

Table 4.1 — continued
Position of ICA within Health Boards

Health Board	Structure of team	Specialist senior social worker	Areas of work covered
St. Mura's	Accredited Adoption Agency in voluntary sector. Contractual arrangement with NWHB	No	A broad based adoption service which includes domestic, inter-country assessments, and tracing in addition to adoption counselling and child placement
SEHB	Social workers based in community care teams, but service headed by a regional senior social worker. Social workers prime identification is as part of local community care team and limited opportunity for formal co-operation across community care boundaries. Dual accountability to adoption senior social worker and community care senior social worker /team leader	Headed by Senior Social Worker with primary responsibility for development and co-ordination of the adoption service.	A broad based adoption service which includes domestic, inter-country assessments, and tracing in addition to adoption counselling /child placement combined with conducting foster care assessments and associated child placement work
SHB	Regional team in central location, with exception of Kerry worker who is based in that community care area. All workers accountable to senior social worker.	Headed by Senior Social Worker	A broad based adoption service domestic, and inter-country assessments, and tracing. Child placement associated with domestic adoption
WHB	Community care based, Social workers prime identification is as part of local community care team, but there is good opportunity for formal co-operation across community care boundaries . Social workers have dual accountability to adoption senior social worker for adoption work and community care senior social worker/team	Headed by Regional Senior Social Worker with primary responsibility for development and co-ordination of the adoption service	A broad based adoption service which includes domestic and inter-country assessments, tracing and adoption counselling and child placement
PACT	Accredited Adoption Agency in voluntary sector. No contractual arrangement with Health Boards. ICA is a small component of entire work	Headed by Senior Social Worker	A broad based adoption service which includes domestic, inter-country assessments, and tracing in addition to adoption counselling and child placement

Finding: A variety of arrangements exist for delivery of the ICA service by health boards, including regional teams, community care based workers, combination arrangements, and through arrangements with the registered adoption societies in the voluntary sector.

The ICA service is delivered by specialist teams, teams which include ICA as part of a related range of services, and by general community care workers. These variations reflect broader organisational arrangements, geographical factors and service demand levels.

4.3 Staffing of the ICA Service

4.3.1 Introduction

The staffing of the ICA service is considered in this section under the following headings:

- assignment of professional staff
- qualifications and experience levels of professional staff

issues in professional staffing
assignment of administrative staff
accommodation and resources

Given the nature of team structures and tasks assigned to individual workers described above, it is not possible to delineate exactly the number of posts assigned to ICA. Staff were asked to ascribe the percentage of their time spent on ICA, and the figures in the tables are therefore an approximation rather than a definitive statement of staffing resources. The large number of posts which were subdivided between ICA and other tasks made it difficult to reliably calculate the actual number of posts in ICA.

4.3.2 Assignment of Professional Staff

Data was collected to establish the numbers of workers employed at basic professional social worker grade, and changes in the work force engaged in ICA between period January 1998 and December 1998.

The number of staff assigned to inter-country adoption in January 1998 and December 1998 is presented in Table 4.2. The number of posts in which the staff had involvement in ICA are identified, and an estimate of the percentage of workers time spent on ICA within these posts is presented. From this a calculation is made of the number of whole-time equivalent staff involved in the ICA service. The data is presented according to numbers of staff allocated to the adoption service as the service is defined and outlined in Table 4.1. The increase in staff in 1998 is noted, if applicable. It should be noted that, because of the complexity of staff assignment, a considerably higher number of workers are involved in the service, over the number of posts assigned. This is illustrated in the Table 4.2.

Table 4.2
Staff associated with Inter-country adoption service

Health Board	Total No. of Social Work (basic grade) posts assigned to ICA on 1 Jan 98	Total No. of Social Work posts assigned to ICA on 20 Dec. 98	Calculation of no. of Wholetime Equivalent staff working in ICA at mid 98*	No of Social Workers conducting ICA Assessments in 1998	SSW/Team Leader	Comments
EHB	6 posts	8 posts 90% ICA	5.5	13	1 SSW .85 ICA 1 team Leader .30 ICA	Increase in staff in year. 3 staff seeking transfers out;
MHB	1.5 posts in adoption service of which .75 is used for ICA	1.5 posts	1.3	4	1 SSW .15% of time to ICA	3 of 4 staff leaving
MWHB	1.5 adoption posts of which .50 is assigned to ICA	1.5 posts .5 post vacant	1	2	.25 of TL post designated to ICA	
St. Cath's	2 posts	2 posts	0.5	3	NA	Small aspect of service
NEHB	2.5 posts	4.5 posts .5 temp 1 vacant	1.5	7	1 SSW for Adoption; .75 ICA	Increase in staff. High level of tracing

Table 4.2 — continued
Staff associated with Inter-country adoption service

Health Board	Total No. of Social Work (basic grade) posts assigned to ICA on 1 Jan 98	Total No. of Social Work posts assigned to ICA on 20 Dec. 98	Calculation of no. of Wholetime Equivalent staff working in ICA at mid 98*	No of Social Workers conducting ICA Assessments in 1998	SSW/Team Leader	Comments
NWHB	1 post .50 ICA	1 post	0.5	1	Supervised by SSW, Community Care	NWHB has just started providing direct service in Sligo area
St. Mura's	1 post .50 ICA	1 post .50 ICA	0.5	1	NA	0
SEHB	2 posts	2 posts 1.2 of posts to ICA 3 staff	1.5	4	1 SSW for Adoption .80 of work	Vacancy during 1998
SHB	3.6 posts	6.6 posts	3	5	1 SSW for Adoption .25 ICA	Increase in staff in year. Vacancies exist
WHB	2 adoption posts .25 ICA 1 vacancy	3 adoption posts .25 ICA; 4/5 c c SW conducted 1 assessment	1.25	7**	1 SSW for Adoption .25 ICA	Vacancy filled in Roscommon, previous long delays.
PACT	1 post	3 on sessional basis	1	5	1 SSW	Small aspect of service
Total	19.6 posts equiv.	26 posts equiv.	17.55	51		

*This figure is an estimate of the full-time equivalent, calculated using the % of posts, many of which are part-time, and includes an adjustment for where the SSW is carrying a significant case load

**Technically correct but 5 social workers only handled one assessment each.

It can be seen from the table that there has been an increase in staffing levels from the 1st January 1998 to the 20th December 1998 in three health boards (EHB; NEHB; SHB), with the overall staffing posts equivalent rising from 19.6 to 26 in the year. Outside of the largest teams dedicated to ICA (in the EHB & SHB) it can be seen that the number of posts allocated to ICA is small.

At the end of 1998, the EHB team is comprised of eight full time posts, which is a 25% increase since January 1998. A number of these posts are job shared. The senior social worker, along with a team leader, carries responsibility for the supervision and management of the team. This management team also have responsibility for running the Fostering Resource Group which contains five posts. It is estimated that approx. 90% of the team's capacity is spent on inter-country adoption. The available time is allocated according to the different tasks such as hosting information meetings, preparation courses, home studies, including second applications and extensions. In recent time requests for post-placement reports are putting an increasingly heavy strain on the team's resources.

Finding: The equivalent of 26 social work posts are assigned to ICA at the end of 1998, a rise during the year from 19.6 posts, or a 25% increase. However, it is calculated that an effective whole-time equivalent of 17.55 workers, made up of fractions of workers time allocated to ICA, was in place in 1998. 51 social workers were involved in the delivery of the service in 1998.

4.3.3 Qualifications and Experience of Professional Workers

The data in this section refers to 51 social workers, across 8 health boards and 3 adoption agencies, as detailed in Table 4.2 above, involved in inter-country adoption in 1998.

From the returns provided, 96.1% (49) of the sample of 51 workers hold a CQSW/ NQSW professional qualification in social work . Of the remaining two workers, one expects to receive this qualification in 1999.

In this table, information is given on the distribution of the range of experience of the 51 social workers involved in ICA in 1998.

Table 4.3
Length of Experience as Social Workers

Length of Experience	2-4 years	5-7 years	8-10 years	11-13 years	14-16 years	17-19 years	20 + years
Number in Category	3	4	7	2	11	4	20
% in category	5.9	7.8	13.7	3.9	21.6	7.8	39.2

Valid cases 51 Missing cases 0

The table shows that 39.2% (20) of workers have been working as social workers for 20 years or more. The overall trend is indicative of a highly experienced workforce assigned to ICA.

In Table 4.4 , information is given on the range of experience in conducting assessments (inclusive of domestic and inter-country adoption and foster care) of the 51 social workers involved in ICA in 1998.

Table 4.4
Number of Years experience of Social Workers involved in general Assessment

Years	0-1 year	2-4 years	5-7 years	8-10 years	11-13 years	14-16 years	17-19 years	20 + years
Number in Category	3	9	10	7	5	1	3	13
% in category	5.9	17.6	19.6	13.7	9.8	2	5.9	25.5

Valid cases 51 Missing cases 0

The majority (77%) of workers in the sample have more that five years experience in assessment. Only three social workers in the sample have less than 1 year's experience of assessment work.

In Table 4.5, information is given on the range of experience of the 51 social workers involved in inter-country adoption in 1998.

Table 4.5
Number of Years Social Workers Involved in ICA

Years in ICA work	0-1 years	2-3 years	4-5 years	6-7 years	8-9 years	10 + years
Number in Category	17	7	12	10	4	1
% in category	33.3	13.7	23.5	19.6	7.8	2

Valid cases 51 Missing cases 0

The table shows that 33.3% (17) of workers are in their first year's experience in inter-country adoption. These workers are located in the NWHB, WHB, SHB, SEHB, NEHB, EHB and PACT, and indicates that new workers are being brought into the service. The distribution of levels of

experience reflects the fact that inter-country adoption is a relatively new phenomenon in Irish society.

Finding: 96.1% (49) of the sample of 51 workers involved in ICA hold a CQSW/ NQSW qualification in social work. The overall trend is indicative of social workers with long experience, including 77% of those assigned to ICA with more than five years in general assessment for child placement. One third of the workers, in keeping with the increases in staffing levels, are in their first year working in ICA.

4.3.4 Issues Relating to Professional Staffing

A number of specific issues emerged in the research in relation to professional staffing in the health boards. These are described briefly in the following paragraphs, and are considered further in Chapter Six, dealing with recommendations.

ICA represents a very small service relative to the overall social work complement. In section 4.2. above, the variation across regions was shown in terms of structure of teams and delivery of service. Isolation of staff in the teams where numbers of assessments are low is a feature of ICA work, especially if workers do not have opportunities for formal team work and development of the service. This tends to impede productivity, as the opportunity to build on other's experience is not utilised, and the wheel is continuously re-invented. It also allows for marked difference in practice within Health Boards.

A major theme which emerged in many health boards was the effect of positions filled on an "acting" basis. This has arisen out of the changes in social work and child care following the accelerated pace of development associated with the Child Care Act, 1991. Since 1993, £70 million has been provided for the general child care service. A substantial proportion of this money has been associated with increased staffing levels. While welcomed, it has had some down-stream effects, with several areas reporting a "sense of transience". A number of boards appear to have sorted out such issues recently, but a number remain where this is a live issue.

There are shortages of social workers generally in the health boards, and this has a knock-on effect in terms of recruitment of staff for ICA. Adoption posts are not advertised separately, and are filled from the general panel. It is generally the case that newly recruited staff work in child protection and it is by transfer, after internal competition, that most positions are filled in ICA.

Retention of existing staff is a major issue in two health boards. In the MHB, three of four staff, including the Senior Social Worker, are leaving. This is attributed to local circumstances, and if it happens, there will obviously be serious implications because of the loss of expertise. The EHB has applications for transfers out from three of the total of eleven staff currently working in ICA. The public controversy is cited as being a factor in this case.

As shown above, in many cases ICA is only one part of the adoption service provided, and staff are striving to balance other aspects of the work. Managing the adoption case load, with all its elements is difficult for workers. In the general teams, ICA assessments may be seen as a lower priority than child protection work, when these cases are allocated to workers.

The social work profession is predominantly female, and replacing staff on maternity leave is seen as a major issue, which can seriously affect continuity of the service.

4.3.5 Administrative Staffing of ICA Service

With the exception of EHB and SHB, there are few administrative staff designated to work in the area of ICA. However, the familiarity of administrative staff with adoption or family placement is

important, as familiarity with the work provides greater efficiency and a sense of ownership of work, with enhanced team-working. The difficulty of obtaining administrative backup was a recurrent theme in the review among professional workers. Few of the social work staff have access to computers, and they are dependent on administrative support. Examples were cited of social work staff using their own computers to type final reports at home. Typing of final reports was given priority in many areas, but this frequently had to be negotiated on an individual basis. The issue of competing interests was accentuated, where administrative staff also support the general community care pool, rather than being a designated adoption or family placement service.

Table 4.6
Administrative Staffing in ICA

Health Board	Admin. Staff	Admin. Staff Specifically Designated (SD) or Shared (S)
EHB	6	Four administrative staff are delegated to work specifically in the area of inter-country adoption (typists) +2 senior administrative staff with responsibility for ICA and other child care functions
MHB	1 .20	No specific staff designated; shared with community care team Severe shortage
MWHB	1 .25	Specifically designated for .25 of work, shared with other service
St. Cath's	1	shared with other aspects of work
NEHB	1	Worker shared many duties i.e. receptionist
NWHB	1	No specific staff
St. Mura's	1	Responsible for other aspects of service also
SEHB	1	Shared with other disciplines
SHB	1	Specifically designated
WHB		No specific staff; admin. staff are shared with community care team
PACT	1	Carries out related tasks
Total	10.5 equivalent	

Finding: 10.5 posts equivalent are assigned to ICA. Most of the administrative/ secretarial staff assigned to ICA are at grade III.

4.3.6 Office Accommodation

While the research did not include a specific inspection of office accommodation used by ICA workers, a wide variation in the office facilities available was noted. It is clear that some staff are working in poor and over-crowded accommodation. This was seen to affect both efficiency and morale. Attention has been drawn to the general lack of, and poor standard of office facilities by the visiting Chief Social Worker Advisor from New Zealand.⁴ In many areas, staff do not have access to interviewing facilities, and as a result locate most interviews in the applicants homes. Attention was also drawn to the fact that, where staff numbers had been increased, additional facilities had not been improved. The NEHB and MWHB had very good facilities, and had access to interview rooms, where many ICA interviews were held.

⁴Mike Doolan, speaking at Conference on Family Group Conferences, Malahide, Co. Dublin 5/3/99

Finding: It is clear that some staff are working in poor and over-crowded accommodation. This was seen to affect both efficiency and morale.

4.4 Service Demand Levels

4.4.1 Enquiries and Applications for Assessment

In this section data concerning levels of enquiries and applications for inter-country adoption assessments in Ireland in 1998 is presented. Table 4.7 gives the numbers of enquiries and applications received by each Health Board from 1 January 1998 to 31 December 1998. The number of applications for assessment is sub-divided according to first and second applications, and applications for extension of declarations received.

Table 4.7
Number of Enquiries and Applications received by Health Board

Health Board	No. of Enquiries	No. of 1st applications received	No. of 2nd applications received	No. of applications for extensions received
EHB	361	266	42	14*
MHB	38	24	1	5
MWHB	86	19	5	11
St Cath's	45	9	0	1
NEHB	100	61	1	7*
NWHB	20	17	0	0*
St Mura's	33	28	1	6
SEHB	95	22	2	4*
SHB	305	142	7	6
WHB	82	30	—	6*
PACT	47	2	1	N/A
Total	1,212	620	60	59

*Denotes data obtained from the Adoption Board

It should be noted that some persons may have made enquiries from both health boards and registered adoption societies in their area of residence. Additionally, some of the enquiries to the registered adoption societies in the voluntary sector may have been made by people without reference to boundaries.

Finding: 1,212 enquiries were made in 1998 concerning ICA, 620 applications were made for first assessments, 60 applications were made for second assessments, and 59 applications were made for extensions of declarations already granted.

4.4.2 Enquiry and Application Rates

To enable comparisons to be made across health boards, and to assist in prediction of workloads, the demand levels for assessment are presented as a ratio of the population of each health board region, as extracted from the 1996 Census of Population. The focus of this research concerns that segment of the population between the ages of 20 and 59. This age cohort was selected as ICA applicants need to be 21 years or over, and declarations have been granted in 1998 to persons up to 57 years of age. This range is taken therefore as representing possible inter-country adopters in the population. The total population of each health board region is also given.

Table 4.8
Enquiry and Application Rates for Inter-country Adoption Assessment by Health Board*

Health Board	Total Population Served	Population between ages of 20-59 yrs	Enquiry Rate per 100,000 pop.	Application Rate for first Assessments per 100,000 pop.
EHB	1,295,939	711,868	51	37
MHB	205,542	100,408	38	24
MWHB	317,069	160,905	81	17
NEHB	306,155	153,109	65	40
NWHB	210,872	101,302	52	28
SEHB	391,517	195,383	49	11
SHB	546,640	279,989	109	51
WHB	352,353	160,032	51	19
Total	3,626,087	1,862,996	Nat Avg. = 65	Nat Avg. = 33

*Table does not include PACT's enquiry and application rates, as PACT takes applications from the whole country, and numbers involved are small.

The MWHB includes St. Catherine's Adoption Society data. The NWHB includes St. Mura's Adoption Society.

Finding: The National Average for ICA enquiry rates is 65 enquiries per 100,000 of relevant population. Rates vary by a factor of three from the health board with lowest to the highest rate of enquiry. The SHB have the highest enquiry rates in the country, while the MHB have the lowest.

Finding: The National Average for first application rates for ICA assessments is 33 applications per 100,000 of relevant population. Rates vary by a factor of almost five from the health board with lowest to the highest rate of application. The SHB have the highest application rates in the country, while the SEHB have the lowest. The SHB's application rate is nearly double the national average, while the SEHB's rate is 33% of the average.

4.4.3 Enquiry to application ratios

The ratio of enquiries to applications, and the fall-off in interest in ICA between making the enquiry and making of applications also varies. This is shown in Table 4.9

Table 4.9
Enquiry to Application Ratios for Inter-country Adoption Assessment by Health Board*

Health Board	Enquiry Rate per 100,000 pop.	Assessment Application Rate per 100,000 pop.	Application to Enquiry Ratios
EHB	51	37	73%
MHB	38	24	63%
MWHB	81	17	21%
NEHB	65	40	62%
NWHB	52	28	54%
SEHB	49	11	22%
SHB	109	51	55%
WHB	51	19	37%
Total	Avg. = 65	Avg. = 33	50%

Finding: The National Average for application following enquiry rate is 50%. The fall off ratio is most dramatic in the MWHB, with only 21% going from enquiry to application stage, while the EHB had the highest at 73% going forward to make application.

4.5 Numbers of Applications Processed in 1998

4.5.1 Applications Processed in 1998

In this section, the numbers of applications for assessment which were processed to completion are considered. The tables in this section contain data for each assessment completed and presented to Placement Committees in the various health boards between 1 January and the 20 December 1998.

Table 4.10
Number and Type of Application Processed to Completion in Each Health Board

Health Board	No. of 1st applications processed to completion	No. of 2nd applications processed to completion	Total
EHB	58	11	69
MHB	11	1	12
MWHB	13	2	15
St. Catherine's	1	0	1
NEHB	14	4	18
NWHB	1	0	1
St Mura's	8	0	8
SEHB	23	2	25
SHB	24	4	28
WHB	13	5	18
PACT	3	0	3
Total	169	29	198

The number of assessment presented in the above table is based on the total numbers presented by individual health Boards. However the total number of applicants for first assessments identified in individual records was 175 while 21 second assessments were identified. This data set of 175 individual records of first assessments and 21 second assessments is used for detailed analysis of the duration of the assessment process in Section 4.6 below.

Finding: 198 applications for assessment were processed to completion, of which 169 were applications for first assessment and 29 were applications for second assessments.

4.5.2 Levels of Activity

Table 4.11 gives information on the levels of activity in each health board. This includes applications allocated to social workers, number of reports presented to the Placement Committees in the health boards, and shows the number of applications withdrawn prior to Placement Committee stage. The number of applications processed to completion is not a full indication of activity rate of the social workers in ICA since they may be undertaking other related duties in ICA such as dealing with initial enquiries, running preparation meetings, attending Placement Committees, completing post placement reports or tasks unrelated to ICA.

Table 4.11
Levels of Activity

Agency	Applications allocated to SWs in 1998	Number of 1st & 2nd assessments presented to Placement Committee 1998	Number of applications withdrawn prior to Placement Committee	Rate of withdrawal
EHB	123	69	6	8%
MHB	16	12	4	31%
MWHB	12	15	1	7%
St. Catherine's	2	1	2	200%
NEHB	38	18	7	44%
NWHB	17	1	0	0%
St. Mura's	18	8	0	0%
SEHB	30	25	1	4%
SHB	41	28	12	37.5%
WHB	23	18	4	24%
PACT	—	3	1	25%
Totals	309	198	38	19%

Finding: The national average rate for withdrawal of applications prior to being presented to the placement committee is 19%. This varies significantly between the agencies, and is connected in part to the different systems of allocations in health boards and adoption agencies.

4.6 Length of the First Assessment Process

4.6.1 Introduction

In this section the length of the assessment process is considered. This is subdivided into a number of sub-sections,

- the time from receipt of application to allocation to social worker;
- the time from allocation to worker to commencement of study;
- the time from date of last interview to submission of the report to the Placement Committee;
- the duration of the assessment part of the process
- the duration of the entire process from receipt of the application to the submission of the completed report to the placement committee.

The data set used in this analysis refers to the applications for first inter-country adoption assessments. In total, there were 175 first applications presented to the Placement Committees. However it was not possible to extract the relevant data from the agencies in all cases. The number of cases used in each section are stated. The proportion of the overall number is stated in the final column and the total number of cases is shown in brackets.

4.6.2 From Application to Allocation

In this section the length of time between the receipt of application and its allocation to a worker is presented. It was not possible to extract the relevant data from the files in eight cases, so the sample in this table is 164 applications.

Table 4.12
Length of Time (months) between Receipt of Application and Allocation to Social Worker

Health Board	0-2 mths	3-4 mths	5-6 mths	7-8 mths	9-10 mths	11-12 mths	13-14 mths	15-16 mths	17-18 mths	19+ mths	Total
EHB	2	3	2	7	6	12	7	12	3	2	34.1% (56)
MHB	1	1	0	0	3	2	1	0	0	0	4.9% (8)
MWHB	4	2	1	2	3	0	1	0	0	0	7.9% (13)
St. Cath's	1	0	0	0	0	0	0	0	0	0	.6% (1)
NEHB	0	2	0	1	1	2	4	5	1	0	9.8% (16)
NWHB* St. Mura's	8	0	0	0	0	0	0	0	0	0	4.9% (8)
SEHB	9	7	3	0	0	1	0	0	0	2	13.4% (22)
SHB	0	1	4	5	9	2	3	1	0	0	15.2% (25)
WHB	3	1	2	1	3	0	0	0	0	3	7.9% (13)
PACT	2	0	0	0	0	0	0	0	0	0	1.2% (2)
Total	18.3% (30)	10.4% (17)	7.3% (12)	9.8% (16)	15.2% (25)	11.6% (19)	9.8% (16)	11% (18)	2.4% (4)	4.3% (7)	100% (164)

No of records missing is 11, sample total is 164

*Only one case was completed in NWHB in 1998 (separate from St Mura's). In this one case limited information was available which results in missing data relating to NWHB in many of the following tables.

36% of applications are allocated within 6 months of being received. 36.6% are allocated between 6 and 12 months, 23.2% are allocated between 12 and 18 months, and 4.3% are allocated after 19 months. However a level of caution is required in relation to these statistics. The way in which allocations are made varies. In one case, a half-time ICA worker had an allocation of 70 cases, which indicates that the applications are allocated soon after being received, even though it is obvious the worker cannot commence the home study in the foreseeable future. Likewise caution is needed in examining the EHB data, as it excludes the preliminary interview conducted by a social worker. This interview is conducted as applicants reach the top of the waiting list. The purpose of the preliminary interview is to establish if the applicants are still interested in proceeding, and to seek submission of all documentation required for assessment purposes. The assessment does not proceed in the EHB until all documentation is submitted. This can account for a long delay between the application date and commencement of the assessment. At the time of research, 35 cases were awaiting documentation for a prolonged period of time which impacted on other cases being allocated to workers from the waiting list.

4.6.3 From Allocation to Commencement

In this section the length of time between allocation to worker and commencement of the home study is shown for first applications only. Out of the 175 cases, there are 169 noted in the table. There are 6 missing observations.

Table. 4.13
Length of Time between Allocation of Social Worker and Commencement of Assessment

Health Board	1 month	2 months	3 months	4 months	5 months	6+months	Total
EHB	56	0	0	0	1	0	33.7% (57)
MHB	9	0	0	0	0	2	6.5% (11)
MWHB	12	0	1	0	0	0	7.7% (13)
St. Cath's	0	0	1	0	0	0	.6% (1)
NEHB	16	0	0	0	0	0	9.5% (16)
NWHB St. Mura's	1	1	2	2	0	0	3.6% (6)
SEHB	12	3	3	2	0	3	13.6% (23)
SHB	24	1	0	0	0	0	14.8% (25)
WHB	13	1	0	0	0	0	8.3% (14)
PACT	3	0	0	0	0	0	1.8% (3)
Total	86.4% (146)	3.6% (6)	4.1% (7)	2.4% (4)	0.6% (1)	3% (5)	100% (169)

Cases missing = 6

Finding: The home study commenced within 1 month from allocation to social worker in the case of 86.4 % of first applications for inter-country adoption. As previously noted the deviation from this norm occurred in the health boards where large numbers of cases were allocated to workers, without realistic prospect of commencing the home study.

4.6.4 From Last Interview to Placement Committee

This section presents information on the period between the last interview and presentation of the recommendation to the Placement Committee. The total number of cases in the table below is 168, as there are 6 missing cases.

Table 4.14
Period of time between final interview and submission of report to the Placement Committee

Health Board	1 mth	2 mths	3 mths	4 mths	5 mths	6 mths	Total
EHB	47	4	3	1	1	0	33.1% (56)
MHB	6	2	0	1	1	0	5.9% (10)
MWHB	8	5	1	0	0	0	8.3% (14)
St. Cath's	0	0	0	1	0	0	.6% (1)
NEHB	14	2	0	0	0	0	9.5% (16)
NWHB St Mura's	8	0	0	0	0	0	4.7% (8)
SEHB	12	3	1	1	3	1	12.4% (21)
SHB	20	4	1	0	0	0	15.4% (26)
WHB	9	2	3	0	0	0	8.3% (14)
PACT	1	2	0	0	0	0	1.8% (3)
Total	74.6% (126)	14.2% (24)	5.4% (9)	2.4% (4)	3.0% (5)	0.6% (1)	100% (169)

Cases missing = 6

Finding: In 74.6% of cases, the time that elapsed from the date of the final interview to the submission of the finished report was 1 month or less. However 11.3% of the total number of cases took from 3 to 6 months to get to the same stage. This pattern occurred in a small number of health boards. The reasons put forward to explain this aspect of the delay included lack of administrative support, sick leave, and delay in organising the visit by the senior social worker. While the numbers of cases in which this happened are small, from the perspective of applicants involved this was a source of enormous frustration.

4.6.5 Duration of the Home Study

The length of time from commencement of the home study to submission of the resulting report to the placement committee gives an indication of the timespan involved in the part of the process where the applicants and social workers are completing the home study.

Table 4.15

Timespan of Assessment Process from commencement of assessment to submission to adoption committee

Health Board	0-5 months	6-11 months	12-17 months	18-23 months	24-29 months	30-35 months	36+ months	Total
EHB	1	27	19	7	2	1		34.2% (57)
MHB		10				1		6.6% (11)
MWHB	2	10	1	1				8.4% (14)
St. Cath's	1							0.6% (1)
NEHB	7	9						9.6% (16)
NWHB St Mura's	3	5						4.7% (8)
SEHB	9	11	3					13.8% (23)
SHB	6	17	2				1	15.6% (26)
WHB	1	14						9.0% (15)
PACT	1	2						1.8% (3)
Total	18.6% (31)	63.6% (106)	15% (25)	4.8% (8)	1.2% (2)	1.2% (2)	0.6% (1)	100% (174)

Almost one fifth of home studies were completed in under five months, and 63.6% were completed between 5-11 months. The small numbers at the upper end of time- scale would suggest complex factors, and may involve deferrals until applicants were ready to recommence. Factors such as pregnancy, bereavement and life changes were put forward as explanations in these cases.

4.6.6 Total Time for processing of Applications

Table 4.16 displays the timespan of the entire assessment process for inter-country adoption, from the date the application was received by the adoption agency to the submission of the report to the Placement Committee.

Table 4.16
Timespan of Assessment Process

Health Board	0-5 months	6-11 months	12-17 months	18-23 months	24-29 months	30-35 months	36+ months	Total
EHB				13	36	6	1	34.8% (58)
MHB		2	2	5	1	1		6.5% (11)
MWHB	1	3	7	1		1		7.7% (13)
St. Cath's		1						.6% (1)
NEHB		2	3	11				9.5% (16)
NWHB			1					.6% (1)
St Mura's	3	5						4.7% (8)
SEHB	2	8	5	5	1	1		13% (22)
SHB		1	12	10	2			14.8% (25)
WHB		5	2	3	4			8.3% (14)
PACT		2						1.2% (2)
Total	3.6% (6)	17.2% (29)	18.9% (32)	28.4% (48)	26% (44)	5.3% (9)	0.6% (1)	100% (169)

Cases missing = 6

Finding: 20.8% of applications for ICA assessments are processed to completion within 12 months of receipt, 47.3% take between 12 and 24 months, 31.3% take between 24 and 36 months, and 1 case took longer than 36 months. Patterns are also evident in the individual health boards. In the EHB, 72% of applications took over 2 years. At the other end of the scale, the NWHB dealt with 88% of their assessments within 12 months. Disparities in the data set are also shown within health boards, for example, the MHB and WHB regions, where the length of the process varies from 6 to 29 months to complete. This may be indicative of variation of practice between community care areas, and particular staffing vacancies within the health boards. A long assessment period may also indicate that there was deferral or suspension of assessment for some reason. Therefore, the figures cannot give an indication of whether the length of time of assessment process is related to agency policy, level of service provision, social work practice issues or difficulties related to the applicants.

4.7 Numbers of Interviews in the Assessment Process

In this section information is presented on the number of interviews undertaken as part of the assessment process. It should be noted that in some cases this includes interviews with a referee as well as individual interviews and couple interviews. In other cases it only includes actual interviews with the applicants and their family.

Table 4.17
Total Number of Interviews Undertaken for First Applicants

Health Board	1-3 IVs	4 IVs	5 IVs	6 IVs	7 IVs	8 IVs	9 IVs	10 IVs	11 IVs	12 IVs	13 IVs	14 IVs	15+ IVs
EHB			1			1	8	14	10	16	5	2	1
MHB					1	1	1		1	6	1	1	
MWHB			1	2	8	1	1			1			
St. Cath's*	1												
NWHB										1			
St. Mura's		2			5	1							
NEHB					7	5	4						
SEHB		1	7	6	2	4					1	1	1
SHB			4	6	7	6	1			1			
WHB			1	1		1	2	1	3	2	2		
PACT				1			1	1					
Total (173)	0.6% (1)	1.7% (3)	8.4% (14)	9.6% (16)	18.0% (30)	10.9% (19)	10.3% (18)	9.1% (16)	8.0% (14)	16.2% (27)	5.1% (9)	2.3% (4)	1.1% (2)

Cases missing = 2

Finding: 36.0% of cases involved between 5 and 7 interviews. 21.2% involved 8 or 9 interviews. 29.3% took 10 to 12 interviews and 8% took 13 or more interviews. In 3.4% of cases, the assessment comprised of less than 4 interviews. These cases may refer to deferrals, or other reasons for rapidly ending the process may have been involved. In four health boards practically all assessments were completed with not more than 9 interviews, whereas in the Eastern Health Board 80% of cases involved 10 or more interviews. In the EHB the data set given specifically mentioned the number of interviews was inclusive of the preliminary interview, interview with senior social worker, interview to read report and interview with two referees. Nonetheless the disparity between the EHB and other agencies is marked.

4.8 Second Assessments

The following data sets refer to cases designated as second applications for inter-country adoption assessment only in the data returned to us. There were 21 applications in this category in total in 1998. These applicants had been previously assessed for eligibility for inter-country adoption. This category raises particular questions, both in relation to the priority given to second assessments, with resultant time implications, as shown in Table 4.17, and the extent of the process involved as detailed in Table 4.18. Caution is needed in drawing conclusions from this data because of the small sample involved.

Table 4.18
Timespan of Second Assessment Process per Health Board

Health Board	0-5 months	6-11 months	12-17 months	18-23 months	Total
EHB			3	8	52.4% (11)
MHB		1			4.8% (1)
SEHB	1	1			9.5% (2)
SHB		2			9.5% (2)
WHB		4	1		23.8% (5)
Total	4.8% (1)	38% (8)	19.2% (4)	38% (8)	100% (21)

Finding: 38.0% of applications for second assessments took from 6-11 months to process from application to presentation to the Placement Committee. 19.2% took between 12 and 17 months, and 38.0% of second applications took between 1 and a half and 2 years from the date of application receipt to the submission of the report to the Placement Committee. The Eastern Health Board had the highest number of applications for second assessments and also took the longest times to process them. This reflects that agency's policy of not prioritising second applications.

Table 4.19
Total Number of Interviews Undertaken in Home Assessment for Second Applicants

Health Board	3 IVs	4 IVs	5 IVs	6 IVs	7 IVs	8 IVs	Total
EHB	1	1	6	3			52.4% (11)
MHB						1	4.8% (1)
SEHB		1			1		9.5% (2)
SHB			2				9.5% (2)
WHB	2	1	1	1			23.8% (5)
Total	14.3% (3)	14.3% (3)	42.9% (9)	19% (4)	4.8% (1)	4.8% (1)	100% (21)

Finding: 71.5% of applicants had five interviews or less in their second assessment, and 19% had 6 interviews and 9.6 % of second assessments had between 7 and 8 interviews in the home study. The reasons put forward by the agency with the highest number of interviews were complexity in the cases which warranted different exploration.

The need for 5-6 interviews as a norm in second assessments may be an issue, particularly if the agency is involved in completing post-placement reports for the applicants.

4.9 The Cost of The Inter-Country Adoption Service

The final data presented in this chapter relates to information gathered on inter-country adoption service as a cost centre. The data refers to total cost involved in financing the inter-country adoption service in terms of expenditure on social work staff, administrative staff, travel and subsistence, overheads and the Placement Committee.

The purpose of this table is to provide base-line information on the ICA service costs. Any differences noted in terms of expenditure on ICA needs to be examined against levels of demand on service, levels of activity and levels of output. This data is further considered in Chapter Eight, where the cost implications of changing the service in terms of service management and practice are examined.

Table 4.20
Inter-Country Adoption as a Cost Centre in 1998

Health Board	Social work staff	Admin. staff	Travel and sub	Overheads	Placement committee	Other	Total
EHB	£292,971	£79,623	£20,000	£70,000	£9,836	£10,000	£482,430
MHB	£21,677	£1,586	£4,079	£1,200	£4,297	—	£32,839
MWHB	£25,000	£7,000	£4,000	£6,000	£3,000	£600	£55,600
						(training) 10,000 (legal fees)	
St. Cath's	£4,670	£2,759	£224	£284	N/A	—	£7,937
NEHB*	£40,250	£4,549	£10,500	£1,072	£720	—	£57,091
NWHB	£30,000	£7,500	£3,000	£2,000	£1,000	—	£43,500
St. Mura's	£22,000	—	—	—	—	—	£22,000
WHB	£37,000	£5,000	£5,000	£3,000	£600	—	£50,600
SHB	£140,273	£16,309	£9,951	Costs included in HQ costs**	Costs included in HQ costs	£2,000	£168,534
				£5,000	£1,000	£500 — Training £500 — Legal Fees	£87,084
SEHB	£65,289	£6,795	£8,000				
PACT	£3,204	£3,552	£537	£816	Voluntary		£8,109
Totals	£681,334	£134,673	£65,291	£89,372	£20,543	£23,600	£1,015,723

*After submission of the report the NEHB provided revised figures for their costs. The amended figures are included above, and also where this information is used in Chapter 8.

**Costs calculated in budget as part of Headquarters costs and could not be broken down for this purpose.

4.10 Conclusion

This chapter has presented data on staffing levels and service delivery. It has shown that while 51 staff were involved in service provision in 1998, the whole-time equivalent in terms of positions is less than 20. A significant growth in provision of staffing levels for the ICA service was noted in a number of agencies, although the potential benefits of this is offset by other problems.

There is very significant variation between different parts of the country in terms of demand for ICA assessments. It can be seen clearly that where demand is highest, the agencies have not been able to meet the level of demand. The ICA service can be seen to be under-resourced in terms of the demands currently being placed on it. This may be viewed as part of a broader pattern of failure to adequately resource responsibilities placed on agencies under different legislation. The rapid growth in numbers of persons exercising their legislative right to demand an assessment has greatly exacerbated the situation.

The overall length of time involved in processing an assessment varies in different agencies. This reflects primarily the pressures on certain agencies in terms of demand levels for the service, and growing waiting lists. This variation diminished when the time-scale from commencement of the home study to presentation of report was examined. When number of interviews involved in the home study was examined, the EHB had higher number of interviews, though their data specifically included all contact interviews with the applicants. In other agencies it was not clear if preliminary and referee interviews were included.

The final data presented related to the costs of the ICA service provision, with the service seen to be costing approx. £1m in 1998.

CHAPTER 5

Current Assessment Procedures and Social Work Practice in Health Boards

5.1 Introduction

In this chapter, the procedures and the process involved in handling an application for an ICA assessment are described. The general stages involved have been identified in Chapter Two, and shown in Figure 2.1. The views of the different stakeholders are described, before the assessment practice is reviewed according to the following steps in the process

- Enquiry
- Application stage
- Assessment
 - Preparation course
 - Home study
 - Supervision of work
 - Involvement of senior social workers
- Completion of home study
- Report writing
- Submission to Placement committee
- Placement committee composition and operation
- Adoption Board decision-making

5.2 The Stakeholders' Perspectives

5.2.1 Introduction

The largely descriptive accounts in this chapter are based on data collected during consultations with the different stakeholders, including:

- personnel from health boards and registered Adoption Societies;
- representatives from organisations representing adoptive parents and inter-country adopters;
- birth/natural parents, and representatives of people working with parents, who have placed children for adoption;
- adoptees;
- the Adoption Board.

In addition to the meetings, documentary data from the agencies pertaining to assessment at both preparation and home study stage was obtained and examined. This overview of assessment describes the situation in individual health boards, and provides a comparative perspective on the data. Information relates to general rather than specific practices, as even within individual boards, there are variations. It is not within the scope of this project to report on individual community care areas, so general descriptions are given, unless there was need to be specific. The description of the process needs to be seen against the following key issues to emerge during consultations with the different stakeholders.

Representatives of Inter-Country Adopters have made complaints concerning the duration and process involved in ICA assessment, including:

- Variation of practices across health boards;

Extended time-scales involved;
 Unwarranted levels of intrusiveness and insensitivity demonstrated by social workers, even 'though there was also acknowledgement of many excellent and dedicated social workers' (PNPIC)
 Negative ethos towards ICA among workers
 Low productivity of staff engaged in ICA work;
 Requirements for second assessments;
 Dissatisfaction with preparation courses;

Key issues to emerge during consultations from the social work perspective include:

Lack of guidance from Dept. of Health and Children and the Adoption Board, particularly in respect of

- Age of applicants — concerns related to lack of regulation of upper age limits;
- Number of children adopted: i.e. single child, two children, siblings;
- Format of report writing;
- Preparation.

Stipulation in existing guidance that the standard in domestic and ICA assessments should be the same, when they perceive the context and circumstances surrounding both to be qualitatively different

- Cultural and race issues
- Infertility and adoption
- Under-resourcing of service

5.2.2 Adopters Views on the Assessment Process

Data was obtained from a nation-wide sample of 60 sets of applicants who had obtained a declaration from the Adoption Board in the year 1998. Responses were received from 32 (51.6%) of those contacted. An elaboration of adopters' views was obtained from the sample, in which the participants were asked three open-ended questions relating to:

- what they found most helpful in the assessment to prepare them for adoptive parenthood;
- what they found least helpful, and
- what changes they would propose to make to prepare them for adoptive parenthood.

5.2.2.1 Most helpful

The respondents reported that the preparation course was the most helpful aspect of the inter-country adoption assessment process. In particular it was noted that dealing with topics such as racism and institutionalisation helped applicants to clarify their thinking around the issue of inter-country adoption and raised their awareness about potential difficulties that could arise. Furthermore the use of case studies, group discussions, videos and other material helped illuminate the benefits and possible drawbacks of inter-country adoption.

Adopters also welcomed the contact with other applicants and adoptive parents, and the advice and information given. Respondents in the SHB were enthusiastic about the establishment of a support group for adoptive parents. Most adopters found the Irish Foreign Adoption Group an indispensable resource. In relation to the helpful aspects of the process, the Adoption Board were noted to be supportive, and Barnardo's Child Care Services were found to be helpful.

5.2.2.2 Least Helpful

The least helpful elements of the assessment process and practice were also reported across the health boards. A number of respondents described the assessment as too negative, intrusive and

repetitive in content. They questioned the relevance of certain topics covered, such as the couple's sex life, and the detail required for the biography question.

A small number reported a negative social workers' attitude and philosophy to inter-country adoption. Many applicants noted a feeling of powerlessness in an unequal partnership, and a sense of being under suspicion.

Some comments were made on poor report-writing, and the length of some of the reports was questioned, especially in the EHB. Applicants in the MWHB expressed concern about the media publicity of inter-country adoption issues, which was leading to a general mistrust of social workers, and which in turn could make it more difficult for children adopted from overseas.

The most common comment in the least helpful category related to the duration of the entire assessment process. 'Waiting', 'delays' and 'duration' are key words repeated in many of the respondents returned questionnaires. The waiting period between application and allocation of social worker, delays before commencement of assessment, the delays between interviews, and the time lag between the last interview and the issuing of a declaration are all pinpointed as areas of concern.

Other issues raised included the lack of standardised guidelines during the assessment procedure, and the fact that assessment criteria remain vague. The need for a second assessment to be carried out on those who wish to adopt for the second time is questioned by respondents in the MHB and the MWHB. In the EHB and SHB regions, respondents questioned the stipulation that, whilst undergoing IVF treatment, a couple's assessment had to be stopped.

5.2.2.3 Changes Proposed

In replying to the question of changes proposed, the respondents made many suggestions. Some called for more help in mediating adoptive placements overseas following the completion of the assessment. They advocated that more detailed information should be made available from the Adoption Board. A change in philosophy and more positive attitudes from social workers, particularly in the EHB area, would also be welcomed. It was suggested that applicants should be given more credit for their life experience, and that the focus during the process should be more on the present and the applicants' capacity to parent a child into the future, rather than the past. The balance of topics covered, and the necessity of including certain questions into the home study (e.g. the occupation of an applicant's brother/sister which was thought to be irrelevant to the parenting skills of the applicant) should be reviewed.

In relation to procedural changes, many respondents questioned the need for a second assessment for second-time applicants. A maximum time limit for the entire assessment process was advocated, along with a definite time-table for interviews including approximate start and finishing times and number and duration of visits. Many applicants proposed that more social workers needed to be employed. A review of the training of social workers was raised by respondents in the EHB area. Greater liaison between the agencies and the Irish Foreign Adoption Group was proposed.

While respondents generally favoured the inclusion of preparation courses in the assessment, attention was drawn to the importance of the use of a range of facilitation skills, other than didactic teaching. Applicants suggested that the option of including other health care professionals for example nurses, doctors, psychologists and counsellors in the assessment process be considered.

5.2.3 Adoptees' Views

As ICA is a relatively recent phenomenon in Ireland, there are no organisations representing children adopted from overseas. However, representatives of adult adoptees were included as part of the consultation for the research. They suggested that the following issues need to be highlighted and considered:

- the need for a thorough assessment;
- an age restriction of forty years;
- the importance of exploring sexuality as an issue in preparation for adoptive parenthood;
- inclusion of an MRI scan to ensure medical fitness to adopt;
- the qualities which should be sought in adoptive parents include being self-controlled, mature, secure, autonomous, light-hearted, energetic, open-minded, fulfilled people make good parents.

5.2.4 Birth/ Natural Parents' Perspective

The birth/natural parents expressed the following views:

- that an increase in the Irish overseas development aid budget would provide a more tangible and beneficial assistance to a greater number of children in less developed countries who are in need material and emotional help than inter-country adoption;
- that inter-country adoption constitutes the worst excess of capitalist power over the developing world;
- that the health board should monitor the placement of each child for six months after their arrival in Ireland;
- that a post-adoption services board should be instituted;
- that a child's birth certificate should always be available to him/her and that the child's name should never be changed. If adoptive parents insist on changing the name, then the adoption certificate should include both sets of names. At 18 years of age the child should be allowed to revert to his/her birth name if he/she so chooses;
- that the child should be allowed to study his/her own language, culture and religion of the birth/natural mother, and should meet regularly with other adopted children from the same country;
- that the child should be informed about the political and social situation in the country of his/her birth which led to the adoption;
- that the child should be encouraged to write to the birth/natural mother, father and siblings and receive letters and photographs in exchange, and that the open adoption system envisaged for domestic adoption should be provided for children from inter-country adoption;
- that there should be a minimum duration for an adoption assessment of at least one year from the time of application;
- that it should be mandatory for a percentage of assessment time to be given over to input from both birth/ natural mothers of adopted children and adopted adults so that adopters can understand the undeniable ties that exist.

5.3 The Enquiry Stage

The methods used to deal with enquiries from prospective adopters to the health boards are described in Table 5.1. Enquirers sometimes start with the Adoption Board, and are referred on to their local health board.

Table 5.1
The Enquiry Stage
Handling Initial Requests for Information on ICA

Health Board	How are requests for information on inter-country adoption handled?
EHB	Information is given on the phone. Applicants are invited to the next monthly information meeting. Attendance is required at an information meeting, prior to being given an application form.
MHB	Differs within the region. In one area, enquirers are dealt with over the phone, and an application form is sent out on request. In another area, a meeting is arranged following a query, and an application form is then sent on request.
MWHB	Information leaflets are sent out in response to query, and specific questions are answered later if applicant phones. Applicants then invited to information meeting.
St. Cath.	Queries dealt with by social worker. Applicants met by social worker and then invited to information meeting with 6/7 couples, within 2 months.
NEHB	Enquiries by phone are dealt with by the Adoption Service secretary. Written requests are dealt with by the SSW. Couples are asked to attend an information session, which is mandatory, before application forms are issued.
NWHB	Enquirers are dealt with on the phone by the social worker. An explanation of the process is given. If enquirer is still interested, they are told to make written request for form, and also to contact IFAG and Adoptive Parents Association.
St. Mura's	They are dealt with on the phone by the social worker. Explanation of process is given. If still interested they are told to make written request for form, and to contact IFAG and Adoptive Parents Association.
SHB	Application forms are issued on receipt of a written request from the couple.
SEHB	By telephone and letter. It is standard practice that all applicants are given an info pack, and told of meetings organised by the IFAG.
WHB	All enquiries are routed through SSW in Galway if enquirers make contact with local community care team. Standard information is available for first contact. An info pack is sent out. Applicants are asked to apply in writing for form.
PACT	Couple sent letter setting out agency's application requirements, and enquiry sheet for completion. Names placed on an enquiry list, and invited to next info meeting.

As can be seen in the Table above, several Health Boards invite enquirers to information meetings, which are convened regularly. The Adoption Board, in its guidance in 1993, recommended holding of information meetings. Table 5.2 describes practice in this area.

Table 5.2
The Enquiry Stage
Regular Information Meetings

Health Board	Format of regular information meeting
EHB	Hosted by 2 social workers on a monthly basis. Information covers: 1991 Act ; Countries eligible for adoption; Assessment process
MHB	No information meetings hosted
MWHB	Information meeting held on monthly basis hosted by 2 social workers for 12 people max. Countries eligible for adoption discussed. Comprehensive information pack provided. PNPIC newsletter given out.
St. Cath's	Information covers history of adoption, 1991 Act, Countries eligible for adoption and process explained
NEHB	Info meeting is also part of the preparation course. Not more than 24 people. Held monthly. Hosted by SSW.
NWHB	No information meetings
St Mura's	No information meetings
SEHB	Planning to start information meetings in 1999. Staff did not put on preparation courses due to lack of resources, and the large geographical spread of the area.
SHB	Applicants invited to information meeting in groups, prior to assessment commencing 3 hours duration.
WHB	No information meeting Comprehensive information pack sent out.
PACT	Unknown

Practice of how initial enquiries about ICA are handled varies across health boards. In general social workers respond to phone calls, and discuss the subject with enquirers. As a follow through, some health boards send out information packs, and others invite interested persons to routine information meetings. The numbers attending these can vary significantly. Where information meetings are convened, the content covered is similar but the numbers attending can have major impact on the process of the meeting, and how the messages on inter-country adoption are interpreted by applicants.

5.4 The Application Stage

Making an application for an ICA assessment to the health board is the formal request to exercise the right given under the 1991 Act. The process involved in making an application is described in Table 5.3

Table 5.3
The Application Stage

Health Board	The Application Stage
EHB	Applicants, after they attend the information meeting are asked to write in for an application form. Each application is given a sequential number on receipt, and assessments are allocated to social workers strictly on this numerical basis.
MHB	An application form is given on request, either arising from phone call or writing in. Application form requires biographical data and motivation only. Permission also obtained for Garda clearance check.
MWHB	An application form is presented following attendance at an information meeting. Form includes basic biographical information.
St. Cath's	Applicants write for application form following information meeting.
NEHB	Applicants, after they attend the information meeting, are asked to write in for an application form. Each application is given a sequential number on receipt, and assessments are allocated to social workers strictly on this numerical basis.
NWHB	Applicants write in for application form, and are put on waiting list
St Mura's	Applicants write in for application form, and are put on waiting list
SEHB	Applicants write in and are placed on waiting list
SHB	Application form issued on receipt of written request.
WHB	Application form sent if requested, when information sought
PACT	

Although practice varies in relation to applying for an ICA assessment, health boards do not generally issue application forms without a written request. Requests for application forms in those boards which hold information meetings generally will not be considered unless persons have attended an information meeting. Application forms used by health boards varied in the level of detail required, ranging from brief biographies to more detailed questions such as motivation for adoption.

The apparent policy of making it hard to get application forms appears to be a general attempt to ensure that applications are made from an informed position, and are bona-fide. This procedure has been criticised by the applicants on the basis of unnecessary bureaucracy and as time-wasting. According to the staff in several boards, the reasons for seeking written requests are twofold:

- to ensure that people can reflect on the ICA information given, and
- to avoid a situation where every person attending an information meeting rushes to complete the application form, and tries to be first to hand it in after the meeting, thereby ensuring a higher place on the numerical listing..

5.5 The Preparation Stage

5.5.1 Use of Preparation Courses

There are differing policies regarding use of preparation courses in advance of, or as part of, the assessment process. Table 5.4 below summarises the position. The format of preparation courses and the contents are examined in the subsequent sub-sections.

Table 5.4
Use of Preparation Courses

Health Board	Is a prep. course part of the process?	When is the preparation Course conducted?		
		Prior to Home Study	During Home Study	No. & Length of Sessions
EHB	Yes	No	Yes	6 sessions of 3 hours duration.
MHB**	No	N/A	N/A	—
MWHB	Yes	Yes	No	4 sessions of 3 hours duration.
St. Cath's	Yes	No	Yes	4 sessions of 2 hrs.
NEHB	Yes	No	Yes	2 sessions of 5 hrs.
NWHB**	No	N/A	N/A	—
St Mura's**	No	N/A	N/A	—
SEHB**	No	N/A	N/A ^o	—
SHB*	No.	N/A	N/A	—
WHB	Yes	Yes	No	3 sessions of 2 hrs duration.
PACT	Yes	Yes	Yes	2 sessions of 2 hrs. 2 sessions of 4 hrs.

*Support group of adoptive parents run a one-day training course aimed at parenting the adopted child.

**Input of preparation course is seen as being done on an individual basis in conjunction with the home study.

Preparation courses are used in five of the eight health boards and in two of the accredited adoption agencies. The duration varies from 3 to 18 hours, with from one to six sessions. Three of the agencies hold the preparation course prior to the home study, two during the home study, and one agency does part of the preparation work prior to commencement, and part during the home study. Preparation courses are not held in three health boards, but they were considered important in enabling applicants to reflect on the implications of ICA, and these areas are actively seeking ways to introduce them. Where agencies do not have formal preparation groups, it is suggested that couples have 'tailor-made individually delivered preparation' as part of their assessments. The content of the courses, and the depth in which subjects are considered during preparation varies also. Many applicants welcomed the opportunity which the preparation courses provided to network with others in a similar position. The view has been expressed that, while those attending preparation courses found them beneficial and applicable, the style of delivery is sometimes too didactic. There is a lack of facilitation, and not enough emphasis on adult education approaches.

Without group preparation courses, there are obvious resource implications in having to cover the same issues repeatedly with each set of applicants. The other disadvantage of not having group preparation is that couples are not networked with others in the same situation, and they may find it hard to link in with groups. In those boards who do not have preparation courses currently, the situation is explained as being due to lack of resources, rather than wishing to conduct assessment on the basis of one-to-one interviews only. Staff in these three regions expressed a preference to provide an opportunity for applicants to obtain training in groups, as there was no provision for information meetings at the point of enquiry either. In two of these areas, the waiting period to commence an assessment was low, and while the workers felt that they were under pressure, they wished to start preparation courses. The view was expressed that the applicants in these areas

obtained a tailor made assessment, which covered the material that other boards dealt with mainly at preparation stage. On the point that lack of group preparation has implications for support for adopters during the assessment and lack of opportunity to network, the addresses of relevant groups and organisations are given to prospective adopters. However geographical location and distance can be a major deterrent. Informal networking of applicants with other adopters is facilitated by workers in some areas.

5.5.2 Approach to Preparation Courses

Considerable variation is also noted in the approach and content of the preparation courses which are currently provided. In this section, one approach to preparation is considered.

The EHB has a comprehensive preparation course, comprising 18 hours of contact. A programme was compiled based on a number of sources and literature, predominantly of UK and USA origin. Topics covered are as follows:

1 Introduction to adoption

- Ground rules of group
- Tasks of parenting/Tasks of adoptive parenting
- History of Adoption
- Adoption triangle
- Losses and gains for different participants

2 Introduction to adoption

- Living with loss
- Tasks of birth parents
- Video: Decision — Decisions
- Stages of grief for birth parent
- Case history of feelings of birth mothers

3 Infertility

- The adoptive parents: second party in adoption triangle
- Developmental tasks of adoptive parenting
- Stages of grief for adoptive parents
- Gains

4 Child as part of the adoption triangle

- Case studies on type of child (Aim to help couples clarify what type of child they can parent)
- Hereditary /environment issues
- Video
- Telling the child

5 Attachment and bonding

- Attachment and bonding : Marte Meo work
- Identity
- Loss for the child
- Moving the child

6 Race and culture

- Mediation exercise on prejudice
- Discrimination
- Case histories/symbols from different countries

There have been criticisms of aspects of the EHB preparation course, including that it is overly negative, and guilt-inducing in the prospective adopters. The subjects outlined above are important considerations in the journey through assessment, and are considered in most of the preparation courses in use, although in less detail, and with different emphasis.

5.5.3 Inclusion of Adoptive Parents in Preparation Work

In this section, the issue of inclusion of existing adoptive parents in preparation work is considered. The results are shown in Table 5.5.

Table 5.5
Inclusion of Adoptive Parents in Preparation of New Applicants

Health Board	Are existing adoptive parents included in the preparation/ assessment?
EHB	Existing adoptive parents are involved in info meeting and first session of the preparation group
MHB	No.
MWHB	Existing adoptive parents involved in info meeting and first session of the preparation group. Available also to new applicants for support and advice. Networked informally
St. Cath's	Yes. Included to share experiences at information meetings.
NEHB	Yes. Existing adoptive parents are included during and at the end of the training period.
NWHB	Yes informally, couples who have already adopted talk to applicants.
St. Mura's	Yes informally, couples who have already adopted talk to applicants and usually keep contact during the process.
SEHB	No. Couples are advised to avail of contact list issued by IFAG.
SHB	Yes Support group of adoptive parents in Cork run a parenting course.
WHB	Yes. They have been involved to give hands-on information re. situation in donor country.
PACT	Yes. In training sessions. An adult adoptee also gives info in training session.

Adoptive parents are included in preparation and training of new applicants in six of the eight Boards and in the three registered agencies. While adoptive parents are involved, they are used to a varying degree. When used in the information/preparation stage, their participation is of short duration and they are not involved in the groups as co-presenters but as speakers at specific sessions.

5.6 The Home Study

In this section a number of issues are considered relating to practice on the home study. These include:

- The location of interviews
- The use of a screening interview
- The use of written personal histories

5.6.1 The Location of Interviews

The location at which interviews are undertaken is considered in this section. The situation is summarised in Table 5.6.

Table 5.6
Location of interviews for home study/assessment

Health Board	Location of interviews. Office /applicant's home?
EHB	Both office and home Lack of adequate interviewing space at offices
MHB	Predominantly home, perhaps one in the office
MWHB	Office mainly Applicant's home — approx. 2
St. Cath's	Both in the office and the applicants home.
NEHB	First and final interviews in the applicant's home. Other interviews/office.
NWHB	Both office and home Interviewing room can be booked in advance
St. Mura's	1 home remainder in office.
SEHB	Both office and home Shortage of suitable office accommodation to conduct interviews. Shortage in part due to increase in staff numbers
SHB	Both office and home, Shortage of suitable office accommodation exacerbated with additional staff
WHB	Both office and home.
PACT	Both, predominantly in people's homes due to geographical spread and lack of accommodation in office.

As part of the home study, interviews were conducted by social workers in both the homes of the applicants and the agencies' offices. The ratio of home to office interviews varies from those agencies who work almost exclusively in the applicants' home, to those who undertake only one home visit, and schedule the remainder in their offices. The availability and quality of offices and interviewing rooms is significant in determining this ratio.

The MWHB, St Mura's and NEHB had a high number of interviews in the agency office, and visited the home to familiarise themselves with the applicant's surroundings. The lack of suitable interview space accounted for the high number of home interviews in other areas, though some workers felt the applicants' home was more suitable. St Mura's stressed that the scheduling of a large number of interviews in the office facilitated the throughput of assessments.

5.6.2 A Preliminary Screening Interview and Co-Working

With significant delays between application being made and the case being allocated, a number of health boards have introduced the concept of a preliminary screening interview. In some instances two workers, or the senior social worker and the allocated social worker, co-host this preliminary meeting. The practices in this regard are described below in Table 5.8.

Table 5.7
Preliminary Screening Interview

Health Board	Screening interview and co-working
EHB	Yes: As applicants reach the top of the waiting list, a preliminary meeting is held to discuss application and adoption process
MHB	No screening interview However at one stage during the assessment, joint interview undertaken for second opinion. The case not discussed between the workers before the visit. It is lateral rather than hierarchical in structure, i.e. co-worker does not have supervisory role for main worker.
MWHB	Yes: office based screening interview carried out by 2 adoption workers or with one SW/line manager. Purpose to outline of fertility history /reason for enquiry; explain processes, identify contra indications. Acknowledge nature of process, applicant to provide forms if proceeding Co-working lateral not hierarchical: designed to facilitate work
St. Cath's	No: co-work though social workers meeting all applicants at information meeting.
NEHB	No: but SSW does visit and also meets everyone at information meeting
NWHB	No opportunity to co-work as a single post only in agency
St. Mura's	No opportunity to co-work as a single post only in agency
SEHB	No opportunity to co-work as a single post only per community care team
SHB	No screening interview. Visit by SSW used in process for second opinion
WHB	No screening interview. Information meetings used as opportunity to see all applicants. SW encouraged to work with other worker for 'marriage interview'
PACT	No opportunity for co work though SSW would meet all applicants at information meeting.

Two health boards conduct initial screening interviews at the start of the process. The purpose of screening interviews varies. In the EHB, the interview is used to ascertain if applicants still wish to proceed and to collect basic data. In the MWHB, the screening interview is used as an opportunity for co-work and to get an overview of the applicants. Some boards employ co-working for one interview, where two workers, or the senior social worker and the allocated social worker, work together in the interview. In a number of other Boards, co-working is also used but at a later stage of the process. In those areas where workers operate in a solo fashion, there is no scope for co-working.

5.6.3 Written Personal Histories

As part of the application or preparation stages, the practice has developed in recent years of asking applicants to fill in detailed personal history forms aimed at facilitating the home study. This is seen to allow the applicants to contemplate the decision to adopt, and to begin to make links between their life to date and their decision to parent a child through adoption. Table 5.8 summarises the position.

Table 5.8
Written Personal Histories

Health Board	Are applicants required to complete written personal history forms?
EHB	Yes
MHB	Yes In one community care area only.
MWHB	Yes.
St. Cath's	No.
NEHB	Yes. Personal history forms given prior to the individual meetings with SW.
NWHB	Yes
St. Mura's	Yes Specific questions taken from final report format and applicants asked to complete prior to formal assessment.
SEHB	Yes Applicants are required to write detailed autobiography. No structured forms used.
SHB	No. The compilation of data is done as part of the assessment process with the social worker.
WHB	Yes
PACT	No.

The practice of requiring applicants to prepare written personal histories is increasingly in use, although there is variation in how this is done. Three agencies did not use this approach, and in one board there was evidence of variation in practice within the board.

5.7 Policies on Specific Issues in Assessment

5.7.1 Introduction

A number of controversial issues were identified in relation to assessment in Chapter Three. These were also raised in relation to ICA by different parties during the research. These include:

- Infertility
- Age
- Referees
- Adopting more than one child
- Second Assessments

The current practices in relation to these issues are described in the next sub-sections.

5.7.2 Infertility

Medical opportunities for assisting couples towards pregnancy have developed greatly in recent years. Some of the controversy in this area arises from the question of whether the preparation for adoption can proceed at the same time as infertility treatments. Inadequate resolution of infertility issues can adversely affect the creation of a supportive post-adoption child-rearing environment. Table 5.9 describes current practice in this regard.

Table 5.9
Infertility

Health Board	Infertility
EHB	An investigation of infertility is regarded as essential before commencing the assessment. Applicants undergoing investigations and treatment for infertility must have completed these before an assessment commences.
MHB	Applicants undergoing investigations and treatment for infertility must have completed these before an assessment commences. There is no written policy to this effect, but it is the belief of SW that Adoption Committee expects all treatments to be considered.
MWHB	Applicants undergoing investigations and treatment for infertility must have completed these before an assessment commences.
St. Cath's	Each case treated individually .
NEHB	Applicants undergoing intensive investigations and treatment for infertility must have completed these before an assessment commences: They are asked to wait Wait also until after bereavement of close family member
NWHB	Not known
St. Mura's	Not known
SEHB	Applicants undergoing investigations and treatment for infertility must have completed these before an assessment commences
SHB	Applicants undergoing investigations and treatment for infertility must have completed these before an assessment commences
WHB	Assessment is deferred for infertility investigations. Childless couples need to have reasons for infertility established
PACT	Infertility investigations required if no children

The issue of infertility is considered in all agencies. In general the practice in agencies is to require applicants to have undertaken infertility investigation, and to have completed this before the home study begins.

5.7.3 Age

The issue of age, and limiting the upper ages of applicants was one of the issues of concern to workers in ICA. Differences in the age criteria was seen as one of the main factors that distinguished ICA from domestic adoption. In domestic adoption, clear policies on age limits existed, but in ICA agencies felt they could not turn people down for an assessment on the basis of age alone. The view was that if they did, in light of the entitlement to an assessment created in the 1991 legislation and Adoption Board Guidelines (1993b), they would be challenged in the courts. As a result they were assessing people well beyond the domestic adoption age ranges. In domestic adoption the preference is for men who are not over 38 and for women not over 35 for first time applicants without children. The reason for this age limit is:

In domestic adoption the birth mothers are involved in the choice of adopters and have a preference for younger parents.

The shortage of babies means adopters have to wait a substantial period following the assessment before a child may be placed.

The voluntary agencies can determine an age limit, as applicants for domestic adoption have no legal right to an assessment in the way that ICA applicants do.

The agencies were asked to designate the upper age they would wish to see for inter-country adoption and their views are given in Table 5.10 below.

Table 5.10
Age

Health Board	Age
EHB	preference for age policy with not greater than 40 year age gap between child and adopters
MHB	Concerns re. difficulties with older couples coping with problems when children reach adolescence
MWHB	Preference for age policy of not more than 40 years older than the first child
St. Cath's	Preference for age policy not greater than 40 yrs between child and adopters
NEHB	Preference for max. age policy mid forties
NWHB	Preference for max. age policy mid forties
St. Mura's	Preference for max. age policy mid forties
SEHB	Preference for age policy with not more than 40 years between adopters and child
SHB	Preference for age policy with not more than 40 year old gap between adopters and child
WHB	Max. age for assessment is 50 years
PACT	Applications received from Over 25 and under 45

The issue of upper age limits is an area where there is major inconsistency between domestic and inter-country adoption practice. This is seen to be as a result of the applicants' legislative entitlement to have an assessment undertaken by the health boards. Persons of up to 57 years of age have been granted declarations by the Adoption Board in 1998. If the health boards could, they would apply an age policy of 40 year differential between child and adopter, or an age ceiling of mid-forties. This is not an issue for the registered adoption societies in the voluntary sector, as they are not bound by a statutory obligation to provide an assessment service, and generally impose their domestic age limits for ICA applicants.

5.7.4 Referees

Applicants are required to nominate referees who will give references on their behalf to the agency. The current practice in this regard is described in Table 5.11 below.

Table 5.11
Referees

Health Board	Referees
EHB	Three obtained and two interviewed
MHB	Two obtained and one interviewed
MWHB	Two obtained and interviewed
St. Cath's	Two obtained and one interviewed
NEHB	Two obtained and one interviewed
NWHB	Two obtained and one interviewed
St. Mura's	Two obtained and one interviewed
SEHB	Two obtained and one interviewed
SHB	Working towards a unified regional policy. Current variation in practice between both community care teams, between one and two referees interviewed
WHB	Two obtained and one interviewed
PACT	Employer; Medical and Garda clearance

It is the practice in all agencies to seek references. In general one referee is interviewed, except in the Eastern Health Board where the number is two. It is usually explicitly stated that the contents of references is not shared with applicants. Some applicants expressed a view regarding the practice of identifying/specifying particular categories of persons as referees e.g. the parish priest. The research did not establish if health boards stipulate the parish priest or whether this is discretionary.

5.7.5 Adoption of more than one child at the same time

As noted in Chapter Two, the placement of children is not regulated or controlled at present after applicants have received their declaration of suitability from the Adoption Board. It is expected that the legislation to implement the Hague convention will address this major gap. During the research, instances were given of two children being adopted using the same declaration. These include case of unrelated children of the same or similar age being adopted at the same time.

The agencies expressed a strong preference to have couples adopt one child at a time, as it was important not to underestimate the stresses arising from the arrival of the child, and the fact that so little may be known in advance about the child. There was a commitment in principle to siblings being placed together. The policy regarding multiple adoptions is presented in Table 5.12 below. The number of declarations granted by the agency for one and two children is presented for comparative purposes.

Table 5.12
Multiple Adoptions

Health Board	Policy	*No. Of declarations for 1 child	*No. Of declarations for 1 child or two siblings
EHB	Approval generally for one child. System in place for two children. Agency is open to more than one child if couple have capacity. Applicants asked to return to Health Board if donor country selects twins or siblings and the Health Board ask the Adoption Board to change the declaration.	64	2
MHB	Open to more than one child if couple have capacity.	6	3
MWHB	Open to more than one child if couple have capacity.	7	3 (named sibs)
St. Cath's	Open to more than one child if couple have capacity.	2	
NEHB	Open to more than one child if couple have capacity.	13	3
NWHB	Open to more than one child if couple have capacity.	1	0
St. Mura's	Open to more than one child if couple have capacity.	7	2
SEHB	Open to more than one child if couple have capacity.	14	4
SHB	Open to more than one child if couple have capacity.	23	2
WHB	Policy of one child per declaration except for twins or siblings	10	1
PACT	Open to more than one child if couple have capacity.	1	2
Total		148	25

*Source Adoption Board 1998. Number of declarations and extensions by health board and Reg. Adoption Societies approved by the Board in 1998

84% of declarations related to adopting one child, while 14% related to one child or siblings. In the absence of regulatory control of inter-country adoption placements, it is possible for applicants to use their declarations to adopt two or more children at the same time. Agencies have a strong wish to see one child adopted at a time, unless siblings are involved.

The different rates of approval of the placement of more than one child would suggest there may be variation in practices across agencies. While agencies expressed a view that they were generally open to applicants adopting siblings/ twins "if they had the capacity" differences were observed in how agencies assessed capacity to parent more than one child. A further distinction existed in EHB, where couples were recommended for a declaration of one child and if siblings/ twins were then identified, the applicants had to return to agency to get their declaration changed. This was interpreted by many applicants as indicating a level of mistrust which, in their view, was misplaced.

5.7.6 Second Assessment

The issue of assessment of second applications was identified as an area of difficulty in the research, especially where agencies do not operate a policy of fast-tracking second assessments. This issue is particularly relevant in the case of applicants who wish to adopt siblings of children who are already placed with them. While it is good practice that the first child settles prior to introducing a sibling, the waiting lists for second assessments combined with a general policy that couples could not apply until the child was with them for 12 months combine to make the process of adopting a second child very complicated. It is also an issue if the family wish to adopt an unrelated child, as it reduce the possibilities for children to grow up in a family of more than one child. The difficulties in this area are compounded when the age profile of applicants, as outlined in Chapter Two, is considered. The different policies and practices in place in the agencies concerning second assessments are outlined in Table 5.13 below.

**Table 5.13
Second Assessments**

Health Board	Second Assessment
EHB	Applications are placed on general waiting list. No system in place for fast tracking second assessments. Assessment will not commence until child is with the family for 12-15 months.
MHB	No formal policy but social workers feel that application for second assessment should be dealt with quickly but concerned about equity for first time applicants
MWHB	Draft policy only which states that applicants who previously adopted will be subject to similar but shorter process as first time adopters
St. Cath's	Numbers very small so application could be taken almost immediately
NEHB	The board priorities second assessments once the adopted child is in the home for 15/16 mths
NWHB	Has not arisen yet as an issue in the agency.
St. Mura's	Take the assessment up as soon as they can
SEHB	Previous adopted child should be with family 12-18 months and then dealt with speedily
SHB	Major issue for adopters in Cork. Board would like to fast-track applicants, but concerned about the equity issue for first time applicants.
WHB	Preference for first child to have settling in period of one year. Second assessments then fast tracked
PACT	Would have very positive attitude towards families adopting a second child. Would facilitate second assessment.

There is variation in terms of periods of time specified that a child should be in place before adopters can apply for a second assessment. In some areas these cases are prioritised to facilitate adopted children to grow up with a sibling. In others they enter the general queue. There is also variation in the length of time the child is required to be in the family prior to the commencement of the second assessment. It ranges from one year in the WHB, between 15 – 16 months in NEHB and 12-18 in SEHB. In these three boards the application is then fast tracked while in the EHB the child must be 12-15 months in place, but there is no fast tracking system. The basis of the time variation is not clear.

5.8 Supervision of work

5.8.1 General Supervision

In this section current practices in relation to supervision of ICA assessment work are described in Table 5.14 below.

Table 5.14
Supervision of Work

Health Board	Supervision of Work
EHB	Regular supervision available High level of informal peer support Group supervision for new workers as part of induction
MHB	Access to supervision only available in one area. Lateral support and consultation used in both
MWHB	Supervision one hour every two months and otherwise team leader available to discuss cases on an ad-hoc basis. Supervision seen as essential for quality service. Informal supervision encouraged.
St. Cath's	Monthly supervision and peer support
NEHB	Available on regular basis by SSW
NWHB	Supervised by SSW though limited experience of adoption
St. Mura's	Not clear
SEHB	Supervised by SSW
SHB	Supervised by SSW
WHB	SSW responsible for development and provides consultation rather than direct supervision
PACT	SSW provides supervision

Supervision of ICA practice varies according to the organisational arrangements. In some agencies, supervision is provided on planned basis, while in others it is on a more ad-hoc basis. Supervision of new workers is regarded as important.

5.8.2 The Roles of the Senior Social Worker

In areas where the numbers of applications are small, the senior social workers have a hands on approach and make direct contact with all applicants. The senior also visits applicants at different stages during the process. This has potential to give rise to role confusion, and other means of supervision may be more appropriate. All seniors are involved in practice to varying extent, with the exception of NWHB where the service has only recently been provided within the board. The nature of involvement varies from conducting assessments in the absence of staff, to becoming involved in difficult cases (e.g. counselling someone out). The seniors are sometimes involved in

picking up second assessments or post-placement reports. While it is understandable, in light of small numbers involved in providing the service in several areas, that the senior carries caseload, in several instances they are carrying an increasingly large caseload, which leaves limited time to manage and run the service with resultant consequences. The current practices are described in Table 5.15 below.

Table 5.15
Visit by Senior Social Worker to Applicants

Health Board	Is a visit by a SSW or team leader a standard part of the assessment?
EHB	Yes. All applicants meet with senior social worker for last visit. On completion of assessment report before presentation to placement committee.
MHB	Yes. SSW visits families in one community care area for supervision and meeting the family Also meets applicants on completion of assessment report before presentation to panel
MWHB	No No visit unless consultation needed, two workers involved at outset, lateral not hierarchical co-working All assessments are supervised by a team leader. A SSW would be consulted and may meet applicants if complexities arose.
St. Cath's	No.
NEHB	No
NWHB	No
St. Mura's	Yes. At the initial enquiry stage, During the assessment and Post placement interviews. Meets applicant with SW Meets applicants if complexities arise.
SEHB	Yes. For supervisory purposes, quality assurance, clarifying and consultancy role. Familiarity with applicants considered important as SSW presents all cases to adoption committee
SHB	Yes. Visits during assessment Final home visit by Senior Social Worker.
WHB	Yes
PACT	No. Couples are seen by SSW during preparation courses and sometimes on an individual basis before assessment starts.

Variation exists in the practice of the Senior Social Worker visiting the applicants during the assessment process. Variation also exists as to the purpose of the visit by the senior social worker. There is confusion as to whether it is intended for supervisory or quality control purposes, for feedback from the applicants or as part of the assessment procedures. In many areas the lack of clarity and uncertainties caused problems for applicants and staff alike.

5.9 The Report Stage

5.9.1 Record Keeping

The current practices in relation to completing the home study and record keeping are described in Table 5.16 below.

Table 5.16
Completion of Home Study and Record Keeping (needs work)

Health Board	Record keeping
Eastern Health Board	Detailed records of interviews put on dictaphone and typed up by secretary. Large number of typists engaged but delays reported
Midland Health Board	Problems with availability of secretarial support
Mid Western Health Board	Detailed records written up on each session
St Catherine's	Core issues summarised following each session Good secretarial support
North Eastern Health Board	Core issues examined and presented. Preference for not too much detail
North Western Health Board	Need to be concise
St Mura's	Aims to have assessment completed in four months, therefore puts priority into assessment.
South Eastern Health Board	Reported major problem with secretarial back up Dictaphone use encouraged but secretarial help not always available to type up
Southern Health Board	Purpose of recording is to draw out substantial conclusions
Western Health Board	Form F used as guide for recording and report writing
Pact	Aims to have report done in short timescale for purpose of recording conclusions.

There is significant variation in the level of recording undertaken, which varies from very detailed typed records of interviews being prepared to cases where there was little indication on file of records being made. The way in which the administrative support is provided also has an impact on the record keeping. Dictaphone machines are used in some agencies, and limited use only appears to be made of computers other than as word processors.

5.9.2 Sharing Reports with Applicants

Section 8 (3) of the Adoption Act, 1991 makes provision for the making available of a copy of the report to the applicants when the declaration is made by the Adoption Board. The apparent intention in specifying post-declaration provision of the report is to avoid applicants circulating reports prematurely to donor countries. However, when the report has been initially prepared, it is common practice to provide an opportunity to applicants to review it. The actual process of sharing the report is important, as are the means by which the sharing is achieved. The current practice in relation to sharing reports with applicants is described in Table 5.17 below.

Table 5.17
Sharing Reports

Health Board	Sharing reports
EHB	reports shared with applicants in office
MHB	reports shared with applicants
MWHB	reports shared with applicants
St. Cath's	reports shared with applicants
NEHB	reports shared with applicants
NWHB	reports shared with applicants
St. Mura's	reports shared with applicants
SEHB	reports shared with applicants
SHB	reports shared with applicants
WHB	reports shared with applicants
PACT	reports shared with applicants

All agencies stated that they share the contents of the reports prior to presentation to the Placement/Adoption Committee. Variation exists in the way this was done. In some instances the content was shared at a hand-written draft stage. In other cases the report was left with the family. In some instances applicants are invited to read the report in the agency's office. This is sometimes perceived as a rushed and unsatisfactory sharing of the report by the applicants.

5.9.3 Report writing

As part of the research, one final report prepared by each of the 51 social workers involved in ICA in 1998 was accessed through the Adoption Board. Information that would identify applicants was blanked out.

A wide variation in the content and length of reports was evident from the reading of these reports. Most agencies use the British Agency for Adoption and Fostering (BAAF) Form F, devised for the selection of prospective foster or adoptive parents as a template. There was evidence however that the many sub headings in the Form F, intended more as a guide for interviewing, were used in some agencies as sub headings in the reports. This gave rise to a more descriptive rather than analytical report style. There was also evidence that too much of the content of the home study interviews were included in some reports, rather than using this information to back up professional judgement and conclusions arrived at.

The standard of record-keeping varied enormously across agencies. The EHB files were of an extremely high standard in their layout and format, and each interview was typed up, usually in great detail. There were also examples of files with minimum information, such as the assessment report and applicant's own documentation. In these instances the quality of record-keeping reflected lack of secretarial support, with priority being given to completing the report over record-keeping, and work levels which left inadequate time to do administrative tasks.

5.10 The Placement Committee

The term 'Placement Committee' is used interchangeably with the term 'Adoption Committee' and 'Case Committee' in the health boards. The committees were instituted initially in the agencies as a form of group review and decision-making for domestic adoption and fostering. Their remit has been extended now also to review inter-country adoption reports. Decision-making, in the form of recommendations to the Adoption Board as to the suitability of applicants, is delegated to the committee. The composition of the placement committees is described in Table 5.18 below.

Table 5.18
Composition of Adoption Committees

Health Board	Adoption Committee
Eastern Health Board	Composition : 6 Social Workers and 2 Administrators (Chaired by Administrator) Same committee for all family placements; fostering and adoption
Midland Health Board	Composition : Multi disciplinary; Seven members No community representatives No adoptive, birth parents or Adoptees
Mid Western Health Board	Composition: broad multi-disciplinary membership with strong community perspective Twelve members Adoptive parent but no birth/natural parents or adoptees
St Catherine's	Presents reports to MWHB Committee
North Eastern Health Board	Composition: multi-disciplinary membership with strong community perspective. Nine members No adoptive, birth parents or Adoptees
North Western Health Board	Composition: multi-disciplinary membership with no community perspective Five members No adoptive, birth parents or Adoptees
St Mura's	presents to NWHB
South Eastern Health Board	Composition: multi-disciplinary membership with strong community perspective Thirteen members Two adoptive parents, No birth parents or adoptees
Southern Health Board	Composition: Multi-disciplinary, limited community participation Adoptive parent 7 members on adoption committee
Western Health Board	Composition: Multi-disciplinary 10 members on adoption committee Adoptive parent member
PACT	Composition: Majority members have social work background and striving currently to encompass a more multi-disciplinary composition. 10 members plus medical advisor Adoptive parent member

The Placement Committees are essentially internal to the organisation. The membership varies across the health boards, in terms of numbers and backgrounds. Variation in membership range from predominantly social work to multi-disciplinary where members are staff of the Health board to multi-disciplinary committees where there is a wide community dimension. The other variation noted was the membership of adopters on the committee. In five boards an adoptive parent is a

member of the placement committee. The only similarity was the absence of adoptees and birth/natural parents from all boards.

5.11 Similarities and Differences in Practice

In this chapter, pertinent aspects of current practice in the processing of applications for assessment for inter-country adoption have been described. While reflecting primarily from the agency perspective, the descriptions given need to be examined against the views of all the stakeholders presented in section 5.2.

In this section, the marked variations and similarities in practice are noted and commented briefly on. The reasons for the trends noted will be dealt with in greater detail in Chapter Six, and recommendations for practice and service management provided. For the purpose of this section, only the broad themes are identified.

5.11.1 Similarities

An initial examination of the tables presented in Chapter Five suggests a high level of similarity in some aspects of current practice and service management. There is a similarity in the overall ICA process, in that all assessments commence with an enquiry; followed by an application, an assessment and culminate in a decision. However, on closer examination, the similarities noted occurs predominantly in the areas of age, infertility, medical issues and information covered at the enquiry stage. This reflects the influence of the guidance issued by the Adoption Board (1991, 1993a 1993b) However, despite the marked influence, there was evidence of differing interpretations of this guidance, which leads to different practices across agencies.

In terms of assessment practice, the influence of the British Agencies for Adoption and Fostering (BAAF) was in evidence. This was apparent in the topics covered and the use and adaptation of the Form F for report purposes. The influence of research and the importance of including race, culture sensitivity, identity and openness as predictors of successful outcomes in adoption, as outlined in Chapter Two, are also evident.

A number of circumstances can be seen to account for the similarity in practice. In the absence of detailed guidance from the Adoption Board, beyond what was described in Chapter Two, or from the Dept. of Health and Children, the Irish Council for Adoption Agencies filled the vacuum to some extent, and provided some training and network support for practitioners. The staff in the EHB have also provided many agencies with material they sourced and developed, and have provided opportunities to members of staff from other agencies to observe their training and information meetings. This support, which was informal and negotiated at practitioner level, was much appreciated by those who availed of it, especially as they were keenly aware of the pressures which the EHB was operating under in terms of increasing demands on their service. The third factor is the number of staff in ICA with long years of experience working in adoption and fostering assessment, which results in the cross fertilisation of many ideas. Staff movement between agencies was not seen as a major factor in ICA.

The last similarity noted was the commitment of staff to the service which they are providing. In spite of the lack of guidance, and considering the limited training and support available, the standards of practice were generally good. This was a reflection of professionalism of many of the staff, and their own commitment to quality service provision.

5.11.2 Variation in practice

Variations of practice were evident at many stages of the ICA assessment process. Variation per se is not necessarily negative, and it is considered important for services to be flexible enough to meet

needs based on local circumstances. However, variation can be problematic if it is seen to lead to lack of equity in delivery of services to those with a statutory entitlement.

Variation was evident at the enquiry stage, where agencies used a combination of methods for dealing with queries, including imparting information over the telephone, hosting information meetings and sending out information leaflets. The variation was accounted for largely by local circumstances, in terms of enquiry rates, geographical distribution of customers and the staff resources available.

The variations at preparation stage were more marked. Some agencies provided formal training programmes, while others did not, and there was major difference in the number and duration of sessions where such training was provided. In these courses, similar topics were covered e.g. the difference between adoptive and birth parents, the needs of the child, the adoption triangle, the effects of institutional care and race. However there was difference in the depth and methods by which these were explored. The familiarity with and use of the principles of adult education varied. There was difference in the clarity about the place of preparation vis-à-vis training, and the importance of not confusing therapeutic domains with experiential training techniques. All agencies, including those who do not currently provide training, expressed a strong interest in doing so. Many agencies now provided such training for the purposes of assessment in domestic adoption.

The difference in the length of time for completion of the ICA assessment process, from commencement to obtaining the declaration was a major difference that was noted in Chapter Four. The explanation of this difference is added to in this chapter, when supervision practices and the place of senior social worker in assessment; the numbers of interviews, and the process of sharing the final report with the applicants are considered.

The differences in supervision practices were marked with some practitioners having access to regular supervision, while in other agencies limited or no supervision was available. The difficulties of this situation are compounded if the practitioner has limited opportunity for peer support, and is based in an area where they are isolated. Support for ICA workers from other social work colleagues was not always forthcoming as

- (a) they did not always understand the nature of the work of assessment;
- (b) it was seen as a service taking resources from an already over-stretched child welfare system and was therefore resented, or
- (c) they did not agree with the concept of ICA.

In social work practice good support and supervision is vital, and its absence has critical consequences in terms of impact on clients, quality control, agency accountability and staff development and welfare.

There was major divergence in the style, content and standard of the reports prepared as a result of the ICA assessments. The absence of guidance on a prototype format for report-writing from the Adoption Board again impacts. The differences in file-keeping practice was also an issue of note, and connected with supervision practice, secretarial support, priority of work, and agency policy.

At a practice level, the difference in how reports are shared with applicants was a recurring theme. Some agencies left the typed report with the applicants either in their home or facilitated the reports being read in the office, while others shared hand written reports which were at draft stage. This practice frequently arose out of sense of urgency to get the report completed rather than an objection to sharing the typed version. The issue of sharing reports in the office needs special consideration, as it is important that the applicants have time and surroundings to consider the contents to avoid difficulties arising at a later stage.

The last major divergence is the naming and composition of the adoption, placement or case committee. While it was beyond the scope of this report to examine in detail the decision-making process in the committee, and there appears to be a good deal of similarity in how the committees operate, the lack of written policy in a number of agencies, and lack of opportunity for committees to undertake training or to review their own work was a cause for concern. Another similarity noted in this area of work is the effort currently being made in all agencies to re-organise these committee.

5.12 Conclusion

The current practices of ICA assessment in Ireland in many ways conform to the hybrid approach to assessment which was predicted in reviewing the development of assessment in Chapter Three. While much of the current work of individuals involved can be described as good practice, the variations noted are a cause of concern on many levels. The absence of adequate guidance on the approach to follow, or for handling difficult issues which have emerged from the limited guidance provided, the lack of a central co-ordinating or standard setting body, the virtual absence of training in the field, the differing organisational arrangements and management cultures in the agencies have all contributed to the emergence of variation in practice, with consequent impact on the services' clients.

The primary concern has to be for the child who will be placed with parents who have been assessed through the current system, with all its variations. From the research we have undertaken, we are satisfied that all applicants are being appropriately vetted. They are also being prepared to varying extents for the role which they propose to undertake. We are concerned that the interests of children in ICA are being jeopardised by the reported child placement practices, which are currently unregulated, and which are in turn impacting on the assessment process itself.

It is inequitable that the applicants for the service, who are exercising a statutory right to seek an assessment from their local health board, are subject to such variation in practice. While there always has to be room for a level of flexibility, particularly in the way in which the service is delivered, it is desirable that applicants should partake in a similar process, regardless of the agency they must apply to. Under the Freedom of Information legislation, applicants have another statutory right to be fully informed of the process that will be used in arriving a decision in their case. However, the issue of an unlimited statutory right to an assessment, and how this statutory right is negotiated and provided for against other statutory rights, needs to be fundamentally reviewed.

From the agency and workers' perspective, there has to be concern at the variation also. While fulfilling a statutory obligation to the applicants, it is essential that all are following the same approach to represent the best interests of the child who may be adopted by those same applicants. A defined process, which can be planned for, resourced and managed, is a pre-requisite to efficient and effective service delivery. For the agency workers, definition enables efforts to be directed into a productive and professional service.

In the next part of this report we make proposals which we believe will address these issues.

CHAPTER 6

Towards a Standardised Framework — Key Contextual, Organisational and Practice Issues

6.1 Introduction

This chapter provides an overview of key issues affecting ICA assessment practice and service management. The issues have emerged from the research findings in the previous chapters. The contextual and organisational issues that have shaped current practice and service management are discussed. Recommendations are made to provide a better contextual and organisational framework in which practice and service management can operate more efficiently. Process and practice issues which emerged are also considered. In Chapter Seven, a standardised framework, building from the analysis of key issues and recommendations made in this chapter, is provided.

The recommendations are based on our view of ICA as a system. The delivery of a quality assessment service requires a best practice approach for the entire system, and not simply for the assessment part. In keeping with our terms of reference, our analysis is in relation to assessment, but we see this subject as inextricably linked to broader contextual issues.

6.2 Contextual Issues

6.2.1 The Legislative Framework

The legislative framework governing ICA issues in Ireland has been described in earlier chapters. In this section we address a number of aspects of the legislative framework

The need for more detailed regulation and/ or the provision of detailed guidance on policy and practice in ICA assessment has been raised by some persons during this research. The shifts which have occurred in assessment practice over the years are described in Chapter Three. It is our view that the development of a highly regulated framework could lead to a rigid and unduly legalistic approach to ICA assessment, resulting in an unworkable system. There is a need for flexibility and judgement, balanced with transparent decision-making and appeal mechanisms. Provided that explicit policy and procedures are defined, it is our view that, in general, the existing legislative provisions are adequate for defining the assessment process. Only if repeated challenges emerge to the explicit policies and practices, would it be necessary to regulate the process by legislative provision.

A best practice based approach (along the lines proposed in Chapter Seven of this report), rather than a highly regulated assessment process, should be defined, agreed and promulgated for ICA assessment. This approach should be reviewed and updated, in light of experience and developments in the field.

However, it would be helpful if specific procedural aspects of the ICA assessment process could be regulated. This includes areas such as the manner of making an application for an assessment in accordance with the provisions of Section 8(1), and the documentation which would be required to accompany the application in order for it to be a valid application.

In the longer term, as recommended in Section 6.4.7 below, it is suggested that consideration be given to extending the power to make declarations of suitability under the 1991 Act to health boards, while retaining the Adoption Board as an appeals body.

The final area of legislative provision in relation to ICA assessment which we consider should be reviewed is the apparent universal right to an assessment. In the area of age limits, this right has superseded what would be seen as good practice in child placement, and no action has been taken to address the issue. Also if demand for assessments continues to grow at the current rate, the increased pressure on the state's child care services may grow to be a considerable burden on agencies. It may have appeared that, at the time this legislation was introduced, there were an infinite number of children available for inter-country adoption. According to Anderson (1990), the Director of an Adoption Centre in Sweden which mediates over 600 inter-country adoptions per annum, the number of children legally available for adoption internationally, aged 2 and younger, is far less than the number of applicants approved as suitable and eligible to adopt. There is also likely to be an ever increasing emphasis on development of child welfare options other than inter-country adoption in donor countries. It would be appropriate therefore that the overall position be monitored and the legislation reviewed if necessary.

The terms of reference for this study relate primarily to the assessment process in ICA. However, this is only one part of a system through which children are moved from abroad to be reared in Ireland. The major gap in current legislation governing ICA relates to an area outside the assessment sphere, but which has a direct impact on the context in which assessment occurs. This is the regulation of the placement and post-placement aspect of the inter-country adoption process. This lack of regulation and control has given rise to a climate of concern among different stakeholders, as described in Chapter Five. Concerns regarding the mediation of placements by a number of international organisations, with an apparent disregard for good child placement practice and with money being charged for the service, has been an underlying source of unease for some social workers, and may have impacted on their underlying attitude to ICA. These concerns were experienced by some applicants as evidence of social workers holding a negative attitude towards inter-country adoption. This added to the tension between the two groups, which has been played out in the media in recent months.

The Department of Health and Children is working to transpose the Hague Convention into Irish law, through which the inter-country aspects of ICA will be regulated. We note and commend the consultative process which has been undertaken by the DoH&C with a view to implementing the provisions of the Convention. It is hoped that The DoH&C will bring forward the legislation necessary as soon as is practicable, as this will regulate the ICA system through which placement of children takes place.

As noted above the benefits of the assessment process for the child can be set aside if other parts of the ICA system, such as the subsequent matching and placement of children are not undertaken with a similar level of care. This miss-match of a high level of control in assessment and little or no control of placement can exacerbate resistance to assessment among couples, and generate a view that it is only a troublesome procedure to be endured. This is one of the principal concerns about ICA, as currently practised in Ireland, which the research has highlighted. This is particularly relevant when compared with the work involved in matching parents and children in domestic adoption and fostering.¹

If legislation is ratified to implement the Hague Convention, inter-country adoptions can only be made through organisation to organisation contacts. This, we believe, will eliminate the practices which have developed and which are not in keeping with the principles of providing for the best

¹There are a number of references to the link between foster care and adoption in the recommendations throughout this report. The inherent differences of the two are acknowledged, especially in terms of legal rights and permanency, but the overlap in terms of both as child placement options are also important. Many of the current international developments in assessment practices have been developed and used in both the foster care and the adoption spheres. While it is recommended that ICA should remain linked to domestic adoption and foster care at a practice level, it is important not to lose sight of the differences, and the implications for the assessment process.

interests of the child. While this may be interpreted as a restriction on individual adoptive parents, we believe there are overwhelming benefits, such as

- Ensuring that proper matching of adoptive parents and children, based on needs and abilities, takes place;
- Ensuring that the adoptive parents can, at a future date, explain to their adopted child that the circumstances through which the adoption was made included a reputable organisation;
- Ensuring that information on the child's origins is collected, validated and held for future reference.

This will have a major impact on practice, as stakeholders will not have to contend with working within a framework that goes against good child care practice.

6.2.2 ICA as a Government-Level Issue

Through the 1991 Act, the state has legislated a right for persons to have an assessment in inter-country adoption, and the agencies involved have since provided a level of resources for its implementation. However, there has been little guidance in the area, and no further enunciation of state policy on the subject since the legislation. The development of ICA during the period 1993 -1999 has coincided with very significant development of other statutory child care services. However there has been no guidance or policy statements on the place of ICA in the spectrum of child-care. This, we believe has contributed to some of the difficulties which have emerged, and which have resulted in conflict between applicants and state agencies. A policy vacuum has emerged in which health boards, the registered adoption societies, and individual workers have developed a range of ad-hoc arrangements for the provision of the ICA service.

There is a need to develop a comprehensive statement of policy with respect to ICA. This should be done in conjunction with the stakeholders. We suggest that, taking a broader view of ICA, it can be seen as an issue which impacts on several government departments in addition to DoH&C, including Education, Justice, Foreign Affairs as well as Finance.

After children are placed in Ireland, education is very important in the development of the individual child. Parents may need to supplement what the child is learning in school in the area of language. There may be a need for training/ development of teachers who have the task of helping overseas children in learning English, and also in coping with racism in schools. Education has a major role to play in making society more tolerant of cultures and nationalities other than the dominant one.

While reports indicate a smooth working of the immigration aspects of ICA, it appears that there is potential for overlap or conflict with the Department of Justice's policies on immigration. The relationship of ICA, as sponsored by the DoH&C, to the Department of Foreign Affairs Overseas Development Aid (ODA) programme also merits consideration. The link to ODA, and targeting of priority countries, with an approach which sees support for children in their home countries, is becoming increasingly significant. Depending on the levels of ICA which takes place, there may be significant downstream resource implications for health and social services, as well as for education services.

We recommend that

As ICA is a child care service, the DoH&C should remain the central government department, with primary responsibility for legislation, and determining the place of ICA within the spectrum of child care policy, for leading implementation of recommendations, including assigning roles and obtaining resources, and for overseeing development of the ICA service;

The government should determine and co-ordinate the inter-departmental aspects of ICA policy, which will be a basis for policy and practice in the implementation agencies.

6.3 Organisational Issues

6.3.1 Introduction

The health boards are empowered by legislation to conduct the assessment of applicants for ICA. The practices which have emerged within the eight health boards have been described in Chapters Four and Five. ICA is one small part of the overall functions and roles of the health boards, and this has to borne in mind in considering organisational issues. It is clear that the ethos in the ICA service depends on the larger culture of the organisation, and the attitude of senior managers.

There is ongoing change and development taking place in the broader context of Health Boards and their delivery of services. In this report we make specific recommendations relating to some organisational aspects. We have framed these to ensure that there is sufficient flexibility to take account of the broader needs of the organisations.

6.3.2 Public or Private Service?

Some criticisms have been levelled at health board involvement in ICA assessment, relating to both the duration involved and professional practice. The issue of removing the health boards and privatising the assessment process has been raised by some parties. The somewhat related issue of charging for the provision of services is discussed in Chapter Eight.

Given the issues of public concern in the area of ICA, the overall thrust of our recommendations in this area is that:

There is a need to retain and strengthen state involvement and control in the area of ICA;

The health boards are the most appropriate agency of the state for the assessment function. There may, however, be scope for health boards to increase capacity, by sub-contracting part of the work through the options discussed below;

There are a number of options associated with retaining the health board's role.

The health boards remain the major provider of the service, and takes on extra staff to deal with the backlogs.

the health board encourage the existing registered adoption societies to play a greater part in the service, and make contractual arrangement to provide a certain level of agreed service for an appropriate price with registered voluntary agencies. As part of this contractual arrangement, health boards placement committees should be used for decision-making purposes. This arrangement would ensure the provision of a standardised service in the area. The waiting list in the area would be administered at health board level, to ensure equity and the names of applicants would be supplied to the agency when they reach their place on the waiting list. The difficulty with this proposal is that existing registered voluntary agencies have shown little interest in taking on this work. While the agencies are empowered under the 1991 Act, to date many existing agencies are not interested as they prioritised their existing resources to provide a tracing and counselling service. However the view of the agencies could change if resources were to be made available and service agreements concluded.

Another option would be to seek applications for new agencies to be registered to do assessment work. Looking at international practice, we would recommend strongly that the task of assessment be kept totally separate from the task of mediating a placement. We would recommend therefore that agencies with connections to international placement organisations should not be registered because of the potential conflict of interest between paying for assessment and then being potential clients for a child placement, which can involve substantial charges. If this option was to develop, we would recommend that new agencies should be sub-contracted

by the health boards, who would again retain the function of managing the waiting list, and decision-making through their placement committee.

A fourth option would be for health boards to make a contractual arrangement with professionally qualified social workers in their area, either on an individual or a group basis, to undertake assessments. In general people are interested in arranging more flexible work arrangements, and suitable qualified and experienced personnel who have left the field may be tempted to return, especially if they could work from their own base. Again these assessments would be presented to Health Board placement committees, who would also oversee standards and would provide a feedback loop to the personnel with responsibility for overseeing the contract.

This issue is explored further in Chapter Eight. Regardless of the option or options which emerge, we believe there will still be a pre-dominant health board role. We have therefore taken the Government's Strategic Management Initiative (SMI) as one of the contexts for this review of the service. The SMI has raised several directly applicable concepts, such as quality, transparency, efficiency and partnership, which we believe can transform the public ICA service from one of criticism and conflict to being a model of public service delivery. We have, in framing our recommendations therefore, utilised the SMI concepts, rather than pursuing the option of privatisation, which is not the norm in Irish service delivery.

6.3.3 Policy Making at Health Board Level

One of the issues to emerge in the study was the notable absence of detailed written policy on ICA. In the absence of such written policy, it falls inappropriately to lower level managers and staff to operate in a policy and practice vacuum. While we have found some excellent policy, procedure and practices in our research, in the general absence of written material, it is not surprising that variations in practice have arisen, even within the same health board. For the reasons outlined at 6.2.3 above we recommend that

A comprehensive statement of policy, procedures and practice relating to ICA should be prepared within each agency, approved at board level, disseminated within each agency, and used to manage the service. Where such policy documents already exist, they should be reviewed in the light of the recommendations in the proposed standardised framework;

The document should in effect be a management plan for the service, which in addition to the high level document approved by the board would include a work programme with service objectives and assigned roles, and expected contribution from each member, specifying operational targets for all functions undertaken, with measurable outcomes and outputs.

The preparation of the service management plan should be led by the service manager, and prepared in consultation with staff, and other stakeholders within and outside the agency;

The service management plan should include and take account of the recommendations of the proposed standardised framework.

6.3.4 Specialist vs. Generic Teams

The positioning of ICA work within each board, and the organisational structure utilised, is an issue which impacts on service delivery. In Chapter Five the diverse current arrangements were described. In general, depending on the scale of the work, there are two models in use, the specialist team in those boards dealing with large numbers of applications, and the community care based workers in the rest, with varying degrees of central co-ordination. There are geographical constraints on the delivery of the service, which vary from board to board, as well as issues of supervision. In several instances workers devote part of their time only to ICA. The current organisational arrangements have merit in how they have evolved within the organisation to meet the service needs. The arguments in favour of the specialist team include that the specialist team operates efficiently through its developed expertise,

skills and a knowledge base. We would have concern at two aspects of the community care based approach, which are causing problems in a number of situations, although the same arrangement is made to work in other agencies. We have seen that ICA is lost as a priority in a general social work team under the pressures of child protection work, and we do not recommend that this arrangement continues. The second concern is the failure in some instances to develop a strong co-ordinating role for the service. Considering the issues involved, we recommend that

In those agencies dealing with large numbers of applications, staff should be assigned to a specialist ICA team for service management purposes. This service could be joined with other specialist areas such as domestic adoption, post-placement and tracing and fostering, as part of an integrated range of services.

In boards where the geographical spread is such that service delivery is based on sub-units of the region, workers can be assigned on a community care area basis, and co-located with a community care team, but should belong and report to the unit, directed by a senior social worker. In this way, the home study part of the service will be delivered on a local basis, but with a very strong regional dimension for delivery of preparation courses, consistency of practice, team development, supervision and training.

6.3.5 Team Development

Where teams are not in existence, or where they already exist, there is a need in our view to focus on team development. The reasons include better organisational response to issues, more effective management, amelioration of the worst effects of isolation, and improved contribution and commitment. There was evidence of very good team structures in place in some agencies. We also see benefit in that a sense of team needs to be created, not just among professional workers, but between professionals and administrative workers, with a common purpose of meeting the targets set out in the service management plan (see 6.3.3 above). We have seen instances of the downside of the “dual structure” which contributes to delays and blaming these delays on “the other side” to persons outside the agency. We therefore recommend that

ICA work should be undertaken as part of a single integrated section, and a strong sense of team developed in relation to ICA work, where the fundamentals of team work, including clear purpose, unity of operations, roles of team leaders, team players and rules are established.

New and existing teams should review their systems and working arrangements, including inter-sectional and cross-functional relationships, with a view to developing into high-performing teams.

6.3.6 Service Management and Leadership

Management and leadership are fundamental to the delivery of a quality ICA service into the future. The general functions of management include defining the purpose of the service, identifying objectives, setting standards, empowering and supporting workers. As with all areas of activity, there are variations in strength of management in ICA. In some cases team leaders, senior social workers and senior administrative personnel were acting in temporary capacities for long periods. The research conducted showed that the higher level of service delivery existed where it had moved from an administrative to a management ethos, emphasising leadership. We therefore recommend that

A programme of management development and training should be undertaken by all managers of the ICA services;

Managers in ICA should meet at a national level, to co-ordinate activities and development of the service;

Appropriate management information systems in relation to ICA should be developed where these do not exist.

6.3.7 Staffing of the ICA Service

The current staffing arrangements for the ICA service were described in Chapter Four. As seen, issues surrounding staffing in ICA, such as temporary staff and difficulties with recruitment reflect general staffing issues in the health boards. Administrative, professional and management staff are involved. There has been a general difficulty in filling social work positions as a result of the dramatic growth of the child protection services in recent years. It appears that working in specialist social work teams such as fostering and adoption is welcomed by social workers who feel burdened by the pressures of child protection in community care teams. It would be expected therefore that there should be little difficulty in obtaining staff for this work. The presence of a cohort of experienced workers in ICA would tend to support this view.

However there are a number of factors which militate against this. The first is that, in view of the general shortages, assigning workers to ICA means removing them from child protection work. Also, there are ethical concerns among some workers, especially in the context where matching and placement of children in ICA are uncontrolled. Individual workers in some areas have been assigned large caseloads, and are carrying responsibility for the delays in a way which is quite inappropriate. Also, since the emergence of the public conflict, some workers are reluctant to become involved with the service. We recommend that

An appropriate establishment of both administrative and professional positions to meet the chosen service level is determined as part of the service planning process;

Positions should be filled to the chosen establishment levels, and positive action taken to ensure that there is retention of workers in the area. In this regard, the development of a culture of a quality service, and high performing teams is relevant;

Individual workers should be assigned roles and tasks in accordance with the service management plan, and the proposed framework;

6.3.8 Staff Training and Development

One of the areas identified in the Government's Strategic Management Initiative is the need for staff training and development programmes. While workers are generally highly qualified and experienced and may have striven to keep up to date in professional practice, it is recognised that there is a need for a programme of training to develop and provide the type of quality service which this report is advocating. Some conferences have been organised by the Central Council for Adoption Agencies, and also by PARC. None have been organised by the state agencies. We recommend that

A commitment to ongoing training of all staff, to the extent recommended in the Governments SMI of 3% of staffing costs, to develop competence in terms of knowledge and skills should be included in service management plans;

Professional workers should have relevant training/ practice reflection/ development on an annual basis. Training should be in complementary modules of practice;

An appropriate national body should undertake the role of co-ordinating training for workers in ICA, and should provide training at national level, which all workers would be expected to attend;

That training should be based on the principles of participative adult education, using a significant degree of workshop/ seminar type arrangements.

All workers involved in ICA should undergo an introductory module of training in the proposed standardised framework. New workers coming to ICA should undergo an induction module, with a high degree of supervision of their initial work.

6.3.9 The Voluntary Sector

The voluntary sector, through the work of some of the registered adoption societies has had a significant role in domestic adoption over the years. The registered adoption societies can undertake assessments on behalf of the health boards, or directly at the request of an applicant, as provided for in Section 8 of the Adoption Act, 1991. For instance St Catherine's Adoption agency conduct assessments on behalf of MWHB. Likewise St Mura's does the ICA assessments in Donegal. However a number of adoption societies have chosen not to be involved in ICA.

In recent years, in addition to the registered adoption agencies, a number of associations of groups directly involved, such as adoptees, birth parents and adoptive parents have come into existence. Those who get involved in voluntary organisations are usually extremely well motivated. They have direct experience of aspects of the process, and have a lot to contribute.

It is suggested that there are a number of areas where it would be appropriate for the voluntary sector to be involved. These include:

Co-running of preparation courses for applicants.

An expanded role in the conducting of assessments (See Chapter Eight).

A nucleus of organisations exist which can develop into these roles. However, there is a major task to ensure that they develop to meet the anticipated needs, that the persons involved have the appropriate skills, and that long-term development and survival is ensured.

The relationship between the statutory services and the voluntary sector is crucial to success in achieving the objectives set out above. The structures and working arrangements will have to be devised to ensure there is sufficient cross-over and transparency in the activities and policies to retain confidence in the partnership approach.

In general, written memoranda of understanding and contracts specifying arrangements for the interfaces between the statutory and voluntary agencies should be prepared and agreed. This could include the issue of state support in return for agencies undertaking specific tasks, and statutory bodies having representation on the board of the voluntary body.

The role of the voluntary sector should be developed and formalised, particularly in the areas of preparation and support.

6.3.10 Office Accommodation and Support Services

Some agencies need to urgently review and upgrade/ extend the accommodation provided for the ICA service.

There are variations in the extent to which Information Technology is used as a tool to assist in dealing with applications. Telephones, personal computers, data-bases etc. all have roles to play in efficiency, and we recommend that

Each agency should review the use of Information Technology to ensure that it is making an appropriate contribution to the efficiency of the process.

6.4 Practice Issues

6.4.1 Common Policy, Practice and Procedures

The eight health boards are autonomous legal entities, which develop and implement policy within national frameworks. These frameworks include legislation and guidance on practice. The Adoption Board is a national body which exercises functions prescribed in adoption legislation. While there

are many fora within which the activities of the health boards are co-ordinated, there is no body formally charged with co-ordination of activity in the ICA area. This is one of the factors which has resulted in the variations in practice described in Chapters Four and Five.

With the exception of three pieces of guidance from the Adoption Board in 1991 and 1993, neither the Department of Health nor The Adoption Board have issued any recent guidance, despite the emergence of issues of controversy. The existing guidance does not meet the current needs of agencies carrying out assessments.

It appears that there is a serious lack of co-ordination and management of the ICA process at national level. It is our view that, in the interests of equity, applicants for assessment should encounter a similar process regardless of which health board area they live in, or to which they apply for an assessment. There is a need for a high degree of commonality to ensure that children who are brought to Ireland have the benefit of parents who have been appropriately prepared and assessed for the task. Similarly, to facilitate people who will move between health board areas, and sending of assessment reports of a similar format and standard overseas, there should be common approach and practice.

In commissioning this report, the DoH&C is moving to exercise a standard-setting role, by having a standardised framework of best practice developed, within which health boards will have a degree of autonomy in implementing accepted recommendations. In conducting the research for this report, there appears to be a desire for this national framework on all sides. In allowing for flexibility, it is important that the recommendations are treated as an integrated package. We make the following recommendations therefore

The recommendations in this report should be incorporated by each health board into their provisions for ICA, and should be written as formal policy and practice, which will govern contact between the agency and applicants (see 6.3.3).

There is a need to designate a central authority which will become in effect the co-ordinating body for ICA in Ireland, which will set and monitor standards, and manage and oversee ICA. Each agency should submit its policy, (see previous recommendation) to the central authority which will check that policies are within the recommended parameters. In view of legislative provisions and its present role, we recommend that this task should be allocated to the Adoption Board.

The Adoption Board should be assigned the role of central advisory and information agency, which would assemble and disseminate information on ICA, and to which health boards would refer issues which arise from time to time. It would be the role of the Board, in association with the relevant interests, to develop and circulate new guidelines or recommendations.

While there is currently a level of inter-action between regional agencies and the Adoption Board about cases, there is a need to strengthen and improve communications on the broader issues in ICA.

An existing national body, such as the Office for Health Management, should assist with the developing and running of annual training, practice reflection, and development for those involved in ICA. Where appropriate, outside assistance should be obtained to fulfil the assigned roles.

6.4.2 Domestic and Inter-Country Adoption

There are similarities and differences between domestic and ICA, many of which have been described in the introductory chapters. There is similarity in that the agency is looking at potential adopters for their capacity to rear a child, and striving to assess if they appreciate the needs of a

child who has been separated from its birth parents. Loss is a significant common issue. In ICA there is the added dimension of race, ethnicity and culture.

It has been an explicit tenet of policy (Adoption Board guidance, 1991, 1993a) that different standards should not be applied in ICA and domestic adoption, so that a two tier system should not be seen to develop in relation to Irish and overseas children. However, as shown in Chapter Five the area of upper age limits is one area where a significant difference has emerged. Many staff working in the area are concerned about the different criteria accepted for domestic and inter-country adoption services.

A good deal of the conflict between applicants and agencies surrounding ICA can be traced to the confusion between the different standards in existence, despite the policy assertion that there was to be no differences. In providing the early guidance, the Adoption Board failed to highlight the difference between domestic adoption and ICA in terms of the implications of the legal right to an assessment in ICA, and how practice in domestic adoption had been shaped by a different context. The use of the upper age limit (38 for men and 34 for women) as a means of rationing the domestic adoption service at a time when there was a reduced number of children available for adoption is an example of this. These age limits could not be introduced as a way of rationing the ICA service because of the legislative entitlement, and such low age limits were not a requirement for good child care practice. Had guidance on the difference between eligibility and suitability in ICA and domestic adoption been provided, then the differences that have evolved might not have been viewed by workers as evidence that no standards or controls were been used in ICA decision-making.

It is also our view that the failure of the Adoption Board to provide guidance since 1993 is responsible for much of the variation in practice that has arisen in assessment practices. As ICA represented a new practice, and accounted for the largest number of unrelated adoption placements since that time, it is a serious omission that issues that emerged have not been addressed in guidance. In the 1993 guidance, agencies were asked to provide feedback to the Board, but there has been an obvious failure of this feedback loop, as no attempt was made to review the practice and service management issues arising from the new legislation. In the absence of guidance on policy and practice issues, social workers moved to fill the vacuum themselves, and have been negotiating the difficult issues at an individual level with applicants.

6.4.3 Location of ICA within a Child Placement Service

Health Boards are involved in responding to requests for information from those who have been adopted in the past. Workers have the benefit of hearing first hand the issues for persons who have been reared through adoption, as they undertake tracing functions. This experience has resulted in workers identifying issues which they include in the preparation and assessment process, such as getting people to project into the future — twenty years down the road, and providing a bank of case examples. This reinforces the importance of the need to look at issues for birth parents and the child, as well as the adoptive parents. It also reinforces the workers' views on the importance of collecting and storing on file information on the child's background, which will be available if the child makes enquiries at a future date. Likewise social workers involved in child placement in the area of foster care are attuned to issues connected with loss, identity and institutionalisation.

It is our view that the experience of domestic adoption, long-term fostering and tracing for previously adopted persons is a very valuable resource towards ensuring quality in ICA. We therefore recommend

Workers in ICA should continue to have involvement in domestic adoption and tracing, as part of an integrated child placement service.

6.4.4 ICA and Open Adoption

One of the big changes that has occurred over the years in domestic adoption is the move towards open adoption, as described in Chapter Two. This concept, although widely acknowledged as beneficial, poses challenges in ICA. The requests for post-placement reports are the most visible aspect of retained links in ICA. The issue of open adoptions is usually included in the preparation and assessment process.

One of the consequences of the present lack of control of the placement aspect of the ICA system is that the openness aspect may not receive the attention it deserves. In particular, the need to gather and retain important background information which may be required by the child as they grow older, may be neglected. This has caused much concern to stakeholders. In order that the practices in ICA correspond with those of domestic adoption, as recommended by the Adoption Board, we recommend that

The principle of open adoption is accepted as relevant and integral in ICA;

Open adoption should be part of the preparation and assessment process;

The contract at the placement stage should include for adoptive parents co-operating in providing stipulated information for transmission to the birth parents, and undertaking to pass on, in accordance with good practice, information on the child's origins, identity and culture.

6.4.5 Multiple Adoptions

The issue of matching and placing of children after the assessment is completed have largely been uncontrolled. As described in Chapter Five, it is reported that parents in a small number of cases have adopted two children using the same declaration. The reported cases include unrelated children of similar ages from the same country, and two children from different countries being adopted at the same time into the same family to create sibling groups. In general, these practices are a cause of concern, and a challenge to the principle of the best interests of the child. They also impact on the assessment process, in that one of the major purposes is to establish the capacity of the parents to care for a child. Subsequent uncontrolled multiple adoptions, based on an assessment of capacity to parent one child, could be seriously damaging to the best interests of the child. This has led to agencies including specific conditions that the assessment approval relates to one child, but this is not necessarily effective in controlling this practice. There is need for a consistent national policy in this area.

There are circumstances where the parents have capacity, and the placement together of siblings from the same family is beneficial. We therefore recommend that

Adoptive parents should generally be assessed and approved for adopting one child at a time; Subsequent assessment for second placements should be prioritised within the agency's waiting lists.

The principles of good child placement, whereby children of the same age are not placed together, and placement of siblings together, should be included as agency policy in preparation and assessment.

6.4.6 Decision-Making in ICA

There are a number of levels to the decision-making process in ICA. Under the present legislative arrangement it is the Adoption Board which is the actual decision-making body. Up to six levels can be routinely involved in making recommendations/ decision-making on a single application, as follows.

front-line worker, who does the assessment and makes the initial recommendation,
 the senior, who ensures the quality of work, and who endorses the primary recommendation,
 the Placement Committee/Adoption/ Case Committee
 the Director of Child Care Services, or the Programme Manager or CEO of the health board
 (unless delegated to the Chairperson of the Adoption Case Committee)
 Senior Social Worker in the Adoption Board, who studies the file and recommendation and
 who makes a recommendation.
 the Adoption Board itself, which make the final determination.

It is difficult to see that value is being added to the decision-making process at each of these levels for the effort involved, particularly as the actual decision-making power rests with the Adoption Board. It appears wasteful of scarce resources in looking at the same case at many levels, and undoubtedly contributes to the delays in completing the assessment process. Considering the distributed approval process, there is scope also for distribution of responsibility. Delays and inefficiencies can also be generated as an application passes through each of these levels.

Mechanisms for appeal have to be an integral part of any decision-making process. Appeal routes should exist at all levels, and be explicit to those involved.

We recommend that

The decision-making process should be rationalised, with the primary recommendation resting with the front-line worker and the senior social worker. In the longer term it is recommended that the placement committee (see also 6.4.7) should become the main decision-making body. To achieve this it will be necessary to change the existing legislative framework, which gives the power to make declarations to the Adoption Board.

Within the existing legislative framework, the Adoption Board retains the role of making declarations. Although we believe that power should be passed to health boards, the Adoption Board should retain a central involvement, and become an appeals body for applicants who are not satisfied with decisions of a health board. The Adoption Board would also continue to have an overseeing role and an inspectorate type role.

The pattern of decision-making at all levels should be subject to routine analysis, and action taken in relation to any undesirable patterns observed. A report should be compiled on an annual basis by each Health Board, and sent to the Adoption Board. The Adoption Board should include a review of its own involvement in the ICA process in its own statutory annual report.

To reduce the number of applications for extensions, the lifespan of declarations should be extended to two years.

6.4.7 The Placement Committee/Adoption/ Case Committee

The Placement Committee plays an important part in the decision-making process in many areas of health board child care practice. In this report, we recommend a strengthening of the role of the placement committee in the overall decision-making process in ICA (See 6.4.6). Placement Committees have evolved their own methods of operation, which reflect the circumstances prevailing in their boards. Placement Committees deal with areas other than ICA, so only part of the routine meetings are devoted to this subject. There are a number of aspects of placement committees, however, which need to be considered in conjunction with the above recommendation, to ensure harmonised practice across health boards.

The composition of the Placement Committee varies across health boards, as described in Chapter Five. We believe the role of the CEO in relation to ICA should be delegated to the placement

committee chair, as is the practice in a number of Boards. The position of vice-chair should be formalised. We believe that, in those placement committees where different professional groups are represented, this gives a strength to the committee. One of the issues which has arisen is whether the placement committee should have representation from outside board staff, as a customer balance, to the professional weight. This could include adoptee, birth parent and adoptive parent representation. The composition of panel members should be balanced. The membership should not generally exceed more than 10 or 11. The membership should be reviewed periodically and last for a duration of 2/3 years.

The composition of Placement Committees should be reviewed to ensure that there is an appropriate inter-disciplinary balance. The question of including persons from outside the organisation to represent consumer views should be considered.

The support given to each placement committee is also crucial to successful and efficient functioning. The secretary fulfils a dual role in terms of preparation for the meeting, and also recording the decision-making process. Papers /reports for the meeting should be sent out in advance of the meeting. Decision sheets have to be kept and put on the file. The decision of the committee has to be notified to the couples in writing.

Each Placement Committee should have written terms of reference assigned to it by the CEO;

Each Placement Committee should have adequate support;

Each Placement Committee should factor in time for reviewing its own activities and process.

6.4.8 Supervision & Support in ICA

The professional grades who supervise social work practice are Team Leaders and Senior Social Workers. It is important to distinguish the two roles of the front-line supervisor — the practice supervisor and the front-line manager. Supervisors need clarity about which role they are operating. The management role is different, in that it will deal with allocation of cases, managing the staff, and human resource issues. Where the two grades exist, the team leader may do practice supervision, while the senior operates in predominantly a management capacity.

As shown in the earlier chapter, the social workers in ICA are generally quite experienced, and would normally be expected to be in the low support, low supervision quadrant of a supervision/support axis. Unless there are new workers, or there is evidence of a particular problem, it should not generally be necessary to move out of this quadrant for supervision practice.

There should, however, be formal supervision at every step of the way — that is a structured time session where the supervisor can be familiar with what is going on. Progress with the allocated case-load should be reviewed at such meetings which are probably best spaced at four week intervals. Also, if complexities arise in a case the supervisor should be accessible to the worker. Practice supervision should be appropriate yet economical. Some organisations have contracts of supervision, specifying what will be dealt with, and maintain a log recording what was discussed and decided.

One of the effects of the numerous levels of involvement in decision-making is the potential for diffusing responsibility for decision-making. The supervisor should not be repeating the front-line worker's job. Rather the supervisor's role is primarily to facilitate individual and group reflection and develop and monitor the action plan to enhance effectiveness. Nor, if they are to have time to manage and develop their service, should the supervisor be doing the assessment themselves. The supervisor's job is the management of the team. This is not to say that the supervisor should not see and meet applicants. When training in a new worker, the supervisor may co-work in all or part of an assessment. The contact of the supervisor with the applicant can act as a way of diffusing any

difficulties at an early stage and avoid getting to formal complaints stage. In a number of health boards the senior social worker visits the applicants at the end of the process. The reason for these visits is not always entirely clear. It is not advisable for the Senior to visit applicants at the end and start to pick up issues which have already been covered. This practice is quite unhelpful and raises a lot of anxiety for the both the applicants and worker. If it is intended to explore a particularly difficult issue which has emerged during supervision, then co-working would offer an option. However this should only be necessary occasionally, and for resource reasons would not be recommended generally. It is essential that the hierarchical relationship between the senior social worker and the social worker is worked out and made explicit to the applicant before such work takes place.

When the report is done, the supervisor must carefully read and critique the report. It should be checked for completeness in the descriptive part, and for rigour in the analysis and recommendation. Any questions/suggestions should be brought to the immediate attention of the worker for action. When satisfied the senior should sign off the report, endorsing the worker's recommendation on the appropriate form. The supervisor should be available to mediate if there are differences between the applicants and the worker about the content of the report.

At the end of the reading of the report, the senior should be available to meet each set of applicants to review their experience of the process if they so wish. Any points raised should be considered and acted upon if appropriate.

We recommend

The approach to supervision and support should be reviewed in each agency, and a written policy included in the Service Management plan.

Training should be provided in supervision and support methods.

One of the supervisor's tasks is to ensure that each worker produces the required amount of output in a timely manner and to the specified standard. The issue of allocation of case-load is important. In some instances it appears that workers have been allocated impossibly large case loads. Workers should not be over-burdened consistently or they will burn out. If a service management plan is in place, this will indicate the ongoing capacity of the unit. We would recommend that a worker should not have more than ten assessments on hand at a time.

It is also important that the supervisor ensures that the worker delivers the appropriate number of completed assessment reports in each time span.

The approach to ensuring appropriate levels of work output, to the specified standard, should be reviewed in each agency, and a written policy included in the Service Management plan.

6.4.9 Formal & Informal Complaint Mechanisms

One of the most striking aspects of the public controversy of recent months has been the failure of feedback loops from applicants to agencies. If these were working successfully, it is unlikely that conflict and attitudes could develop to the point which they have. As discussed in Chapter Five, it has been widespread practice for the Senior Social Worker to meet the applicants at the end of the process. However as discussed, depending on the approach taken, this has not elucidated views on the process, but has, in some cases, exacerbated tensions. When operating in the process evaluation role, the supervisor has to very clear on the purpose of the conversation with applicants. We have already recommended the preparation of agency policy documents, so that applicants can be clear on the process which they are entering, and can judge their experience against the stated policy and practice approach. With clear process, transparent decision-making and an appeals system, the

apparent reluctance of applicants to raise negative feedback, for fear of endangering their application, should be reduced.

We believe it would be useful if there was an informal route for applicants to make complaints to the agency. This would involve designation of a position in the line management that persons with a grievance can talk to, to air their grievance. They need to have recourse where they can say “I didn’t particularly appreciate that”. At this level there is some room for negotiation and coming to some kind of mediation if appropriate. The informal complaint should stem from both parties reflecting on what is going on, and resolving issues through a problem-solving approach.

However, there is also need for a formal complaint system to be specified. This should set out the procedure of how a formal complaint is to be handled by the organisation. Formal complaints are usually referred to the CEO of the agency. The formal procedure should specify how the investigation should be conducted, and who should be the decision-making party when investigation is complete to see if it is upheld. The policy should generally be to have two investigators, one independent investigator from outside the organisation, and a second from a different section within to ensure that the process is in line with organisation policy. Investigating officers should always be a grade above those being investigated. The appointed adjudicating officer then considers the investigation report, and makes the adjudication. After the matter is adjudicated, the complainant would be informed by the adjudicator of the outcome, including the specific aspects of the complaint, and perhaps improvements proposed as a result. If the complainant remains unhappy, they could raise the matter again with the CEO, who will call on the head of the service to explain how the complaint has been dealt with, or refer it to the office of the ombudsman, an external body to whom persons dealing with organisations may complain if dissatisfied with what has happened. The role of the Inspectorate of Social Services would be important in this context.

Formal complaints can involve a major effort on behalf of the organisation. If applicants have opportunities for redress at earlier stages as suggested above, they may not need to use the formal system. However the formal complaint mechanism should exist in all agencies.

Formal and informal complaint mechanisms should be developed within agencies

6.5 Conclusion

In this chapter, the contextual and organisational issues that have shaped current practice and service management were discussed. Recommendations were made aimed at providing a better contextual and organisational framework in which practice and service management can operate more efficiently, effectively, and ethically. In Chapter Seven, a standardised framework, building from the analysis of key issues and recommendations made in this chapter, is provided.

CHAPTER 7

The Standardised Framework

7.1 Introduction

The current practices around assessment were described in detail in Chapters Four and Five. In Chapter Six, the contextual and organisational issues impacting on ICA have been reviewed and recommendations made to enhance practice. In this chapter, building on the literature review, international practice and discussions with the stakeholders, we propose a standardised process framework in which future ICA assessments would be carried out. This chapter sets out the method to be used for processing ICA applications, from enquiry stage to final decision. These are linked to the recommendations on the contextual and organisational issues discussed in Chapter Six.

The framework is intended to build on and integrate the many strengths of practice which were observed in the research, and to address those weaknesses which were evident. Again the frame of the Government's Strategic Management Initiative, including quality and excellence in service, efficiency, accountability and openness of decision-making are woven throughout the proposed process. In addition examination of the Swedish and Dutch systems together with the published material from the Swedish, Dutch, English, American and Australian authorities have served as a basis for the recommendations.

The proposed process framework is a statement of the elements of practice which we consider should be included in inter-country adoption assessment work. It reflects the stages and specific sub-tasks as shown in Figure 7.1. Each of these is discussed in turn, and recommendations are proposed.

The framework sets out broad parameters within which practice and service management can develop. It sets out an outline and rationale of the topics which should be considered during the assessment. It is intended that the detail of the preparation course, home study stage and report outline should be developed by the practitioners in the consultation and training phase, as it is essential that they have an ownership of the new practice. A highly prescriptive approach was avoided therefore.

7.2 The Place of the Assessment

Having a family is a private matter, for which the majority of people do not wish the point of view of others, or the state to be imposed on them. (N.I.A. 1998) If a desired pregnancy does not arise it is natural to seek other ways to have the longed-for child. It is not strange therefore if some applicants initially regard their adoption plans as their private business, and find the involvement of health boards and the Adoption Board as unnecessary, if not annoying. Many do not understand what the assessment is all about. Others would wish it to be speeded up, as they regard it as a mere formality.

The essential point is that the role of the state is to ensure the child's right to a good family. As discussed in Chapter Two, the adoptive parents and their family face a major challenge, and it is the role of the public authority to ensure that they have had preparation, and in the final instance, have the capability to meet the long-term challenges. While the applicants desire for a child to rear has become a secondary consideration, the needs of child and adopters are not exclusive or necessarily in conflict. For success, the methods used in assessment must try to meet the needs of both. There was evidence that this has been achieved to date by a number of health boards.

The role of the social worker is to carry out the assessment on behalf of the agency. It is a difficult and, in part, very delicate task. It can involve several perspectives, including being the child's representative, preparing and educating the applicants, helping applicants explore relevant issues, investigating and deciding on the applicants' suitability, recognising the needs of the applicants and being an advocate on their behalf if they decide to recommend them.

To achieve co-operation in all these roles, the purpose of the assessment must be clear right from the outset, and the social worker must have the confidence of the applicants. It is important that the process is clear to applicants from the start. The main purpose of the assessment and the report is to serve as a basis for the decision to consent to the application by the Health Board in the first instance, and by the Adoption Board. It must also be capable of being used to present the family to the representatives of the child in the donor country.

People are influenced by personal pre-conceived notions, experiences and values. Social workers attitudes to children and childlessness, towards adoption and especially towards inter-country adoption can affect the assessment and co-operation of the applicants. It is therefore important that workers realise this, and are clear on their own attitudes on these points. Workers have a responsibility to reflect and should not introduce their own views in a way which can hinder the process. It is particularly important that, in raising challenges to applicants, views are not interpreted as being the workers own attitudes.

There has been lack of clarity about the purpose and functions of the different stages of the process, which has led to conflict of expectations and role confusion. The objectives of each stage have to be clear, and the activities related to each integrated into a logical and streamlined process, while recognising the interaction between the parts. We propose the following objective for the assessment process:

The process must be based on the recognition that the needs of both child and applicants are not mutually exclusive, and that meeting both sets of needs, rather than disallowing one set, while retaining the child's needs as the primary interest, has to be the objective.

7.3 Defining the Process Framework

In Chapter Three, we have traced the evolution of assessment through its various stages. In the conclusion of Chapter Five, we expressed the view that, in many ways current assessment practice is a hybrid of some of those stages. No specific format has been devised to date for ICA assessment, and it is therefore in our view appropriate that the relevant and best parts of current practice used in inter-country adoption assessment are selected. However a high degree of clarity and flexibility is required from workers in this situation. It is for this reason that we include the systemic framework in the review in Chapter Three, as we believe it is directly relevant and should underpin practice in this work.

A five stage sequential assessment process is proposed

an information stage where applicants are given access to relevant information essential to understanding the needs of children, the needs of birth parents and the ICA process,
a preliminary assessment stage where applicants are considered against specified criteria,
a preparation stage where the applicants are helped to explore issues relating to ICA in depth,
an assessment stage where applicants continue the process of matching their experience to the intended task while the agency appraises them, and
a decision-making stage.

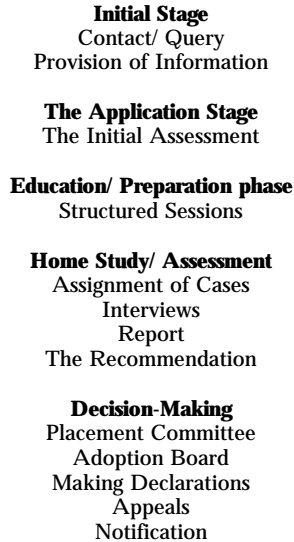
Having identified the main components of the process, it is necessary to organise for each stage of the process and to set objectives, standards and outputs for each. It is crucial to make the process explicit to the applicants throughout each stage.

We recommend that

The proposed framework should be incorporated into each health board's service management plan, as a description of the process in accordance with the requirements of Freedom of Information legislation.

The stages in the process should be explicit, with expected standards set, against which people can judge their experience.

Figure 7.1
Stages in the Proposed Assessment Process



7.4 The Initial Stage

7.4.1 Handling the Enquiry

As seen in Chapter Five, the way in which enquires are dealt with varies. There have been some criticisms of this part of the current process. The response of the agency at the enquiry stage should be to make relevant information available which enables the enquirer to begin to understand and appraise the option of ICA for themselves. In our research we have seen several very useful information packs on aspects of adoption or fostering, which could serve as a model for ICA (BAAF 1998; N.I.A. 1998; Department of Health, 1999). In order to ensure consistent practice and efficiency we therefore recommend:

Agencies should log every enquiry on ICA. Queries should only be dealt with by experienced workers. Where workers are not available to take calls, callers should be informed when a return call is likely to be made.

An information pack should be sent to enquirers to start the process of self-reflection and should include the following

- A booklet which contains general information on***
 - Aspects of Inter-Country Adoption***
 - Child's needs in ICA***
 - The situation of the Adoptive family in Ireland***
 - Information and Advice to potential applicants***
 - Adoptive parents contacts and helpful organisations***
 - Organising the placement and linking with overseas***

A booklet on Understanding the Assessment Process should be prepared also for issue at this stage, so that interested persons can be aware of the role of the agency and the assessment process ahead.

For the sake of consistency and to avoid duplication of effort, these two booklets should be prepared at national level by the Adoption Board, in consultation with the agencies.

A booklet prepared by the individual agency, outlining its own particular policy and procedures for dealing with applications, should accompany the national information leaflets.

The practice of sending the booklets as a means of meeting the information needs of enquirers should be considered as an alternative to conducting information meetings. Flexibility is necessary, however, at local level as to how best to meet the information needs.

Many enquirers about foreign adoption may not be aware of the other options of family building including fostering children in alternative care in Ireland. We recommend therefore

The person handling the call should check if the enquirer is aware of the situation with respect to children in alternative care. If appropriate, the enquirer should be informed that it is policy to include an information booklet on fostering with the pack sent to enquirers on adoption. This is for information purposes only and should not denote an attitude that the agency does not support ICA. The difference between fostering and adoption needs to be clearly spelt out.

7.4.2 The Application

The current practices in relation to issuing application forms were described in Chapter Five. It is, in our view, appropriate that potential applicants should have an opportunity to reflect on information provided at the enquiry stage, so they can make an informed choice if ICA is an option they wish to take further. When they do revert to the Health Boards with a request, the relevant forms and accompanying explanatory leaflets should be forwarded to them.

The form to be used in making an application under Section 8 of the 1991 Act should be considered at national level, and a common form and requirements for accompanying documentation to be developed, together with a standard explanatory note.

The application forms should be sent out on receipt of a request, together with explanatory notes. Documentation which the applicants are required to obtain and submit should be specified in detail, such as certificates, (birth, marriage, divorce etc.), authorisation for Garda report, references, financial information and health status report.

On receipt of an application, an acknowledgement, including a written outline of how the application will be processed should be sent to applicants. If such a description has already been provided to enquirers with the information pack, the applicant should again be referred to this in the letter of acknowledgement.

7.5 The Preliminary Assessment

7.5.1 Introduction

The first step for the agency on receipt of an application should be to validate that it contains the required documentation. Relevant parts, such as the health status report, should be sent to the agency's medical adviser for a recommendation. The application should be subject to a preliminary assessment against the issues described in section 7.5.3. It is noted that the legislation does not set out criteria for assessing applicants suitability. It is open to agencies to specify criteria in their policy

documents against which they will assess the eligibility of the applicants. In the interests of equity and consistency these criteria should be agreed at national level.

7.5.2 Outcome of the Preliminary Assessment

It is not possible to specify exact criteria for approving applicants as it is the overall capacity of the applicants in individual cases that has to be assessed. However, from the application submitted, it may be clear that the applicants will not be recommended for approval by reference to some or all of the criteria in this section. In that case, the more detailed preparation and assessment stages will not occur, and the applicants should be informed of the proposed decision, and the reasons for this.

There are three possible outcomes to the preliminary assessment. The first is that there may be inadequate information provided, which does not accord with the specified requirements. In this case the applicant should be informed that the application is not valid and invited to provide the specified material.

If the preliminary assessment has a positive outcome, the applicant will proceed to the next stage.

If, as a result of the preliminary assessment, it is decided that applicants fall outside the specified criteria, then applicants should be advised of this decision. The applicants can withdraw their application at this point, or the agency should move the application to the decision-making stage. It is open to the applicant to appeal a negative decision.

We recommend that

The preliminary assessment should be concluded within one month of the receipt of the application, and the applicants advised by letter of the decision.

If the decision is that the application which has been received and subjected to preliminary assessment is valid, the applicant should be so advised. This letter should inform the applicant of how a decision will be made as to when it will be further processed. The letter should give an indication of when they can expect to be called for the next stage, the preparation course, and when the worker will meet them to commence home study process.

If there is a negative decision as a result of the preliminary assessment, the applicant should be advised of the reasons, and that they may appeal the decision through the specified appeal mechanisms.

7.5.3 Age Limits

Specifying age limits for eligibility is one of the more controversial aspects of the ICA process. As noted in Chapter Five, this is an area where practice in inter-country adoption has deviated from domestic adoption practice. Notwithstanding the current position, for the reasons given below, it is our view that it is appropriate that limitations are placed on applicants age in considering suitability. It should be noted that overseas countries may also stipulate age limits for prospective adopters.

7.5.3.1 Lower Age Limits

The special needs of ICA children suggest that a degree of maturity and stability is required in the applicants. We therefore recommend

The lower age limits for adoptive parents should be 25 years, unless special circumstances exist.

7.5.3.2 Upper Age Limits

Upper age limits derive from the concept that the family situation of adoptive children should not deviate from that of other children in Ireland. A small number of children are born to women in the age range of 40 to 49.¹ However, our view is that the adoptive child should not be exposed to a special situation to any greater extent than the adoption itself involves. The consideration of the applicants age should be made having regard to the entire childhood of the child, and should look to a future perspective of twenty years. The rising age of the applicants must be viewed in relation to the growing needs of the child/ teenager. We therefore recommend that

There should not be more than a 42 year age gap between child and the older of the applicants at the time of placement.

7.5.4 Language

Currently English is the first language for the majority of people that reside in Ireland. It is suggested that applicants should have good English language skills, to enable them to support the child growing up. Special circumstances may exist if the child is a relative of the applicants or if the child comes from the same language or cultural area as the applicants. In such cases their capability in the English language may be of less importance.

For bi-lingual families, i.e. where only one partner speaks English, the extent to which the family can enable the child to become bi-lingual, and to define a family language is important.

7.5.5 Garda Records

Part of the documentation required with the application is an authorisation to obtain a check on applicants' Garda records. On receipt of the application, a check is run with the Garda by the agency. If there is a criminal record, a full copy should be obtained.

Applicants should be informed that most countries will not accept applicants with any criminal record whatsoever.

7.5.6 Health Status

The purpose of the check on health status is to ensure there is a reasonable expectation that the applicants will continue to enjoy good health and be able to fulfil their duties to the child over its period of growing up.

It is outside the scope of this report to consider the approach or issue of medical standards which should be used for this purpose. However, it is important that assessment in relation to health status should be consistent across the country. We recommend that

Medical Advisers be nominated in each agency who will assess the medical reports provided by applicants.

Under the aegis of the Adoption Board, a representative group of medical advisers with a knowledge of ICA issues should review the subject of health status of applicants, and prepare guidance for doctors preparing reports and health board ICA medical advisers. The relationship of medical standards to age should particularly be considered, as should the positions of applicants who smoke and drink.

¹The most recent vital statistics (Department of Health, 1997) show that 1707 children, out of a total birth population of 54, 311 were born to women between the ages of 40 to 49. Of these, 1,620 are born to women in the 40-45 age category, while 87 were born to women in the 45 to 49 age category.

7.5.7 Financial Circumstances

Section 13 of the 1952 Act requires that the agency establish that the applicant has sufficient means to support the child. We recommend that

Applicants should provide a statement of employment (giving position, period in post, status & income) include P60s, details of regular household outgoings, details of savings, assets and liabilities.

Financial circumstances cannot be described solely in terms of income or capital assets. People with small incomes can have more stable, more orderly finances than people in higher income brackets. Facts and information need not be enumerated in the report. The main thing is for the worker at the assessment stage to establish that the family's finances are in good order and can fulfil requirements of the Adoption Act, 1952.

7.5.8 The Referees

Applicants are requested to provide personal references from persons to whom they are known. An information note for referees should be provided with the application form, giving areas to be covered in their letter, such as context and length of connection with applicants, assessment of strengths and weaknesses etc. At the preliminary assessment stage the validity of the references should be checked.

As the worker approaches the assessment, the references should be reviewed for issues which should be explored during the interviews. Workers would generally make contact with the referees prior to commencing the assessment process. The confidentiality of references is sometimes an issue. Confusion can arise if the referees have given something which is negative or raises concerns. Sharing this with the applicants, without divulging the source, can be very difficult and can be a cause for conflict. This could be an area for the senior to intervene and help.

We recommend that two references are sought with the application. An information note for referees should be provided with the application form. There should be no requirement by agencies to obtain a reference from specific categories of persons e.g. clergy. The bona-fides of the referees should be established at the preliminary assessment stage. Both references should be reviewed by the worker prior to commencing the home study, and issues followed up as appropriate. At least one referee should be interviewed. Further interviews should only be necessary if the written reference indicates a contra-indication for adoption suitability.

7.6 The Preparation Stage

7.6.1 General

As reported in Chapter Five, there are variations in practice in relation to use of preparation courses as part of the ICA process. It is our view that, as discussed in Chapter Three, preparation should be an integral part of the assessment process, and should be included in the standardised framework. Also for the reasons discussed in Chapter Three, it is our view that preparation should take place in a group setting.

7.6.2 The Preparation Course

It is generally recognised that there is a period of adjustment required in preparation for parenthood. For biological parents there is a normal nine month adjustment, and then development as the child grows from infant to toddler. In ICA the parents can be moved straight into the toddler stage. Preparation is therefore important and essential for applicants.

There is variation in the stage that the preparation work is currently undertaken at. Preparation need not necessarily be part of the 'home study' process and, indeed, there are arguments for separating the two stages. As issues are explored in preparation, there will be a strong element of self-reflection for applicants. Where the assessment follows the preparation stage it is appropriate to see what impact issues covered in preparation have had on applicants. Sequencing of the preparation and assessment stages would also allow for a shorter interview set at the assessment. For reasons of efficiency and consistency therefore, we recommend:

That a preparation course be provided for all applicants who have been approved at preliminary assessment, prior to commencing the Home Study.

Preparation courses should be in the format of group courses with six to eight sets of applicants. They should be participative, based on the principles of adult education. They should extend over a defined preparation period, and should generally comprise six to eight sessions (see content at 7.6.4 below), giving eighteen to twenty-four hours of preparation.

7.6.3 Arrangements for Providing the Preparation Courses

The current preparation courses are provided through a number of arrangements, principally by Health Board workers, and with input from adoptive parents. There are likely to be few who have experience of adoption in the general community, and it is therefore appropriate that applicants turn to adoptive parents, birth parents and adoptees in order to get advice and comment, and to become members of a group where this way of family-building is a shared experience.

It is recommended that:

The current practice with participation of experienced adopters, birth parents and adoptees should be extended in the preparation and delivery of preparation programmes, making the content appropriate in meeting needs of children and the parenting experience of adopters. Consideration should be given to the model of co-presentation of the preparation groups rather than delivery of set pieces of information by the stakeholders in the system.

Health Boards should endeavour to develop partnerships with appropriate voluntary bodies in their area, with a view to providing joint preparation courses. Such partnerships, and the expectations from each partner should be clearly set down to the agreement of both.

Trainers/ facilitators for preparation courses should be trained at national level.

Courses could be organised on a joint basis as the application rate in individual health boards may not be sufficient to run courses on a timescale to facilitate preparation courses being run prior to the home study.

7.6.4 Content of Preparation Courses

There are many aspects of similarity between a biological family and an adoptive family. However there are differences which need to be anticipated and prepared for. This is part of the function of the preparation course. A number of health boards are currently providing preparation for applicants and have built up useful resources which could be utilised more extensively.

We suggest the preparation phase should include the following general contents:

- Why adoption? Motives for adoption.
- Involuntary childlessness.
- Which children are adopted and why?
- Children's needs
- Difference between adoptive and biological parenthood
- Preparing for adoptive parenthood : a way forward

The Home study.
 Nature and Nurture.
 What it means to be a parent?
 Ethnicity and race.

If applicants are considering an older child, we would recommend that a supplementary preparation course be considered for inclusion. This could include subjects such as

What the child leaves when going to a new country?
 How can the child be prepared for what happens to him/her.
 Adjustment difficulties.
 Language development.
 Identity formation.
 Research

The preparation phase should also include a practical child care course, geared for people with limited experience of children. This could be in the format of a week-end course, covering subjects such as food, sleep, clothes, toilet training, playing or other tasks in the daily life of the child.

Preparation courses could also be provided on the history and culture of various regions/ areas or countries of origin of children, ideally provided by groups of adoptive parents currently adopting children from these countries.

The content of existing preparation courses should be examined by a review group under the auspices of the Adoption Board, with a view to devising a series of standard preparation courses, drawing on existing and international practice;

The courses should be built on the principles of adult education, and an appreciation of different learning styles. The purpose of the training should be clear and explicit. Material developed in one context should not be used in a training context without reference to its origins and original purpose. Every attempt should be made to have access available to a broad range of material that outlines different theoretical approaches and research findings on the subject covered (e.g. loss).

7.6.5 Preparing for the Home Study

It is suggested that at the end of the preparation course, applicants should be asked to prepare a personal history using a standard form drawn from the final report. With the knowledge of adoption issues from the preparation course, this should be related to the adoption task and role. This should be completed prior to the home study commencing, and will facilitate some of the discussion between the worker and the applicants. The worker should consider the accounts written in advance of commencing the home study. We recommend

At the end of the preparation stage, applicants should be assigned the task of, and given guidelines on preparing written accounts of their own life stories, especially in respect of connections to the adoptive role. It should be made clear that this will be an integral part of the home study and completion of the final report.

7.7 The Assessment or the Home Study

7.7.1 The General Approach

As explained previously, the purpose of the assessment or home study is to determine that the applicant is a suitable person to have parental rights and duties in respect of the child, as required by Section 13 of the Adoption Act, 1952. The concept of, the definition and the purpose of 'Assessment' was discussed in Chapter Three.

The model of practice which has been developing from the mid-1980's to the present is known as self-selection and may be more aptly named as self-assessment. This approach is a refinement of education/ preparation model. As discussed in Chapter Three, current views on assessment regard the homestudy process as educative and supportive, joined with the concept of preparation through partnership, and the approach is more or less task-centred. However many prospective adopters continue to feel the historical, evaluative legacy of practice, which often increases their anxiety and undermines their self-confidence. Power is a central issue in inter-country adoption assessment. Assessment is a two way process, however, the balance of power in this process is nevertheless unequal since the agency ultimately makes the decision.

In the self-selection model, the social work role is more one of facilitator. The ramifications of this include a shift in the balance of power between applicant and worker, and more openness and honesty expressed by the potential adopters. The approach is based on the principal of self-determination, and the applicants play a major role in evaluating their own families as resources and in the decision-making process. Empowerment is not achieved solely by giving information or by training but by helping applicants redefine themselves as adoptive parents. Workers should be clear about their role, their use of power, their attitude and their goals in empowerment-oriented practice.

The practice activities in the self-selection approach to assessment are not greatly different from the techniques discussed in the education/ preparation model. (The distinction between the two models regards the increased emphasis, in self-selection, placed on enabling applicants understand the process they have entered into and makes explicit an openness for the applicants to select themselves out of the process if they wish to do so.)

The approach to Inter-Country Adoption assessment should be grounded firmly in the self-selection model, while accepting that the State has the ultimate role in deciding if the applicants have the capacity to parent an adopted child.

The purpose and approach to the home study should be explained to the applicants at the preparation stage. This should be repeated at the beginning of the home study. There has to be clarity about the process involved for it to work, with openness and transparency on both parts. It is important that there is sensitivity and mutual respect between the worker and the applicants. A framework which highlights rights and responsibilities of different parties is essential.

7.7.2 The Assessment Method

The impact of systemic thinking on the approach and methods used in assessment was discussed in Chapter Three. It is our view that systemic theory and practice has a significant contribution to make to ICA assessment, and that it is an extremely useful method with which to support the self-selection approach which we recommend above. The systemic model provides a widely-used, ready-made and comprehensive framework for understanding families and the systems which impinge on them. Importantly, the assessing worker is encouraged to maintain a reflective and objective stance as a result of the rigours of systemic hypothesising and consultation. The emphasis in systemic thinking on context, language and meaning also facilitates relationship building based on openness, mutual respect and accountability. However, a systemic application does not rule out the fact that social workers can never fully determine risk, or rule out the possibility of abuse by adoptive parents, or predict successful outcomes.

According to systemic theory, individuals do not function in isolation but rather as part of highly organised systems, often with consistent behavioural patterns and beliefs. A systemic assessment model is based on the premise that the adoptive family as a whole serves as the context for any placement. The approach gives due attention to the need to achieve a fuller understanding of family relationships and possible points of strain and tension, as every member of a household will both

affect and be affected by the presence of an adopted child. The systemic framework brings into focus the “who’s who” in the adoptive family configuration and provides a collaborative and co-operative milieu for the assessment. Therefore, it goes some way to make the assessment process “more open and objective and less dependent on the judgement and intuitive flair of the individual worker” (McCracken and Reilly, 1998:20). The richness of working with what happens, not just what is said, provides another level of evidence for assessment. Most importantly by understanding family networks and the systems which impinge on them, the systemic approach values and empowers adults and children alike, giving voice to all the significant family members.

The content of systemic assessment includes material from the applicant’s own life experience and how this has influenced them as adults. However, the focus is firmly on the present as opposed to the past. By identifying the systems and sub-systems which make up the day to day lives of potential carers the applicants, together with the social worker, are freed to explore behaviours and relationships, the routines and rituals, the family rules and boundaries, the support networks and stresses. The British Agency for Adoption and Fostering embraces the current support surrounding the systemic perspective in assessment (BAAF 1998).

We therefore recommend that:

Systemic theory should inform the methods used to undertake the recommended self-selection approach to assessment in inter-country adoption.

7.7.3 The Techniques of Assessment

It needs to be understood that there is no simple set of techniques to use in assessment. Rather, the practice should be firmly surrounded by an approach and method of the type we recommend above. Styles of questioning need to be future and solution-focused and developed as part of the systemic perspective which are designed to bring forth information that is required as part of the home study.

Different techniques may be employed in the different areas of the assessment. Underpinning the techniques should be an approach which includes

- emphasis on clarity of purpose;
- good interviewing style;
- coherent framework for assessment;
- an emphasis on the need for respect, openness and honesty in dealing with applicants;
- a responsibility for the worker to reflect on the impact of their own attitude and values and how this affects their practice.

7.7.4 Who should be interviewed (and in what combination)

The technique employed also has relevance for who is interviewed, and in what combination. To date the assessment practice in most agencies involves conducting couple and individual interviews with the adults and separate interviews with children. The rationale for separate interviews can be located in part in Section 13 (2) of the 1952 Adoption Act which requires that where the applicants are a married couple, the suitability of each should be assessed. The rationale for conducting individual interviews, while perhaps rooted in the 1952 Act, also embodies more in the traditional approach to assessment, in which the worker could assess the truth claim of individuals. Taking the systemic approach may mean that separate interviews are not necessarily required. Part of the benefit of the systemic approach recommended above is that the members of the family are viewed as a system. Experienced workers should be able to understand how the family works, and be able to separate the need for individual information from how the information is collected. It may be that separate interviews are still warranted if, in consultation with the applicants, they express an interest or if it is the view of worker that the individual application warrants it.

The interviewing of family members is also crucial. It is important to involve everyone living in the family unit in the decision to adopt a child from overseas, especially existing children in the family. The reason for meeting with the children should be shared with the applicants, and the topics the worker proposes to discuss with the children discussed. Account also needs to be taken of the child's age, developmental stage and special needs if relevant, when making this arrangement. Workers also need to be aware that, as ICA is a long drawn out process, children's needs should be safeguarded, especially if talk of adoption raises their expectations/ hopes prematurely. Likewise children's disinterest or objections to another child joining the family should not be misinterpreted as it may be an appropriate age related response, or reflect the child's dislike at the prospect of having to share their parents and possessions!

7.7.5 Scheduling Home Study Interviews

The approach to conducting the home study should be clear from the outset. The following are general recommendations with respect to the home study process itself:

The home study should be undertaken as a regular scheduled process.

The process should be fully prepared, so the worker goes in with specific topics or issues to discuss for each meeting. The interviews should have an opening, where the intended areas are outlined, the interview itself, and a closing. The applicants should be told before what is intended in each session, and checked back with at the end of the process. At the end of each session, items should be summarised and clarified. If there is something which is not clear it should be checked over.

7.7.6 Interruptions to Assessment

Once the assessment process has commenced, it should generally proceed without delay to conclusion. However, an issue may quickly emerge which indicates that there will be a negative recommendation, or that some action is needed by the applicants before the process could continue.

The approach to dealing with infertility issues is an area where difficulties can arise. Blanket approaches, such as declaring that assessment and infertility treatment should not go on at the same time do not take account of the different stages of dealing with issues that couples may be at. We do not favour the deliberate widening of the gaps in scheduled interviews to facilitate this situation. We recommend that

Where a major issue emerges early in the process which leads the worker to conclude that a negative recommendation will be made, this fact should be worked through with the applicants, who may decide to withdraw. If they do not, the worker should prepare a report, without having explored the full range of issues, detailing the conclusion and the basis for this, and submit it through the normal decision-making process.

Where an issue emerges, such as infertility, and where it appears that applicants are not in a position to proceed at the time, this should be discussed, and there should be flexibility to suspend the process until the applicants are ready to proceed.

7.7.7 Duration, Frequency and Location of Interviews

As described in Chapter Five, the practice with respect to duration, frequency and location of interviews varies considerably across health boards. For the sake of consistency, to enable the service to be managed and controlled, and so that applicants reasonable expectations can be met, we make the following recommendations:

The duration of each interview, as is generally the case, should not exceed more than an hour and a half to two hours.

Once started, the interviews of the home study should proceed at scheduled intervals of two weeks, subject to scheduled holidays, etc. The allocated workload of the social worker should enable them to follow such a schedule, and should allow for preparation for the interview, and analysis and updating of the file after each interview.

Provided the applicants have undertaken a preparation course, the areas to be covered in the interview process should generally be dealt with in six to seven interviews. This should include a visit to the referees and discussion of the final report.

Nine to ten hours of contact should, in normal circumstances, enable an appropriate assessment to be made. This indicates that the process should be completed within a twelve (six by two week intervals) to fourteen (seven by two week intervals) week time band. Where, as happens, it is necessary to deviate from the above expected norms, (or to stop the clock) this fact and the reasons should be mutually agreed by worker and applicant, and recorded.

The locations at which interviews are conducted also varies between those who work almost exclusively in the home of the applicants, and conducting interviews in offices. While there are benefits in conducting interviews in the applicants homes, some health boards recognise the advantages of office-based interviewing, with provision for one home visit. This reduces staff travelling time which, in both city or rural settings, involves a great deal of time and is a waste of a valuable resource. The time spent travelling would be better deployed preparing for the interview, and analysing it after. It is however the case that some of the health boards do not have appropriate rooms for interviews. In order to meet the anticipated schedules and workloads, we therefore recommend:

The venue for the interview should be a balance between the home and the office. There is a need to consider how an increase in the number of office based interviews can be achieved, by having suitable offices or interview spaces. It is suggested that one interview be held in the applicants home so that an assessment of the surroundings for the child can be made. After that agencies should strive towards the remainder of interviews being office-based. This would facilitate co-working and supervision, as well as efficiency.

7.7.8 Handling Intrusive Issues

One of the general complaints made relates to the handling of the intrusive issues, such as the stability of the applicant couples relationship, sexuality, and the impact of infertility on the relationship. (The rationale for examining these broad issues are considered in section 7.8.) Some applicants may be vulnerable, and anxiety levels can be very high, especially if issues have to do with infertility. While it is our view that the general self-selection approach recommended for assessment will be of assistance in dealing with difficulties in this area, we make the following recommendations:

The applicants have to be clear from the outset of the process that there are valid issues of a sensitive nature which should be explored, in terms of parenting somebody else's child. It should be clearly stated at the information and preparation stage, and repeated at the start of each relevant session why there is a need to know about the stability of the relationship, sexuality, or about infertility, if this is an issue;

A therapy role is not part of the Social Worker's brief in conducting the ICA assessment. However, it may emerge that therapeutic conversations are required. The possibility that this may emerge should be highlighted at the information stage, before applicants launch into the process. If issues arise which, in the worker's and agency view, needs resolution, applicants should be advised to suspend the process while this is resolved. The applicants should be facilitated in every way possible, and the assessment should re-commence at the couples request.

Use social work and systemic principles and ethics to help position the worker to deal with applicants in an open, respectful manner. Preparation for these sessions is essential, and training and practice in use of different styles of questioning for dealing with issues in a sensitive manner is required.

7.8 The Areas to be Covered

7.8.1 General

The Hague Convention, which it is intended will be transposed into Irish law, contains provisions about the types of information which should be included in the assessment process. This information is similar to existing adoption formats. The areas which the applicants and the worker must go through together are also those areas that the representative of the child in the other country generally wish to have explained in order to determine to which family a child should be proposed for adoption.

It is primarily the capacity and preparedness of the applicants to meet the child's needs that is being assessed. A number of the parameters which need to be addressed include:

Are the applicants sensitive to the needs of the child?

Have they a sufficient insight, and stability to provide a child with both stimulus and security?

Have they the capacity to re-adjust their life to meet the special needs of the inter-country adoptive child?

How will the applicants cope with the issues that can arise at each stage of the child's development and particularly during puberty?

The Areas to be Covered

The following are the areas recommended to be covered in the interviews. This is an outline only of core concepts. In the conversations, space needs to be given to enable the applicants to decide what they also need to cover in order to make decisions. The following list is not intended as sequential, or indicating an order of importance.

The current conditions in their lives

Relationship stability

Motives for adoption

Knowledge and experience of young children

Capacity for parenting role

Expectations concerning the child

Identity and culture,

Attitude to birth parents

Impact of infertility

Background

Relations and other social networks

Personality and interests

Religion and attitude to life

Openness to individual differences

Each of these areas is discussed briefly in the sections below. Discussion is informed by practices developed in the USA (CWLA 1988), Sweden (NIA 1998), England, (BAAF 1998) and Australia (Western Australia 1991).

7.8.2 The Current Conditions in the Applicants' Lives

This would include information concerning employment, and future plans. Satisfaction at work, relationships with colleagues at different levels, the working hours and the location of workplaces

are also important. Every child needs its parents' time and commitment, and so it is important to be able to combine gainful employment and family life without too much difficulty. (If both parents are working, the proposed child care arrangements need to be explored and how these arrangements fit with the child's needs.)

If any of the applicants are unemployed it is necessary to discuss how this will influence the family socially and financially. Is it a source of significant stress in the family? Applicants should be informed that applicants chances of being accepted by a donor country are influenced by this factor. If there are issues on finances generally to be clarified from the preliminary assessment process, the worker should undertake this.

A description of the home should also include immediate surroundings, access to playgrounds and play areas, as well as play-mates, and the proximity to opportunities for leisure activity for different age groups. The presence of pets should be evaluated.

The applicants plans for the child can also be considered in the context of the home. Will the child be able to move about, climb, jump and play there? Where is the child going to sleep? This can present an opportunity for talking about children's primary needs such as sleep, food, activity, bodily contact and security. A child coming from another country may not readily accept some of the intended plans.

7.8.3 Marriage Stability

The reasons for interest in this area are twofold. First, it is the couple that are being assessed for parental capacity. Ideally, the child should grow up in an intact family, and if the couple separate there is an impact on the child. There is need to draw the applicants attention to the child's need for security and stability. The marriage relationship is crucial to this. It is important to give this message to applicants, and they have a responsibility to take on the issue. Secondly, the arrival of a child can cause a strain of its own, especially if there is unevenness of motivation. The worker is looking for evidence of a firm, secure relationship, although there are no guarantees available as a result of an assessment.

Profoundly personal relationships can be difficult to gauge. Direct questioning is unlikely to elicit much insight into the marriage. Conversations about childlessness, attitudes to child's education, applicants own childhood and adolescence and about practical arrangements within the family are often a better source of insight to family relationships.

It is also necessary to make sure that both applicants are equally committed to the adoption. Adoption is a long term commitment. The issue of distribution of responsibility among parents is important. Issues such as who will stay home when the child is sick can indicate commitment to the concept of adoption. The child should not be the responsibility of one parent.

Other issues to be considered include voluntary childlessness, plans for other children, either biological or adopted, and bereaved families who have lost a child.

Discussion of the sexual aspect of couple's relationship, and of applicant's previous relationships has been criticised extensively in the media. However, sexuality is one aspect of an overall relationship and should be addressed as an indicator of the stability of the relationship, and not as a topic which stands alone. Although widely publicised, there was no evidence in the research that this aspect was a widespread problem for applicants, or that workers were asking inappropriate questions. The purpose of discussing the topic may not have been adequately explained to applicants, and there were some suggestions that workers needed more sensitivity in raising this issue with applicants.

It is appropriate to explore sexuality for a number of reasons. Firstly, many applicants who undergo infertility treatment report that their relationship can be affected, especially the sexual aspect, and this may have an impact on the overall stability of their relationship. A second reason for exploring sexuality is the link between the origins of the adoptive child, especially if born outside marriage, and the applicants' own attitudes. At a future date, when the child may need to explore issues in connection with their identity and sexuality, they will need parents who are sensitive to these issues.

For the worker it is important to be explicit about purpose of having this conversation, to be sensitive towards the applicants, and to be respectful of their wish to maintain privacy. The topic of sexuality should not be confused with the details of sex, and specific details about sexual behaviour or past relationships are not required to assess suitability for adoptive parenthood.

7.8.4 Motivation for adoption

One of the vital questions preceding an adoption concerns motive. The development of the idea, and the timing of the decision to come forward for ICA, which can illustrate either hesitancy or maturity, can also be explored. In the discussions, the applicants should explore and process the motives underlying the desire to adopt a child. This may involve a reflection on work done at the preparation stage. It is also important that both partners want to do it, and that one is not just supporting the other in his/ her wish.

Behind the desire and motive lies the expectations for the child, and this may indicate the likely type of parent they will be. What is it that applicants want to get from the children? What demands — expressed and implicit — will be put on the child?

Developing the applicants thoughts on motivation will help them when it comes to explaining the decision to adopt to their wider circle, particularly if they encounter negativity or doubts. As the child grows, they will also rapidly pick up the circumstances surrounding the adoption. Later in life, the child may themselves pose the question “Why did you do it, really?” and the applicant will need to be able to answer honestly.

The important thing is that the applicants are clear on their own motives, and have an ability to see how their motivation may impact on the child.

7.8.5 Knowledge of and experience of young children

It is self-explanatory that applicants should have a satisfactory knowledge of children and their needs, including knowledge of what an adoption means, in terms of the breaking of contacts, identity and living circumstances for the child, especially for older children. The applicants should have covered this in the preparation course. The job of the worker during the home study is to discuss and explore the applicants view on this, as it will give an indication of ability to take on an issue from the child's perspective.

Our attitudes to children are to a great extent influenced by our own childhood experiences. The relations with applicants own parents is important and happy childhood often helps indicate capacity for secure parenthood. It is also important to explore from their own childhood what they would propose to replicate or do differently as parents themselves. Everybody has good and bad experience, and the ability to cope with adversity encountered is also important to explore.

7.8.6 Capacity for Parenting Role

In the selection process, the agency looks for families who will understand the importance of the child's early life experiences and the way this may affect their general behaviour and development.

Furthermore the family must be able to deal with difficult behaviour, and accept the child's family background.

This area will focus on what the applicants need to be able to parent, and their understanding and openness to learning and changing. Future-oriented questions may be a useful way to facilitate the couple to explore parenting issues. The couple should be encouraged to talk to parents with children to become aware of issues of parenthood. Adolescence often involves duality and problems for young people. Consideration of the applicants suitability at the time of adoption should also include an assessment of their capacity to function as parents of teenagers. This means, amongst other things that the applicants age and state of health must relate to the demands that may be placed on them in 15-20 years time.

If everything is very organised within the family prior to the arrival of the child, will there be sufficient flexibility to alter set ways, and to accommodate the child? There should be understanding and insight into the development stages. The child is a baby today, but will not remain a baby. The child will grow up. What happens during that child's development needs to be considered.

7.8.7 Expectations concerning the child

Prospective parents always pin hopes and expectations on the child they are waiting for. Expectations today are mostly concerned with emotional desires for family life and close lasting relationships.

Assessment of their own resources in relation to the expressed wishes can help applicants define what they want out of parenthood. It is important that prospective parents see the connection between their expectations of the child and their own resources, and realise the impossibility of predicting the individual child's development. There is no guarantee of a healthy child of normal intelligence for either biological or adoptive parents.

7.8.8 Identity and Culture

A crucial tenet in the care of children is the importance of the child's family background. All adoptive families would be expected to assist children placed with them to understand and appreciate their backgrounds and culture, and to this end enlist the help and support of others; to provide opportunities to meet others of similar background, maintaining continuity of heritage of birth family, and knowledge of their identity. Although the child has left the birth family, they need to be given an appreciation of lost cultural, religious or linguistic values of their community.

For black children there may be the issue of racism, as difficulties may be greatly magnified purely because of the colour of the skin, and the adopter has to be very sure about how they are going to deal with this. It is not about having politically correct views, but in a hypothetical situation, where the child is being abused or bullied at school what would applicants do to deal with racist issues? How will applicants manage the child and the environment in which the child lives, including the wider family network?

Racism can take many forms and is a destructive force, especially in the life of a child. ICA children are vulnerable to this. The adoptive family will need to prepare the child for when it occurs and how to deal with it, so the child can maintain a positive attitude about him/herself and their heritage. The responsibility to prepare children to deal with racism rest with families caring for them. For children born to parents of different backgrounds, it is important to help the child to understand and take pride in all the elements in their heritage.

As previously highlighted in this report, the applicants' attitude to the birth parents is a central and crucial issue in adoption. Openness to the background, the needs and the feelings of the birth

parents is essential. Every effort needs to be made at placement stage to get as much detailed information as possible.

7.8.9 Impact of Infertility

Involuntary childlessness is the most common reason for adoption. The causes of childlessness and its effect on the applicants need to be discussed, and included in the report. Childlessness may be a severe strain on the individual and the marriage. Difficulties won't be dispelled by the arrival of the adoptive child, so it is important to discuss with both partners their childlessness, their possible disappointment and the way they have worked through the difficulties. If the child is expected to improve a difficult situation, excessive expectations can be pinned on it. However, it needs to be recognised that people can simultaneously hold disappointment and still experience tremendous happiness when a child arrives. What is important is the balance between the emotions and how this is managed.

Medical opportunities for assisting couples towards pregnancy have developed greatly in recent years. Medical treatment can however be a long and trying business. It is important that applicants have reached a point concerning childlessness that they can choose to adopt a child for the sake of the child itself. The applicants must be able to unreservedly accept the child, irrespective of their previous wishes and plans of the family.

For many adults, the capacity to have a biological child is at the core of their identity. Infertility can create great personal and inter-personal conflict, making it difficult for a couple to reach a mutual understanding of themselves as "infertile", let alone a mutual agreement about whether or not to pursue adoption.

Embarking on either adoption or assisted fertilisation does not provide the certainty of achieving the goal of having a child. Many will want to keep both options open. Applicants may well be able to pursue the option of preparing for adoption wholeheartedly in conjunction with medical treatments. We concur with Ryburn's (1991) challenge to the philosophical belief that infertility must successfully be grieved and resolved before someone is "ready" to adopt. This belief, as well as not recognising that infertility is a living grief that cannot be grieved like a bereavement, is supposed to ensure that adopters can manage the impossible. However, inadequate resolution of infertility issues can adversely affect the creation of a supportive post adoption child-rearing environment, as well as the ability to explore this area in assessment, and it is thus important for social workers to explore how applicants have handled the stress and strain of infertility, and whether the decision to adopt was by mutual agreement or primarily a reflection of one parent's need.

We do not favour having a blanket policy that infertility investigation and treatment must be completed before assessment commences. Rather we favour consideration of applicants position on a case by case basis.

However, once through the assessment process, and at the stage of submitting application documents for adoption to another country, the applicants need to understand that it would be irresponsible to continue attempts to get pregnant. By that time the choice should be made. It is not that the applicants may not have the capacity for two children, but the needs of the child may be such that he or she may have great difficulty sharing the adoptive parents with another newly arrived child. The capacity of the parents cannot compensate for the time that the adoptive child needs to be the person who receives the primary attention of the adoptive parents.

7.8.10 Background

A short account should be given of the circumstances in which the applicants grew up, their education and previous jobs, and the subjective experience of their childhood and adolescence. Applicants are usually comfortable talking about this. Examples of areas to be considered included did parents give time to their children, who did they best relate to, issues about discipline and enabling in the family. Discussion of these issues should provide an opportunity for the applicants to link their past experience with their own potential parenting skills.

7.8.11 Relationships with Relatives and Social Networks

If there are already children in the family, this will greatly influence the surroundings in which the child will grow up. The existing child's development, the relationship with the parents and other siblings, and the views about a potential new family member need to be explored. If there already is an adoptive child in the family, the home study should indicate how well the child has adjusted to the family.

It is particularly important to explore if an applicant is already a parent of a child who is not living with them. What is the level of contact and how the applicant is discharging parental responsibility are important issues to explore.

It is also important to consider the applicants' relationships with their nearest family members and circles of acquaintances. ICA brings radical changes not just to the couple and immediate families, but to their relatives and friends. There is a need to establish not just that the applicants are capable of the task, but that they fully appreciate the implications of bringing an unrelated child from abroad into their own family. Applicants could be asked to anticipate the likely reactions from people in these circles, and to consider ways of coping with this. The anticipated attitudes of grandparents is important, as they can mean a lot to the child. The grandparents may need time to adjust to the concept. Contact with other families who have children is important, as are the applicants social contacts generally.

7.8.12 Personality and Interests

The applicants' personalities and interest should be explored.. Leisure activities, occupational and social life have a bearing on different functions of the family. Discussion of leisure after the arrival of a child will give an indication of expectations of parenthood, understanding of changes in life style and commitment to the expected child.

7.8.13 Religion and Attitude to Life

Religion is an issue that is considered during the mediation with the country of origin of the child, and therefore should be explored, and recorded. It may also be important to consider how the applicants will incorporate information about the child's religion if it is different to their own.

7.9 The Report

7.9.1 Purpose of the Report

There are two purposes for the report prepared at the end of the assessment. The first is that it is required by Section 8 (1) (a) of 1991 Act. In this case the report is the basis for decision-making as to the suitability of the applicants. The second purpose is to enable the family to be presented to representatives of children in countries of origin after the declaration is made.

7.9.2 Format of the Report

The report itself should be a balance of information and analysis leading to a conclusion and recommendation. It is the analysis, feeding into the professional judgement, based on the information obtained from the applicants which is of crucial importance to the decision-makers. Reports should not be totally descriptive and contain facts alone. Describing a person's childhood does not necessarily give an idea of what that is about, unless it is then analysed according to what it may contribute to the applicants capacity as parents. Details compiled for analysis purposes do not all need to be included in the report.

The two purposes for which the report is written must be borne in mind in achieving this balance. The local decision-makers need a certain style of report, which facilitates them to get to assess the suitability of the applicant. They need a clear recommendation, with supporting analysis to make a decision. The countries of origin want relevant background information to help them reach a decision on placing and matching a child with the family described. An aspect that is currently missing in ICA is guidance for agencies on the information and formats of reports which particular countries of origin require. There is a need for feedback on what is required and acceptable for this purpose, as reports may be overly elaborate or inadequate otherwise. This type of monitoring of requirements should be done at national level. We recommend therefore that

the Adoption Board should monitor report requirements for various countries of origin, and provide guidance to agencies for use in compiling reports.

With respect to the report itself we recommend that

The headings of the report would follow the format of the subjects to be covered in the assessment (see 7.8 above). The detail of the report format should be developed by a working group under the auspices of the Adoption Board. While the BAAF Form F is currently the most common format, we suggest that the report outline could also adapt the Swedish model which is normally written in a report format of 5-8 pages. We would suggest the following as the broad headings of the report

Background, inclusive of childhood, education, occupation, current relationship with family members and other social networks

Current conditions, inclusive of housing, occupation

Health

Stability of the marital relationship inclusive of brief history

Personality and interests / religion and attitude to life

Motives for adoption including deliberations regarding the process

Attitude towards children and expectations concerning the child including identity and culture and attitude to natural/ birth parents and openness

Knowledge and experience of young children, ideals of parenting and preparation for parenthood, capacity for parenting role

References

Recommendation, and summarise basis on which decision is made

A good report should have the following characteristics

- Balanced between analytical and a descriptive account
- Thoroughness, not to be confused with including all details
- All headings explored and documented
- Issues identified, followed and concluded
- Evidence that process followed
- Balance

Clearly argued recommendation

Be presented well, under main headings, avoiding too many sub-headings

7.9.3 Analysis of information and professional judgement.

The worker requires a high level of skill in assessing the information coming forward during the assessment. Analysis and insight can arise during the sessions and can also emerge on reflection of what has transpired. The significance is not so much in the information itself, but in what this contributes to the conclusion about the applicants. It is important that the analysis is done during and in the immediate aftermath of the interview, so that issues which may need to be followed up can be identified, and a plan made to take it to conclusion. The worker should make notes of points which occur during conversations. Patterns should be identified, and confirmed as the process develops.

It may also be helpful to reflect on applicants with colleagues and the supervisor. Notes of analysis should be made at the same time that the information from the interviews is being recorded (see file keeping 7.10)

Methods and techniques that can assist in analysis include

- a systemic approach with its focus on context, meaning, language and relationship;
- reflective conversations with peers and supervisors;
- use of genograms to map relationships and processes;
- recording important issues.

7.9.4 Compiling the Final Report

The conclusion which is arrived at should generally be developed as the assessment process goes on, so that hypothesis can be confirmed before the assessment process is over. When the analysis is done, writing the final report should be a straight-forward piece of work, working from the conclusion that the applicants are either going to be recommended or not. Writing the report should not be confused with decision-making. It is the recording of the decision, and the process and basis for the conclusion. Any relevant descriptive or evidential pieces should have been compiled on a contemporary basis during the assessment (See also record keeping in 7.10). The final report is a pulling together into a conclusion of all the elements covered during the assessment. The justification for the recommendation has to be explicit. The reasons the worker thinks the applicants are/ are not suitable has to be clear, argued out and based on available information.

The final report should be compiled within four weeks of the completion of the assessment.

7.9.5 Sharing Contents with Applicants

Apart from the legal requirement under Section 8 (3) of the 1991 Act, the provisions of the Freedom of Information legislation require that applicants be facilitated to be fully aware of what is written about them by agencies to which the legislation applies, including health boards. The self-selection approach recommended should ensure that this is discussed with the applicants throughout the assessment process, so there are no surprise conclusions at the end.

It is essential for the whole process to be transparent to the applicant, and therefore sharing of the report is absolutely vital. Good practice in this regard requires workers to share the contents of the report, reading it through and discussing any differences of opinion, and recording and logging these carefully. These should be included with the report, so that the Placement Committee can also take this information into consideration.

Applicants should be given a full opportunity to review the contents of the report, and to raise issues with which they do not concur. These should be considered by the worker, and if agreed the report should be amended. If there is not agreement, after mediation by the supervisor, the applicants should be afforded an opportunity to provide written comment on the matters in dispute and this should be submitted with the report to the placement committee for consideration.

7.10 Decision-Making

The decision-making process was discussed previously in Chapter Six. Although, the recommended approach to ICA assessment is firmly rooted in “self-selection”, there remains a residual decision-making role, with several levels to the process, in both the assessing agency and the Adoption Board. Each of these carries its own responsibility regarding the interests of the child, and the need to be fair to the applicants. It is important to bear in mind that the recommendations/ decisions in ICA are part of a legal process. Applicants have to be treated fairly, and be seen to be treated fairly. The reasons for decisions must be sound and defensible. The Freedom of Information Act, 1997 has established new statutory rights, including a legal right to obtain reasons for decisions affecting oneself. The applicants should be clear on the basis of recommendations and decisions at all stages of the process.

The basis for decision-making has to be set down clearly in writing, and applicants have to be given an opportunity to challenge aspects with which they disagree. The language of the recommendation should be clear.

The recommendations/ decisions in ICA are part of a legal process. In accordance with the principles of natural justice and freedom of information, applicants are entitled to have their views considered at all stages, and if they are unhappy with the recommendation or decision, they should have the right to appeal that recommendation/ decision to the next level of authority. Although the Adoption Board is the final decision-making body, the same principles should apply at the earlier stages of consideration. Applicants should be informed of these principles, and of the appeal systems in place.

On the first level, if an applicant is unhappy with an aspect of the workers report and recommendation, and on discussing this with the worker and the supervisor, is unable to come to a mutual agreement, the applicant should be afforded an opportunity to make a written submission of their own for consideration by the placement committee at the same time as the workers report. The workers should have an opportunity to examine any submission, and make any further written comment. It should be open to decision-making bodies to meet with both applicants and workers to clarify issues, as part of their decision-making process.

The decision, and the basis on which the decision is made, should be clearly recorded. The applicants should be informed in writing of both the decision, and the basis on which it is made, and of the relevant appeal mechanism. If the applicants are dissatisfied, it is open to them to have their input heard on the relevant matter by the next level in the decision-making process. The applicants should again be afforded an opportunity to view and make comment on the report and recommendation which is being sent forward from the agency, and which will be used by the Adoption Board as the basis for decision-making.

If applicants choose to make a written submission, the Adoption Board should pass these to the agency for comment, and after receiving any written comment, proceed with the decision. The decision, and the basis on which the Adoption Board makes their decision should be clearly recorded. The applicants should be informed of both the decision, and the basis on which it is made in writing, and of the appeal mechanism.

At each stage of the decision-making, from workers recommendation to the Adoption Board, the applicants should be afforded an opportunity to see the documentation being used in the consideration of their case, and be afforded an opportunity to make their own submission for consideration.

7.11 File Keeping/ Recording

During the research, considerable variations were noted across the agencies in the area of file-keeping and recording of the process of dealing with applicants. Clarity of purpose is needed in determining the format of files and to get the balance between recording material which should be retained on file, and that which can be discarded. The Freedom of Information legislation impacts on this judgement. It is our view that the file should retain a record of the passage of the applicant, from the enquiry stage to completion and closing of the file.

This information should be in two formats. The first is a summary sheet, such as that contained on the inside of a file cover, which records factual information such as dates of enquiry, correspondence, applications, preparations courses, the assessment, meetings to discuss the report and the decision-making. In this way the history of the application can be seen at a glance. The purpose of such a summary record is to enable supervisors and managers to ensure that the organisation is meeting its targets for quality customer service. Such a summary record will also facilitate input of data to a data-base system, where the relevant Management Information can be compiled.

The actual file itself should contain all records of the agency's dealing with the applicants. Storing of correspondence and letters on file is a straightforward task. To record phone conversations, we recommend that each worker in an agency uses a standard telephone contact record sheet, where the incoming and outgoing phone contacts relating to a case are summarily recorded, including date, who contacted, and main items of discussion. Files should also contain records of preparation courses undertaken by applicants.

The area of recording of assessment interviews is the area where there is greatest diversity of practice. This varied from extremely detailed transcripts running up to twenty pages per interview, to those where there was no contemporary record of the interviews, until the final report was compiled. The reasons put forward for the detailed work included to enable supervision, to retain a record, and to enable compilation of the final report. Very considerable resources, in terms of both the worker's time and the necessary administrative support, are required for this level of recording, and it is questionable if this is the best use of available resources. We believe that, for the purpose of recording the facts surrounding an interview, a format with standard headings should be used which would include details such as

- Date, Applicants, Worker
- Areas covered in conversation, questions
- Relevant information obtained
- Issues emerging & areas requiring further exploration
- Analysis/ insights obtained
- Contribution to conclusion

This should be adequate for supervision purposes, and would help towards strengthening the analytical aspect of the process. If an agency decides that it is necessary to type a record of the interview from the notes, this should be in a format from which relevant parts can be imported directly into the final report. In this way the record becomes part of the report. Any reports of interviews should be compiled on word processors and stored for the final report.

It is suggested that originals of certificates and letters from referees should not be on the main working file. There should be a corresponding certificates file where these documents are kept. The references should be kept on a restricted basis, because they are confidential

All contact and correspondence should be logged on the front of file

Contemporary records should be made of all significant matters related to the processing of the file. These should be in a standard format, dated and signed.

A genogram should be constructed to illustrate family composition and connections

The area of ICA can generate considerable volumes of representations by and on behalf of applicants. Improving the clarity of the process for applicants, which is integral to this proposal, should help reduce the volumes of representations. It is suggested that standard letters are devised to assist in generating replies to these.

7.12 Conclusion

In this chapter, a proposed standardised framework involving five different stages has been presented. Issues related to application of the framework have been discussed in detail, and recommendations made specific to each stage. The framework needs to be considered in conjunction with the contextual, organisational and practice recommendations highlighted in Chapter Six. A discussion of resource issues and options for implementing the proposed framework is outlined in Chapter Eight.

CHAPTER 8

Resource Implications and Implementation of Change

8.1 Introduction

8.1.1 General

In the earlier chapters of this report the background in ICA assessment was described, key issues and concerns in the area of ICA were identified, and in chapters six and seven, recommendations towards improving and standardising the process are proposed. In this chapter the implications of the recommendations in terms of resources and for working arrangements are identified and considered. A strategy, in the form of a three-year national plan, is proposed to implement the recommendations for change.

8.1.2 Defining Objectives for the Service

One of the purposes of this report is to propose new parameters for the service, in terms of best practice and efficiency. The high level objectives which we propose for the service are to:

- Meet the Hague Convention requirements in terms of children's interests;
- Deliver a service which the applicant understands and sees to be beneficial and fair;
- Delivers defined levels of service for the resources employed;
- Be efficient internally and externally.

In Chapter Seven we have proposed a system through which applications should be processed. The objectives in terms of time involved in processing an application, as compared with that which currently pertains are shown in Table 8.1 below. The times which we would see as reasonable are as follows:

Table 8.1
Target Times for Processing an ICA Assessment Application

Stage	Current Process	Proposed Framework	Typical target periods for proposed framework
Information	Invited to regular meetings	Info pack sent out on enquiry. Info meeting may not be required	Immediate
Application	Held until process ready to start	Subject to preliminary assessment within four weeks of receipt	1 month
Waiting	Varies, over twelve months in cases, and growing	Suggested typical target waiting time of 3-4 months	3-4 months
Preparation	Varies	Defined over a four month cycle	4 months
Assessment	Varies	Defined over a four month cycle	4 months
Decision-making	Varies	Within one month of completion of assessment	1 month
Total	Varies, 47.3% between 12 and 24 months, and 27.3 between 24 and 36 months (See table 4.16)		13-14 months

To achieve these objectives and targets it is necessary to:

- streamline and standardise the process, as recommended;
- deliver elements faster, and in greater quantities;
- be reliable in terms of service delivery and quality;
- have leadership in making the changes;
- develop team-based working;
- have the right mix of skills to achieve the established goals;
- develop an effective supervisory culture;
- improve the operating environment and culture in some cases.

8.1.3 Applicability of Strategic Management Initiative (SMI) Concepts

The Strategic Management Initiative is about

- efficient and effective use of available resources
- quality of services with a customer focus
- openness and transparency

In providing good public services, agencies have to be able to demonstrate that they are efficient at achieving the objectives of their services, and that they make efficient uses of the resources employed. This report has addressed both these issues.

In ICA, as discussed previously, there are two customers of the agency. The primary customer is the hypothetical child, who may be placed with the secondary customer — the applicant family. The applicant is a direct customer of the agency in respect of several aspects of the process, such as enquiry, application, preparation. The concept of customer is difficult in some ways to reconcile with the assessment phase. In this situation, although the label ‘customer’ may not be entirely appropriate, applicants should feel that their application has been dealt with fairly, in accordance with a defined process, that they understand what is happening and that they have benefited, no matter what the outcome. The decision-making has to be open, and co-constructed largely, and there has to be appropriate appeals and complaint mechanisms. Under Freedom of Information legislation, applicants have rights to review and have corrected information that agencies hold about them on file. There is a need to be proactive rather than reactive, if such ideals are to be met. Communication is the key. Applicants must be worked with actively and listened to. It represents a major challenge to move the service from one where, in some areas, applicants were apparently willing to endure a difficult process in silence rather than complain, to one where the outcome is achieved and agreed through a mutually respectful process. In this context complaints can be viewed in a positive light, despite the natural tendency to be defensive when confronted with criticism and difficulties.

8.2 Service Demand Levels

The level of demand for ICA assessments has been rising dramatically as shown in Chapters Two and Four. The level of applications received and processed to completion by health boards in 1998 is shown in Table 8.2 below. This shows a serious deficit between service demand and the current capacity of certain health boards to deal with them.

Table 8.2
The Difference between Applications Received and Processed in 1998

Health Board	No. of 1st applications received	No. of 2nd applications received	Total Recd	No Processed to Completion	Difference
EHB	266	42	308	69	239
MHB	24	1	25	12	13
MWHB inclus. of St. Cath.	28	5	33	16	17
NEHB	61	0	61	18	43
NWHB inclusive of St. Muras	45	1	46	9	37
SEHB	22	2	24	25	1
SHB	142	7	149	28	121
WHB	30	0	30	18	12
PACT	2	1	3	3	0
Total	620	60	680	198	481

In excess of three times more applications for ICA assessments were received in 1998 than were processed to completion. A national deficit of 481 applications arises from the difference in demand and what was undertaken in 1998. This is concentrated primarily in four health boards. The EHB has a deficit of 239 applications. The SHB have 121, the NEHB have 43, and the NWHB have 37. Unless there is a significant injection of resources, the waiting lists are likely to become unmanageable.

8.3 Current Resource Allocation

8.3.1 General

The levels of staffing and resources currently allocated to ICA were discussed in Chapter Four. The eight health boards together have 26 professional and 11.5 administrative posts assigned, and utilise a budget of approximately £1.015m for ICA. This level of resources has only enabled less than one-third of the demand for assessments under the Adoption Act 1991 to be met in 1998. Even allowing for improvements which may result from implementation of the recommendations of this report, current demand greatly exceeds the capacity of the present resources, especially in the four health boards referred to above, although difficulties are evident in all.

There are a number of complicating factors in the case of ICA. There has been a general lack of social workers, due to the enormous increase in pressure on child protection services. Even with radically increased funding, there could still be a scarcity of workers for ICA assessment. Many of the 51 social workers involved in ICA operate a variety of arrangements, giving part of their time only to this task. This gives an effective full-time staff equivalent of 17.55 workers at mid 1998 (See Table 4.2). Even where staff work full-time on ICA, there are several other related tasks besides conducting the actual assessments. The introduction of requirements for post-placement reports is likely to provide an increasing demand on ICA resources, and indicates that there is not necessarily a linear relationship between resources input and output, in the form of assessments completed.

The research found that there was an awareness among health board management of the nature and volume of demand for ICA assessments. The current and growing waiting lists mean that applicants in those areas where there is a difficulty are waiting twelve months and over between application being made and assessment commencing. ICA has not, in general, been prioritised over other statutory child protection services.

Having legislated for a specific right to an assessment for the purpose of being declared eligible to proceed with ICA, it appears incumbent on the state to take one of three steps in light of the present situation:

Provide the necessary resources to meet the demand;

Encourage the existing voluntary adoption societies, who are enabled by the legislation but who by and large have not chosen to become involved in ICA, to provide the service.

Introduce a form of rationing as part of a national policy. For example, if a level of ICA adoptions were set at an arbitrary level of 200 per annum, the applicants to be assessed could be selected on a lottery basis. This would conflict with the current legislative entitlement. It may well be that, in a global context where the number of couples who wish to adopt is in excess of the number of children legally available, the state may be undertaking assessments for people who have a limited chance of legally obtaining a child through inter-country adoption. According to Anderson (1990), the Director of Adoption Centre in Sweden which mediates over 600 adoptions per annum, the number of children legally available for adoption internationally, aged 2 and younger, is far less than the number of applicants approved as suitable and eligible to adopt. This is important especially given the profile and age of children adopted to date in Ireland. (See Chapter 2)

In accordance with our brief, we examine the first of these options in detail in Section 8.4

8.3.2 Typical Outputs from Resources Deployed

From the research we have established the current levels of assessments which are being completed with the resources allocated. Critics of the service point to the low ratio of assessments completed per worker engaged. However throughout the report we have indicated that ICA is not just conducting assessments, and workers are engaged in a range of functions in the area. As a result of the pressure, ICA has become one of the most scrutinised of public services. However, despite the efforts of individual workers and managers, this report has catalogued factors which we believe have reduced the efficiency of the service. The current system is additionally stretched dealing with queries, representations and complaints from applicants caught on long waiting lists. One of the most commonly reported difficulties arises when applicants identify a potential child through premature contact with donor countries, and use all possible means and pressures to try to expedite their particular assessment.

Despite limitations referred to in Chapter Four with the data on staffing, in Table 8.3 the average rates of output for staff engaged in the service are calculated.

Table 8.3
Average Allocations and Outputs per Worker

Health Board	No. of 1st applic. processed to complet.	No. of 2nd applic. processed to completion	Total processed to completion	Estimated Number of workers at mid 1998*	Approx. notional ratios of Output/ Worker	Applications allocated to workers	Allocation rate/ worker in 1998
EHB	58	11	69	5.5	13	123	22
MHB	11	1	17	1.3	13	16	12
MWHB** incl. of St. Cath.	13	2	15	1.5	9	8	5
NEHB	14	4	18	1.5	12	38	25
NWHB** incl. of St. Mura's	9	0	9	0.5†	17	28	28
SEHB	23	2	25	1.5	17	30	20
SHB	24	4	28	3	9	41	14
WHB	13	5	18	1.25	14	23	18
PACT	3	0	3				
Total	169	29	198	17.55	11	307	17

†8 of the 9 cases completed by one worker who spent .50% of time on ICA.

*This figure is an estimate, (See Table 4.2) based on the numbers of posts, and the % of time which workers estimate they give to ICA.

**Includes adjustment for workers in Adoption Agencies who provide services in association with health board.

Subject to the limitations on staffing data, the calculated notional average rate of applications processed to completion per worker was 11 cases per worker. The range varied from a minimum of 9 to a maximum of 17. This figure does not recognise the other related work involved in extensions and post placement reports (Table 4.7)

8.4 Towards Consistent Output Levels

It is clear from the research that those workers involved in the delivery of ICA services are fully engaged at the moment. The variation in output rates reflects the different structures, approaches and methods used for processing applications which have been described in Chapters Four and Five. One of the objectives of the standardised framework is to develop an approach which can be employed by workers across all regions, and which should therefore result in bringing the notional output rates into a smaller range. Table 8.4 below provides a comparison of social worker input into current practice and that anticipated for the Framework Proposals, and indicates areas where it is anticipated that substantial resources will be freed up. It should be noted that in some areas, additional requirements, over and above what are currently in place, will be required to comply with the Framework. In addition, in accordance with SMI, the Framework recommends the introduction of a substantial training/ professional development aspect which is not currently in place in any region.

Table 8.4
Comparison of Current Procedures with Standardised Framework

Stage	Current Task	Framework Proposal	Comment
Enquiry	Handling telephone Queries	Issue Info Packs	Reduced requirement for professional input.
	Information meetings	Recommends to be used more selectively	Resources released
Applications	Preliminary (Screening) meetings, and reports to Adoption Board	Preliminary assessment on basis of documentation submitted	Meeting dropped, in favour of documentary assessment, and local decision
Preparation	Varies, but up to six sessions	Six sessions required in Framework	New requirement in some areas, but covers areas currently being done on individual basis
Assessment Interviews	Large variation in practice, up to 12 interviews	Norm of six interviews recommended, on basis that preparation phase covers a lot of material, and purpose of interview is changed	This should release significant resources in some health boards
File Keeping	Practice varies from very elaborate record-keeping to nil	Use of formatted hand notes of interviews recommended./use of personal computers	This should release significant resources in some health boards, while in others it is a minimal new requirement.
Travel to Applicants for interviews	Practice varies, with interviews in both applicants home and office	Recommended that bulk of interviews are office based	Should release significant resources, but office accom. has to be addressed in a number of boards for benefit to be obtained
Preparation of Final reports	Some very long and descriptive.	Analytical reports recommended, which should be built from notes	Will release some resources, by being more focused.
Reports on renewal of declarations	It is currently a significant requirement	Extend period of declaration to 2 yrs. so that requirement eliminated	Should release all resources so engaged
Change of Country Reports	It is currently a requirement in many boards	Declarations non country specific No need for reports	Should release all resources so engaged
Team-meetings	Varies	Recommended monthly	
Supervision	Varies	Recommended at once per month or if the need arises/more depending on experience	
Post-Placement Reports	Currently using resources	Examine legal basis for these reports	Need to introduce post-placement support
Training & Professional Development	Not a feature presently	Annual reflection and training recommended as per SMI	A new requirement, which can enhance efficiency and quality of service

The recommendations in this report are designed to streamline the assessment process, to provide clarity about the approach, and to eliminate areas which are seen not to be the best use of the resources (principally social workers time) deployed. We believe the Framework, through freeing resources as shown in Table 8.4, can standardise output levels at a higher rate than is currently the

case in most health boards for the same level of effort. We suggest a range of 18 to 24 cases completed per worker per annum as the target. While no agency is currently achieving this throughput, we believe that this target range is achievable as a national norm across the country.

The way in which the work is approached can have a significant bearing on the output. A number of constraints have been identified on work arrangements, and it is our view that the current approach to undertaking work should be examined carefully in each agency, with a view to enhancing efficiency and output. We believe the approaches of the following type could help to achieve the required efficiency and output levels:

Workers should be assigned to operate in complementary pairs, for running preparation courses, for co-working on analysis and difficult issues.

The working year should be divided into three four month cycles (e.g. Jan- April; May- August; Sept.-December). Depending on the number of pairs of workers in a team, the start of cycles can be staggered by a suitable interval (e.g. one month or two month) to ensure a continuity of output.

Workers should be assigned two sets of 8 cases per cycle. The first set of applicants will be at preparation stage for the cycle. The second set will be at assessment stage.

Working in pairs, and each worker bringing one group, each worker will be involved in two preparation courses and one set of assessment interviews per four month cycle. This involves a work-load of 2 x 6 preparation sessions = 12 per cycle, and one set of assessment interviews or 8 applicants x 6 interviews = 48 interviews over first 12 weeks of cycle. This leaves 8 reports to be prepared over the last four weeks at the end of the sixteen week cycle.

The following would be a typical workload for the first twelve weeks of the cycle with this type of arrangement. Week 1, 3, 5, 7, 9 and 11 has preparation sessions for one worker's preparation group. Week 2, 4, 6, 8, 10 and 12 has the same preparation session for the other worker's preparation group. With 8 applicants each for assessment in the period, each worker has to conduct an average of 8 interviews every two weeks to complete the six interviews in the first twelve weeks of the cycle. In this arrangement, each applicant is scheduled once every two weeks, or the worker has an average schedule of four interviews per week. This is not to say that workers should only do four interviews per week, but this should be the average over the cycle. This type of schedule over a twelve week period should provide the normal flexibility required to cater for training, holidays, sick leave etc.

The last four weeks of the cycle would be used for preparing final reports for submission to the placement committee, including sharing these with applicants.

The above is suggested as the type of working arrangements which should be defined as part of each agency's service management plan, taking account of the local circumstances. A plan in this or similar format is fundamental to enable the service to be planned and managed effectively.

8.5 Towards a Balance in Demand and Capacity

8.5.1 General

In the ideal world, there would be a balance between service demand, i.e. requests for assessments, and the capacity of the resources available to meet that level of demand in any given year in a health board. This is close to the case in four health boards, but in four boards there is a serious divergence. It should also be noted that, although the present numbers are small in four boards, the correspondingly small numbers of staff are under considerable pressure, and if the application rate moves towards the national average, as discussed in Chapter Four, that a similar crisis could develop rapidly in these health boards.

There are four options apparent about resourcing ICA in Ireland.

Do nothing (i.e. continue as is). This is not considered a real alternative, as waiting lists are close to the unmanageable stage, and if trends of divergence between demand and capacity continue they will have passed into a declining spiral of unworkability in less than a year.

Implement the standardised process to gain efficiencies with existing levels of resources, and optimise the number of cases which can be dealt with within these resources. In this case the waiting lists will continue to expand.

Implement the standardised process and provide additional resources to meet an explicit number of ICA approvals, and resource to meet this. A form of rationing would be necessary.

Implement the standardised process, and provide additional resources to bridge the present gap between demand and capacity, i.e. to deal with the current rate of new applications and work systematically through the backlog until an equilibrium between demand and capacity is achieved at a point in time, say four years hence, at end year 2002.

The brief for this report is to proceed on the basis of Option 4, with a demand based on 1998 figures. We have selected what we believe is a reasonable and achievable time-scale for doing so, that is a three year period from January 2000 to December 2002.

8.5.2 Dealing with the Backlog

In this section we outline a methodology which could be used to make a plan to deal with the backlog of applications, and achieve an equilibrium with demand. While we undertake this exercise in respect of each board, we would recommend that a similar exercise be undertaken by each board, taking account of the individual circumstances, such as previous years deficits, as part of its preparation of a service management plan.

The system which has been in use to manage waiting lists is to assign each application a sequential number according to the order in which they are received. This is an equitable, fair and just approach. New applications continue to be assigned a number. The hope is that the gap between the last number submitted and the number being processed is reducing.

For the purposes of making a plan and estimating the resources required to deal with the current backlog, we assume that current levels of demand hold. For the exercise, we take a four year programme to restore equilibrium between demand and capacity. This includes for gearing up the service (planning, recruitment, accommodation and training) to meet the anticipated service levels throughout the remainder of 1999, and operating a three year plan from January 2000 to December 2002, to eliminate the backlog and deal with current annual demand levels. Calculations are made in Table 8.5 below to show what the deficit will be at the start date of the plan in January 2000.

Table 8.5
Calculation of Expected Demand Capacity Deficit at January 2000

Health Board	Deficit* from 1998	Anticipated no. of applns in 1999**	Total	Less 1999 Expected Output***	Deficit at Jan 2000
EHB	239	308	547	80	427
MHB	13	25	38	15	23
MWHB inclusive of St. Cath	17	33	50	25	25
NEHB	43	61	104	40	64
NWHB inclusive of St. Mura's	37	46	83	20	63
SEHB	1	24	23	25	2
SHB	121	149	270	40	230
WHB	12	30	42	30	12
PACT	0	3	3	3	0
Total	481	680	1,160	258	842

*See Table 8.2 above

**Taken as the same as 1998 levels

***This estimate includes for a 40% increase of completed applications over 1998 figures

To achieve equilibrium requires a two-pronged approach.

A number equivalent to the current annual intake of applications has to be processed. Using an average figure of expected output rate of 20 assessments/ worker/ annum, (this is between the 18 and 24 cases predicted see 8.3.3 above) the number of workers required to deal with intake in year 2000, which is taken at the 1998 rate of 680 divided by 20 = 34 workers required. To eliminate the expected deficit of 842 applications at January 2000 over three years would require $842/3 = 280$ cases per year for each of the years 2000, 2001 and 2002. 280 applications divided by 20 = 14 workers required.

In this model a total of $34 + 14 = 48$ workers are required for the three years to deal with the backlog of applications, and meet the current annual demands.

To achieve the desired equilibrium between demand and capacity in a three year plan from January 2000 to December 2002 would require a work force of 48 social workers to be put in place, together with the necessary support services. This is an almost doubling of the number of social work posts (26) assigned to ICA currently, and almost treble the effective staffing of 17.55 (See Table 4.2).

Table 8.6
Additional Posts Required by Health Boards with Largest Deficits

Health Board	Deficit on Jan 2000	Deficit over 3 years	Annual Application Rate	Total Annual Requirement	Total / 20 cases per worker	Current No of Workers	Additional Requirement
EHB	427	142	308	450	23	8	15
NEHB	64	21	61	82	4	1.5	3.5
NWHB	63	21	46	67	4	1.25	2.75
SHB	230	77	149	226	11	3	8

8.5.3 Typical Current ICA Service Costs

In Table 8.7 below, some calculations are made of typical costs associated with the provision of the current ICA service by the health boards. One of the major elements of cost, and the key unit for productivity, is the number of social workers engaged in the service. We have, again subject to the caveats about staffing posts, calculated norms in relation to the total costs per front line worker, and the ratios of workers per hundred thousand of population. These are used for calculating estimated resources required to bring the service to the point where it has the capacity to meet the current demands, and to eliminate the backlog in accordance with the suggested three year plan.

Table 8.7
ICA Service Expenditure Levels

Health Board	Total Population Served	Est* Expenditure	Expenditure/ 1000 population	No of Posts**	Expdt / social worker post	Staffing / 100k of pop
EHB	1,295,939	£482,430	372	5.5	£87,715	0.42
MHB	205,542	£28,542	138	1.3	£21,955	0.63
MWHB	317,069	£55,600	175	1.5	£37,066	0.47
NEHB	306,155	£57,091	186	1.5	£38,060	0.49
NWHB	210,872	£65,500	311	1	£65,500	0.47
SEHB	391,517	£87,084	212	1.5	£58,056	0.38
SHB	546,640	£168,534	308	3	£56,178	0.55
WHB	352,353	£50,600	144	1.25	£40,480	0.35
Total	3,626,087	£1,015,724	280	17.55	£57,876	0.48

*Derived from Table 4.19. Please note there are differences in the ways that figures were compiled, especially in relation to organisational overheads, which may affect the overall figures.

**Please note previous caveats re staffing posts referred to previously

The average cost, subject to the limitations of the data, of having full-time equivalent front-line social workers in place was £57,896, with a range varying from £21,955 to £87,715. The average would appear to reflect a realistic cost figure.

The average front-line social worker staffing equivalent level per hundred thousand of population is 0.483, with a range from 0.383 to 0.632.

8.5.4 Costs associated with the ICA Service

As shown in Chapter Four, the current estimated expenditure on the ICA service is £1.015m. The budget required to provide the level of service described above could be calculated simply by multiplying the current cost by the ratio of the increased staffing. This would give an estimate of service cost of £2.7m approx. per annum for the three years 2000 — 2002.

However, it is our view that some of the actual costs associated with service provision are underestimated at present. Likewise implementation of the proposed framework will involve new areas of expenditure. We set out below what might constitute a typical annual budget for an ICA team, capable of dealing with 120 to 140 assessments per annum. These costs could be scaled up or down, depending on the actual demand, or chosen level of service provision. As part of each agency's service management plan, we recommend that realistic total cost estimates are prepared for the service, taking account of the local factors. These could be modelled on the example given.

Staffing Costs

SSW — 30% commitment to ICA =		£13k
TL full time, supervision and management roles		£30k
6 No Social Workers	6@ £30k =	£180k
1 No senior administrator		£30k
2 No support administrators	2 @ £20k =	<u>£40k</u>
		£293k
Placement Committee (Guestimate 20 meetings @ £2.5k ea.) =		£50k
Contributions to Voluntary Agencies (Guestimate) =	£25k	
Organisational Overheads @ 30% of staffing (recruitment, training, processing, legal, library etc.) =	£80k	
Charge for Accommodation		
7 offices +group area (2,000 sq. ft @ £20/ sq. ft) =		£40k
Services (post, electricity, telephone etc.) =		£20k
Consumables (include IT, etc.) =		<u>£20k</u>
	Total =	£526k

The average cost per front-line worker in this situation would be £87,666, which is significantly above the current average cost per worker. This would reflect realistic overhead and accommodation charges, which appear currently to be underestimated.

In this scenario, the total cost of providing the enhanced service would be 48 x £87.6k = £4.2m

The figures of £2.7 to £4.2m are the range of annual costs within which the ICA service could meet the target of dealing with the backlog, and meeting current demands. However, these would need to be refined after the preparation of individual service management plans in each agency.

8.6 Charging for the Service

At the moment, there is no power in law for the Health Boards to charge for the provision of the ICA assessment service. The terms of reference require that the question of charging for the service in the future be considered. Using the figures of costs above, the cost per application processed in 1998 is £5,129 (£1.015m/198). In Section 8.5.4, the cost per application would range from £3.75k to £4.38k, depending on position in output range of 120 to 140 applications.

A unique aspect of the ICA debate has been that some applicants are actively lobbying to be allowed to pay for the service, presumably on the basis that they can then demand that the resources be used for this purpose, and that they get a quality service, delivered speedily. At a time when charges for public services are being actively opposed, this is a rare situation. Another argument put forward is that ICA is a costly service and a contribution towards the cost could help to provide other child welfare services, thus removing the suggestion that ICA is a service that takes from Irish children.

Opposing arguments are raised by some staff in the agencies. A high level of resistance was encountered in discussing this subject during the research. It appears that many people were making an immediate link between charging for the service, and it being done by private agencies, after the US model. However, we see charging and privatisation as two quite separate issues.

The opposition voiced to charging for the service was as follows:

First, that it would be inequitable to those who could not afford to pay. However, a scale of sliding charges, based on the declared salary levels in their application could be used to ensure equity;

A means-tested service is expensive to administer thus the hypothetical savings made as result of charging may not be realised;
 It was suggested that people who could pay would be prioritised over those that couldn't and two separate waiting lists would develop;
 Setting charges could be a serious deterrent to persons making applications, and this could add to the view of ICA as a service for wealthy persons only;
 The relationship between applicant and agency would be changed if the agency had charged for dealing with the application, and would in some way be compromised in making its assessment.

There are some obvious benefits from the state's perspective in charging for the service.

Applicants paying would help to meet the cost of this service;
 Resources would be freed up to provide different child welfare services and/or to pay for assessments for those that could not afford it;
 A better level of service can be provided with additional resources;
 The level of demand may be reduced by charging for the service.

On balance, we would recommend that charges be made towards the cost of the ICA service provided by the health boards. The additional resources so generated could be used to explore some of the additional service provision options in Section 6.3.2. This could assist in the task of effectively trebling the capacity of the ICA service to meet current demands. In making this recommendation we also recommend that

In the interests of equity, the charge should be a nationally determined figure, and consistent for applicants across the regions.
 As discussed in Section 6.3.2, the health boards should be the only bodies who can charge for the provision of the service, and that any adoption societies or individuals who provide the service should be sub-contractors of the health boards.

If a decision is made to institute charges, it has to be borne in mind that fees would only be charged in respect of applications after the operative date for the required legislation. It will not provide resources to deal with the backlog of applications on hand.

8.7 Output Measures and Performance Indicators (OMPIs)

8.7.1 General

The purpose of OMPs is to allow aspects of services to be compared, both with similar services in other organisations, and to other related sectors. OMPs generally relate to specific quantifiable outcomes, which are derived from Management Information Systems (MIS). In this report we have presented several tables which include what could be termed as OMPs for the ICA service. The importance of defining them on a national basis arises from the need to compare across regions, and so that MIS collection systems can be specified and put in place. There are different levels of OMPs, varying from local (of interest to the team leader or service manager), agency level, and national level. There is also an international aspect of ICA, and it is likely that there will be a requirement to supply statistics to an international forum. There should be a logical progression in management information systems from local to international levels. Information technology has a crucial role to play in this area.

While we believe that development of OMPs is essential, we would also wish to point out their limitations. Figures by themselves mean very little. It is the trends over time which are significant, and which enables service management to detect patterns, and point to enquiries which are merited. There is always a danger of distortion of effort to massage key OMPs. They are not a substitute for qualitative research on issues, or for customer feedback. Likewise they do not touch on other

less quantifiable areas, such as more satisfied clients, improved relationships with interest groups, or improved public awareness and attitudes to issues.

In the next sections we suggest what could be typical OMPs for the ICA service. These include : service demands; service delivery; outcomes; staffing; and financial resources expended. However we recommend that these are considered in a national context by service providers, before being adopted.

8.7.2 Service Demands

Key indicators could include:

- level of enquiries per 100k of population
- level of applications per 100k of population
- Ratio of applications to enquiries

8.7.3 Service Delivery

Number of Applications received over number processed to completion

% of applications processed to completion within 14 months of application date

% of applications where initial assessment stage completed within 4 weeks

% of applications where time from decision on initial assessment to commencement of preparation does not exceed 3 months, 4 months, between 4 and 6 months, 6 and 12 months, is greater than 12 months.

% of applications where assessment and report stage completed in less than 4 months, between 4 and 6 months, greater than 6 months.

% of applications where declaration made less than one month after completion of report, between 1 and 2 months, and greater than 2 months

8.7.4 Outcomes

% of ICA applications where applicants recommended by Health Board for declaration of suitability

% of ICA applications where applicants not recommended by Health Board for declaration

% of applications where applicants appealed/ made written submission on health board recommendation to the Adoption Board

% of cases where recommendation overturned

8.7.5 Staffing

Social Work Staff (at basic grade) assigned to ICA as a % of total SW staff in agency

Administrative staff (at grade) assigned to ICA as a % of total admin. staff in agency

Applications processed to completion per social work post

Social Work staff/ 100,000 of population

8.7.6 Financial

Cost of ICA as a % of child care budget

Revenue Expenditure on ICA per 1000 of population

Cost per application processed to completion

8.8 A National Plan to Implement the Recommendations

This report has examined issues relating to the provision of an ICA assessment service in Ireland. It has looked at contextual, organisational and process and practice issues that could lead to improvement of the service, in accordance with the terms of reference. It has considered the resource implications of implementing the recommendations in this chapter.

Certain assumptions have been made in this chapter about taking the service forward. Confirmation is required if the recommended three year program is to be implemented (to end 2002) to restore an equilibrium between demand and capacity, and that resources will be made available accordingly. If this is to be the case we recommended that

A national ICA Service Plan should be prepared to implement this decision.

It is suggested that a high-level ICA Steering Committee should be put in place to ensure that the necessary steps are taken to implement the decision. The following are the steps which we see as necessary to implement successfully the recommendations of this report

Obtaining high level decisions on resourcing and framework issues, and the concept of the National Plan

Convene Steering Group, assign roles to various participant organisations, and identifying groups and individuals to achieve the desired outcome

Leaders

Change Agents

Team members

Identify a sequence of events and undertake a critical path analysis

Develop the National Action Plan

Establish senior management acceptance and commitment to change and development

Develop actions plans within organisations

Recognise that this is a new way of working, and requires a time commitment

Increased understanding of management role, and skills necessary for this role

Begin interactive workshops as a form of development and training

Convene required working groups to address identified issues

Tackling behaviour and attitudinal issues, as well as skills

Cascade on approaches in agencies

Develop communications strategy

Provide local information sessions, workshops,

Collect and analyse reactions and address issues

Ensure all employees have access to positive support throughout change process

Aim to reduce anxiety, address concerns and support morale

Anticipate and counter hostility and resistance — encourage staff

8.9 Time Scales

If the overall timescale for a national plan is accepted, it is anticipated that preparations for the introduction of the standardised framework could be completed within 1999, and would be used for three years 2000 — 2002. The tentative time-scale would be as follows:

Year 1999

Consultative Process

High level decisions, include announcement & publication of report and National Plan

Preparation of Service Management Plans within agencies

Convening Working Groups

Motivating staff

Training Workshops

Clear applications which are currently being processed

Putting systems in place for standardised framework

Procuring additional resources and support services

Establishing new physical locations (if reqd)

Year 2000

Begin operating standardised framework

Continue review workshops and training

Evaluate impact after each cycle of year one of operation

Adjust National and Agency Plan as required

Years 2001 — 2002

Operate standardised framework

Continue review workshops and training

Routine (monthly or cyclical) review of performance towards established and defined outcomes.

End of year report

Do a new 3 year plan for service. Change is a process — not an event.

8.10 Risk Factors

There are a number of factors which could indicate a risk to successful implementation of a National Plan and the Standardised Framework. These risks occur where:

Central policy is not clearly enunciated

The global situation affects the availability of children for ICA

There is failure to regulate the placement and post-placement aspects of ICA

Broader organisational issues such as major external changes impact

There are undue levels of changes in personnel where staff are placed in temporary acting senior social work positions, are moved within the service or inappropriate staff allocation to the ICA service.

There is a loss of experienced people to the service

There is failure to diffuse present antagonisms

There is failure to develop the role of voluntary sector

There is a failure to develop the detailed training material needed for running preparation courses, conducting assessments and providing formats for report writing.

8.11 Conclusion

This report has considered the delivery of the ICA assessment service in depth. It has brought forward recommendations across a range of areas, including the proposed standardised approach which we believe, if implemented, can provide benefits for all the participants involved with the service.

8.11.1 The Child

Benefits from being placed through a consistent national system

Family have been prepared to meet the child's needs

Family have been assessed as having the capacity to meet the child's needs

8.11.2 The Applicants

Knowledge of process and purpose of assessment

A comprehensive plan to address issues raised

Clear process, laid out, and against which they can compare their individual experience

Clear decision-making with proper appeals system

Preparation to help them with their intended roles

Support mechanisms in place

Opportunity to contribute to process

Speedier delivery of service

8.11.3 The Agency

Clear process, recommended from national level, which they can implement

Commitment on resource issues

Integrated process

A model of service delivery in prospect

A good service for workers to be associated with, clear expectations, well led and managed towards the specified targets

Professional Validation

8.11.4 Birth/ Natural Parents in Donor Countries

Ensure their children are placed in families who are suitable and have the capacity to meet the needs of their children.

Keep links open so that at a future date children and parents can access information or arrange to meet if they so choose.

Summary of Principal Findings

CHAPTER FOUR

Structure of Service

A variety of arrangements exist for delivery of the ICA service by health boards, including regional teams, community care based workers, combination arrangements, and through arrangements with the registered adoption societies in the voluntary sector.

The ICA service is delivered by specialist teams, teams that include ICA as part of a related range of services, and by general community care workers. These variations reflect broader organisational arrangements, geographical factors and service demand levels.

Staffing of Service

The equivalent of 26 social work posts is assigned to ICA at the end of 1998, a rise during the year from 19.6 posts, or a 25% increase. However, it is calculated that an effective whole-time equivalent of 17.55 workers, made up of fractions of workers time allocated to ICA, was in place in 1998. 51 social workers were involved in the delivery of the service in 1998.

96.1% (49) of the sample of 51 workers involved in ICA hold a CQSW/ NQSW qualification in social work. The overall trend is indicative of social workers with long experience, including 77% of those assigned to ICA with more than five years in general assessment for child placement. One third of the workers, in keeping with the increases in staffing levels, are in their first year working in ICA.

10.5 posts equivalent is assigned to ICA. Most of the administrative/ secretarial staff assigned to ICA is at grade III.

1,212 enquiries were made in 1998 concerning ICA, 620 applications were made for first assessments, 60 applications were made for second assessments, and 59 applications were made for extensions of declarations already granted.

It is clear that some staff are working in poor and over-crowded accommodation. This was seen to affect both efficiency and morale.

Service Demand Levels

The National Average for ICA enquiry rates is 65 enquiries per 100,000 of relevant population. Rates vary by a factor of three from the health board with lowest to the highest rate of enquiry. The SHB have the highest enquiry rates in the country, while the MHB have the lowest.

The National Average for first application rates for ICA assessments is 33 applications per 100,000 of relevant population. Rates vary by a factor of almost five from the health board with lowest to the highest rate of application. The SHB have the highest application rates in the country, while the SEHB have the lowest. The SHB's application rate is nearly double the national average, while the SEHB's rate is 33% of the average.

The National Average for application following enquiry rate is 50%. The fall off ratio is most dramatic in the MWHB, with only 21% going from enquiry to application stage, while the EHB had the highest at 73% going forward to make application.

198 applications for assessment were processed to completion, of which 169 were applications for first assessment and 29 were applications for second assessments.

The national average rate for withdrawal of applications prior to being presented to the placement committee is 19%. This varies significantly between the agencies, and is connected in part to the different systems of allocations in health boards and adoption agencies.

Time for Dealing with Applications

The home study commenced within 1 month from allocation to social worker in the case of 86.4 % of first applications for inter-country adoption. As previously noted the deviation from this norm occurred in the health boards where large numbers of cases were allocated to workers, without realistic prospect of commencing the home study.

In 74.6% of cases, the time that elapsed from the date of the final interview to the submission of the finished report was 1 month or less. However 11.3% of the total number of cases took from 3 to 6 months to get to the same stage. This pattern occurred in a small number of health boards. The reasons put forward to explain this aspect of the delay-included lack of administrative support, sick leave, and delay in organising the visit by the senior social worker. While the numbers of cases in which this happened are small, from the perspective of applicants involved this was a source of enormous frustration.

Almost one fifth of home studies were completed in less than five months, and 63.6% were completed between 5-11 months. The small numbers at the upper end of time- scale would suggest complex factors, and may involve deferrals until applicants were ready to recommence. Factors such as pregnancy, bereavement and life changes were put forward as explanations in these cases.

20.8% of applications for ICA assessments are processed to completion within 12 months of receipt, 47.3% take between 12 and 24 months, 31.3% take between 24 and 36 months, and 1 case took longer than 36 months. Patterns are also evident in the individual health boards. In the EHB, 72% of applications took over 2 years. At the other end of the scale, the NWHB dealt with 88% of their assessments within 12 months. Disparities in the data set are also shown within health boards, for example, the MHB and WHB regions, where the length of the process varies from 6 to 29 months to complete. This may be indicative of variation of practice between community care areas, and particular staffing vacancies within the health boards. A long assessment period may also indicate that there was deferral or suspension of assessment for some reason. Therefore, the figures cannot give a definite indication of whether the length of time of assessment process is related to agency policy, level of service provision, social work practice issues or difficulties related to the applicants.

Number of Interviews

36.0% of cases involved between 5 and 7 interviews. 21.2% involved 8 or 9 interviews. 29.3% took 10 to 12 interviews and 8% took 13 or more interviews. In 3.4% of cases, the assessment comprised of less than 4 interviews. These cases may refer to deferrals, or other reasons for rapidly ending the process may have been involved. In four health boards practically all assessments were completed with not more than 9 interviews, whereas in the Eastern Health Board 80% of cases involved 10 or more interviews. In the EHB the data set given specifically mentioned the number of interviews was inclusive of the preliminary interview, interview with senior social worker, interview to read report and interview with two referees. Nonetheless the disparity between the EHB and other agencies is marked.

Applications for Second Assessments

38.0 % of applications for second assessments took from 6 — 11 months to process from application to presentation to the Placement Committee. 19.2% took between 12 and 17 months, and 38.0% of second applications took between 1 and a half and 2 years from the date of application receipt to the submission of the report to the Placement Committee. The Eastern Health Board had the highest number of applications for second assessments and also took the longest times to process them. This reflects that agency's policy of not prioritising second applications.

71.5% of applicants had five interviews or less in their second assessment, 19% had 6 interviews and 9.6 % of second assessments had between 7 and 8 interviews in the home study. The reasons put forward by the agency with the highest number of interviews were complexity in the cases, which warranted a different exploration.

CHAPTER FIVE

Enquiry Stage

Practice of how initial enquiries about ICA are handled varies across health boards. In general social workers respond to phone calls, and discuss the subject with enquirers. As a follow through, some health boards send out information packs, and others invite interested persons to routine information meetings. The numbers attending these can vary significantly. Where information meetings are convened, the content covered is similar but the numbers attending can have major impact on the process of the meeting, and how applicants interpret the messages on inter-country adoption.

Application Stage

Although practice varies in relation to applying for an ICA assessment, health boards do not generally issue application forms without a written request. Requests for application forms in those Boards, which hold information meetings generally, will not be considered unless persons have attended an information meeting. Application forms used by health boards varied in the level of detail required, ranging from brief biographies to more detailed questions such as motivation for adoption.

Preparation Stage

Preparation courses are used in five of the eight health boards and in two of the accredited adoption agencies. The duration varies from 3 to 18 hours, with from one to six sessions. Three of the agencies hold the preparation course prior to the home study, two during the home study, and one agency does part of the preparation work prior to commencement, and part during the home study. Preparation courses are not held in three health boards, but they were considered important in enabling applicants to reflect on the implications of ICA, and these areas are actively seeking ways to introduce them. Where agencies do not have formal preparation groups, it is suggested that couples have 'tailor-made individually delivered preparation' as part of their assessments. The content of the courses, and the depth in which subjects are considered during preparation varies also. Many applicants welcomed the opportunity that the preparation courses provided to network with others in a similar position. The view has been expressed that, while those attending preparation courses found them beneficial and applicable, the style of delivery is sometimes too didactic. There is a lack of facilitation, and not enough emphasis on adult education approaches.

Adoptive parents are included in preparation and training of new applicants in six of the eight Boards and in the three registered agencies. While adoptive parents are involved, they are used to a varying degree. When used in the information/ preparation stage, their participation is of short duration and they are not involved in the groups as co-presenters but as speakers at specific sessions.

The Home Study

As part of the home study, interviews were conducted by social workers in both the homes of the applicants and the agencies' offices. The ratio of home to office interviews varies from those agencies who work almost exclusively in the applicants' home, to those who undertake only one home visit, and schedule the remainder in their offices. The availability and quality of offices and interviewing rooms is significant in determining this ratio.

Two health boards conduct initial screening interviews at the start of the process. The purpose of screening interviews varies. In the EHB, the interview is used to ascertain if applicants still wish to proceed and to collect basic data. In the MWHB, the screening interview is used as an opportunity for co-work and to get an overview of the applicants. Some boards employ co-working for one interview, where two workers, or the senior social worker and the allocated social worker, work together in the interview. In a number of other Boards, co-working is also used but at a later stage of the process. In those areas where workers operate in a solo fashion, there is no scope for co-working.

The practice of requiring applicants to prepare written personal histories is increasingly in use, although there is variation in how this is done. Three agencies did not use this approach, and in one board there was evidence of variation in practice within the board.

The issue of infertility is considered in all agencies. In general the practice in agencies is to require applicants to have undertaken infertility investigation, and to have completed this before the home study begins.

The issue of upper age limits is an area where there is major inconsistency between domestic and inter-country adoption practice. This is seen to be as a result of the applicants legislative entitlement to have an assessment undertaken by the health boards. Persons of up to 57 years of age have been granted declarations by the Adoption Board in 1998. If the health boards could, they would apply an age policy of 40 year differential between child and adopter, or an age ceiling of mid-forties. This is not an issue for the registered adoption societies in the voluntary sector, as they are not bound by a statutory obligation to provide an assessment service, and generally impose their domestic age limits for ICA applicants.

It is the practice in all agencies to seek references. In general one referee is interviewed, except in the Eastern Health Board where the number is two. It is usually explicitly stated that the content of references is not shared with applicants. Some applicants expressed a view regarding the practice of identifying/ specifying particular categories of persons as referees e.g. the parish priest. The research did not establish if health boards stipulate the parish priest or whether this is discretionary.

84% of declarations related to adopting one child, while 14% related to one child or siblings. Agencies have a strong wish to see one child adopted at a time, unless siblings are involved.

There is variation in terms of periods of time specified that a child should be in place before adopters can apply for a second assessment. In some areas these applications are prioritised to facilitate adopted children to grow up with a sibling (adopted or blood). In others they enter the general queue. There is also variation in the length of time the child is required to be in the family prior to the commencement of the second assessment. It ranges from one year in the WHB, between 15 — 16 months in NEHB and 12-18 in SEHB. In these three boards the application is then fast tracked while in the EHB the child must be 12-15 months in place, but there is no fast tracking system. The basis of the time variation is not clear.

Supervision of Work

Supervision of ICA practice varies according to the organisational arrangements. In some agencies, supervision is provided on planned basis, while in others it is on a more ad-hoc basis. Supervision of new workers is regarded as important.

Variation exists in the practice of the Senior Social Worker visiting the applicants during the assessment process. Variation also exists as to the purpose of the visit by the senior social worker. There is confusion as to whether it is intended for supervisory or quality control purposes, for feedback from the applicants or as part of the assessment procedures. In many areas the lack of clarity and uncertainties caused problems for applicants and staff alike.

The Report Stage

There is significant variation in the level of recording undertaken, which varies from very detailed typed records of interviews being prepared to cases where there was little indication on file of records being made. The way in which the administrative support is provided also has an impact on the record keeping. Dictaphone machines are used in some agencies, and limited use only appears to be made of computers other than as word processors.

All agencies stated that they share the contents of the reports prior to presentation to the Placement/Adoption Committee. Variation exists in the way this was done. In some instances the content was shared at a hand-written draft stage. In other cases the report was left with the family. In some instances applicants are invited to read the report in the agency's office. This is sometimes perceived as a rushed and unsatisfactory sharing of the report by the applicants.

A wide variation in the content and length of reports was evident from the reading of these reports. Most agencies use the British Agency for Adoption and Fostering (BAAF) Form F, devised for the selection of prospective foster or adoptive parents as a template. There was evidence however that the many sub headings in the Form F, intended more as a guide for interviewing, were used in some agencies as sub headings in the reports. This gave rise to a more descriptive rather than analytical report style. There was also evidence that too much of the content of the home study interviews were included in some reports, rather than using this information to back up professional judgement and conclusions arrived at.

The Placement Committee

The Placement Committees are essentially internal to the organisation. The membership varies across the health boards, in terms of numbers and backgrounds. Variation in membership range from predominantly social work to multi-disciplinary where members are staff of the Health board to multi-disciplinary committees where there is a wide community dimension. The other variation noted was the membership of adopters on the committee. In five Boards an adoptive parent is a member of the placement committee. The only similarity was the absence of adoptees and birth/natural parents from all boards.

Conclusion: Approach to Assessment Practice

The current practices of ICA assessment in Ireland in many ways reflect a hybrid approach to assessment practice. While much of the current work of individuals involved can be described as good practice, the variations noted are a cause of concern on many levels. The absence of adequate guidance on the approach to follow, or for handling difficult issues that have emerged from the limited guidance provided, the lack of a central co-ordinating or standard setting body, the virtual absence of training in the field, the differing organisational arrangements and management cultures in the agencies have all contributed to the emergence of variation in practice, with consequent impact on the services' clients.

Summary of Principal Recommendations

CHAPTER SIX

Contextual Issues

The recommendations are based on our view of ICA as a system. The delivery of a quality assessment service requires a best practice approach for the entire system, and not simply for the assessment part. In keeping with our terms of reference, our analysis is in relation to assessment, but we see this subject as inextricably linked to broader contextual issues.

The Legislative Framework

A best practice based approach (along the lines proposed in Chapter Seven of this report), rather than a highly regulated assessment process, should be defined, agreed and promulgated for ICA assessment. This approach should be reviewed and updated, in light of experience and developments in the field. The introduction of legislation currently being drawn up by the DoH&C for the Hague Convention will provide an important framework to address many of the concerns surrounding ICA, especially the lack of controls on international placement/mediation organizations currently operating in Ireland

ICA as a Government-Level Issue

As ICA is a child care service, the DoH&C should remain the central government department with primary responsibility for legislation, and determining the place of ICA within the spectrum of child care policy, for leading implementation of recommendations, including assigning roles and obtaining resources, and for overseeing development of the ICA service;

The government should determine and co-ordinate the inter-departmental aspects of ICA policy, which will be a basis for policy and practice in the implementation agencies.

Organisational Issues

There is ongoing change and development taking place in the broader context of Health Boards and their delivery of services. In this report we make specific recommendations relating to some organizational aspects. We have framed these to ensure that there is sufficient flexibility to take account of the broader needs of the organizations.

Public or Private Service?

There is a need to retain and strengthen state involvement and control in the area of ICA;

The health boards are the most appropriate agency of the state for the assessment function. There may be scope for health boards to sub-contract part of the work;

The role of the Adoption Board should change to overseeing and co-ordinating the ICA services of the health boards;

The voluntary sector can play a significant role in ICA, and that a partnership ethos should be developed involving health boards and the voluntary sector (see 6.3.9)

Delivery of Service

In those agencies dealing with large numbers of applications, staff should be assigned to a specialist ICA team for service management purposes. This service could be joined with other specialist areas such as fostering, domestic adoption, post-placement and tracing, as part of an integrated range of services.

In boards where the geographical spread is such that service delivery is based on sub-units of the region, workers can be assigned on a community care area basis, and co-located with a community care team, but should belong and report to the unit, directed by a senior social worker. In this way, the home study part of the service will be delivered on a local basis, but with a very strong regional dimension for delivery of preparation courses, consistency of practice, team development, supervision and training.

The Health Boards should retain a central role in ICA and consider arrangements to sub contract work to Registered Adoption Agencies and suitably qualified individual social workers or groups of social workers

Policy Making at Health Board Level

A comprehensive statement of policy, procedures and practice relating to ICA should be prepared within each agency, approved at board level, disseminated within each agency, and used to manage the service. Where such policy documents already exist, they should be reviewed in the light of the recommendations in the proposed standardised framework;

The document should in effect be a management plan for the service, which in addition to the high level document approved by the board would include a work programme with service objectives and assigned roles, and expected contribution from each member, specifying operational targets for all functions undertaken, with measurable outcomes and outputs.

The preparation of the service management plan should be led by the service manager, and prepared in consultation with staff, and other stakeholders within and outside the agency;

The service management plan should include and take account of the recommendations of the proposed standardised framework;

Team Development

ICA work should be undertaken as part of a single integrated section, and a strong sense of team developed in relation to ICA work, where the fundamentals of team work, including clear purpose, unity of operations, roles of team leaders, team players and rules are established.

New and existing teams should review their systems and working arrangements, including inter-sectional and cross-functional relationships, with a view to developing into high-performing teams.

Service Management and Leadership

A programme of management development and training should be undertaken by all managers of the ICA services;

Managers in ICA should meet at a national level, to co-ordinate activities and development of the service;

Appropriate management information systems in relation to ICA should be developed where these do not exist.

Staffing of the ICA Service

An appropriate establishment of both administrative and professional positions to meet the chosen service level is determined as part of the service planning process;

Positions should be filled to the chosen establishment levels, and positive action taken to ensure that there is retention of workers in the area. In this regard, the development of a culture of a quality service, and high performing teams is relevant;

Individual workers should be assigned roles and tasks in accordance with the service management plan, and the proposed framework;

Staff Training and Development

A commitment to ongoing training of all staff, to the extent recommended in the Governments SMI of 3% of staffing costs, to develop competence in terms of knowledge and skills should be included in service management plans;

Professional workers should have relevant training/ practice reflection/ development on an annual basis. Training should be in complementary modules of practice;

An appropriate national body should undertake the role of co-ordinating training for workers in ICA, and should provide training at national level, which all workers would be expected to attend;

That training should be based on the principles of participative adult education, using a significant degree of workshop/ seminar type arrangements.

All workers involved in ICA should undergo an introductory module of training in the proposed standardised framework. New workers coming to ICA should undergo an induction module, with a high degree of supervision of their initial work.

The Voluntary Sector

The role of the voluntary sector should be further developed and formalised, particularly in the areas of preparation and assessment.

Office Accommodation and Support Services

Some agencies need to urgently review and upgrade/ extend the accommodation provided for the ICA service.

Each agency should review the use of Information Technology to ensure that it is making an appropriate contribution to the efficiency of the process.

Practice Issues

Common Policy, Practice and Procedures

The recommendations in this report should be incorporated by each health board into their provisions for ICA, and should be written as formal policy and practice, which will govern contact between the agency and applicants (see 6.3.3).

There is a need to designate a central authority that will become in effect the co-ordinating body for ICA assessment in Ireland, who will set and monitor standards, and manage and oversee ICA. Each agency should submit its policy, (see previous recommendation) to the central authority that

will check that policies are within the recommended parameters. In view of legislative provisions and its present role, we recommend that this task should be allocated to the Adoption Board.

The Adoption Board should be assigned the role of central advisory and information agency, who would assemble and disseminate information on ICA, and to whom health boards would refer issues, which arise from time to time. It would be the role of the Board, in association with the relevant interests, to develop and circulate new guidelines or recommendations.

While there is currently a level of inter-action between regional agencies and the Adoption Board about cases, there is a need to strengthen and improve communications on the broader issues in ICA.

An existing national body, such as the Office for Health Management, should assist with the developing and running of annual training, practice reflection, and development for those involved in ICA. Where appropriate, outside assistance should be obtained to fulfil the assigned roles.

Domestic and Inter-Country Adoption

Clarification is needed from the Adoption Board on the grounds whereby different standards are applied in the assessment of applicants for domestic and intercountry adoption.

Location of ICA within a Child Placement Service

Workers in ICA should continue to have involvement in domestic adoption and tracing, as part of an integrated child placement service.

ICA and Open Adoption

ûNormalû

The principle of open adoption is accepted as relevant and integral in ICA;

Open adoption should be part of the preparation and assessment process;

The contract at the placement stage should include for adoptive parents co-operating in providing stipulated information for transmission to the birth parents, and undertaking to pass on, in accordance with good practice, information on the child's origins, identity and culture.

Multiple Adoptions

Adoptive parents should generally be assessed and approved for adopting one child at a time; Subsequent assessment for second placements should be prioritised within the agency's waiting lists.

The principles of good child placement, whereby children of the same age are not placed together, and placement of siblings together, should be included as agency policy in preparation and assessment.

Decision-Making in ICA

The decision-making process should be rationalised, with the primary recommendation resting with the front-line worker and the senior social worker. In the longer term it is recommended that the placement committee (see also 6.4.7) should become the main decision-making body. To achieve this it will be necessary to change the existing legislative framework, which gives the power to make declarations to the Adoption Board.

Within the existing legislative framework, the Adoption Board retains the role of making declarations. Although we believe that power should be passed to health boards, the Adoption Board should retain a central involvement, and become an appeals body for applicants who are not satisfied with decisions of a health board. The Adoption Board would also continue to have an overseeing role and an inspectorate type role.

The pattern of decision-making at all levels should be subject to routine analysis and action taken in relation to any undesirable patterns observed. A report should be compiled on an annual basis by each Health Board, and sent to the Adoption Board. The Adoption Board includes a review of its own involvement in the ICA process in its own statutory annual report.

To reduce the number of applications for extensions, the lifespan of declarations should be generally extended to two years.

The Placement Committee/Adoption/ Case Committee

The composition of Placement Committees should be reviewed to ensure that there is an appropriate inter-disciplinary balance. The question of including persons from outside the organisation to represent consumer views should be considered.

Each Placement Committee should have a written terms of reference assigned to it by the CEO;

Each Placement Committee should have adequate support;

Each Placement Committee should factor in time for reviewing its own activities and process.

Supervision & Support in ICA

The approach to supervision and support should be reviewed in each agency, and a written policy included in the Service Management plan.

Training should be provided in supervision and support methods.

The approach to ensuring appropriate levels of work output, to the specified standard, should be reviewed in each agency, and a written policy included in the Service Management plan.

Formal & Informal Complaint Mechanisms

Formal and informal complaint mechanisms should be developed within agencies

CHAPTER SEVEN: THE STANDARISED FRAMEWORK

The assessment process must be based on the recognition that the needs of both child and applicants are not mutually exclusive, and that meeting both sets of needs, rather than disallowing one set, while retaining the child's needs as the primary interest, has to be the objective.

A five stage sequential assessment process is proposed

An information stage where applicants are given access to relevant information essential to understanding the needs of children, the needs of birth parents and the ICA process.
 a preliminary assessment stage where applicants are considered against specified criteria,
 a preparation stage where the applicants are helped to explore issues relating to ICA in depth,
 an assessment stage where applicants continue the process of matching their experience to the intended task while the agency appraises them, and
 a decision-making stage.

Handling the Enquiry

Agencies should log every enquiry on ICA. Experienced workers should only deal with queries. Where workers are not available to take calls, callers should be informed when a return call is likely to be made.

An information pack should be sent to enquirers to start the process of self-reflection and should include the following:

- A booklet which contains *general information on*
 - Aspects of Inter-Country Adoption
 - Child's needs in ICA
 - The situation of the adoptive family in Ireland
 - Information and Advice to potential applicants
 - Adoptive parents contacts and helpful organisations
 - Organising the placement and linking with overseas

A booklet on *Understanding the Assessment Process* should be prepared also for issue at this stage, so that interested persons can be aware of the role of the agency and the assessment process ahead.

For the sake of consistency and to avoid duplication of effort, these booklets should be prepared at national level by the Adoption Board, in consultation with the agencies.

A booklet prepared by the individual agency, outlining its own particular policy and procedures for dealing with applications, should accompany the national information leaflets.

The practice of sending the booklets as a means of meeting the information needs of enquirers should be considered as an alternative to conducting information meetings. Flexibility is essential, however, at local level as to how best to meet the information needs.

The person handling the call should check if the enquirer is aware of the situation with respect to children in alternative care. If appropriate, the enquirer should be informed that it is policy to include an information booklet on fostering with the pack sent to enquirers on adoption. This is for information purposes only and should not denote an attitude that the agency does not support ICA. The difference between fostering and adoption needs to be clearly spelt out.

The Application

The form to be used in making an application under Section 8 of the 1991 Act should be considered at national level, and a common form and requirements for accompanying documentation to be developed, together with a standard explanatory note.

The application forms should be sent out on receipt of a request, together with explanatory notes. Documentation which the applicants are required to obtain and submit should be specified in detail, such as certificates, (birth, marriage, divorce etc.), authorisation for Garda report, references, financial information and health status report.

On receipt of an application, an acknowledgment, including a written outline of how the application will be processed should be sent to applicants. If such a description has already been provided to enquirers with the information pack, the applicant should again be referred to this in the letter of acknowledgment.

The Preliminary Assessment

The preliminary assessment should be concluded within one month of the receipt of the application, and the applicants advised by letter of the decision.

If the decision is that the application which has been received and subjected to preliminary assessment is valid, the applicant should be so advised. This letter should inform the applicant of how a decision will be made as to when it will be further processed. The letter should give an indication of when they can expect to be called for the next stage, the preparation course, and when the worker will meet them to commence home study process.

If there is a negative decision as a result of the preliminary assessment, the applicant should be advised of the reasons, and that they may appeal the decision through the specified appeal mechanisms.

Age Limits

The lower age limits for adoptive parents should be 25 years, unless special circumstances exist.

There should not be more than a 42 year age gap between child and the older of the applicants at the time of placement.

Health Status

Medical Advisers should be nominated in each agency that will assess the medical reports provided by applicants.

Under the aegis of the Adoption Board, a representative group of medical advisers with a knowledge of ICA issues should review the subject of health status of applicants, and prepare guidance for doctors preparing reports and health board ICA medical advisers. The relationship of medical standards to age should particularly be considered, as should the positions of applicants who smoke and drink.

Financial Circumstances

Applicants should provide a statement of employment (giving position, period in post, status & income) include P60s, details of regular household outgoing, details of savings, assets and liabilities.

The Referees

At least one referee should be interviewed. Further interviews should only be necessary if the written reference indicates a contra-indication for adoption suitability.

The Preparation Stage

A preparation course should be provided for all applicants who have been approved at preliminary assessment, prior to commencing the Home Study.

Preparation courses should be in the format of group courses with six to eight sets of applicants. They should be participative, based on the principles of adult education. They should extend over a defined preparation period, and should generally comprise six to eight sessions (see content at 7.6.4 below), giving eighteen to twenty-four hours of preparation.

Arrangements for Providing the Preparation Courses

The current practice with participation of experienced adopters, birth parents and adoptees should be extended in the preparation and delivery of preparation programmes, making the content appropriate in meeting needs of children and the parenting experience of adopters. Consideration should be given to the model of co-presentation of the preparation groups rather than delivery of set pieces of information by the stakeholders in the system.

Health Boards should endeavour to develop partnerships with appropriate voluntary bodies in their area, with a view to providing joint preparation courses. Such partnerships and the expectations from each partner should be clearly set down to the agreement of both.

Trainers/ facilitators for preparation courses should be trained at national level.

Courses could be organised on a joint basis as the application rate in individual health boards may not be sufficient to run courses on a timescale to facilitate preparation courses being run prior to the home study.

Content of Preparation Courses

The content of existing preparation courses should be examined by a review group under the auspices of the Adoption Board, with a view to devising a series of standard preparation courses, drawing on existing and international practice;

We suggest the preparation should include the following general contents:

- Why adoption? Motives for adoption.
- Involuntary childlessness.
- Which children are adopted and why?
- Children's needs
- Difference between adoptive and biological parenthood
- Preparing for adoptive parenthood : a way forward
- The home study.
- Nature and nurture.
- What it means to be a parent?
- Ethnicity and race.

Preparing for the Home Study

At the end of the preparation stage, applicants should be assigned the task of, and given guidelines on preparing written accounts of their own life stories, especially in respect of connections to the adoptive role. It should be made clear that this will be an integral part of the home study and completion of the final report.

The Assessment of the Home Study

The approach to Inter-Country Adoption assessment should be grounded firmly in the self-selection model, while accepting that the State has the ultimate role in deciding if the applicants have the capacity to parent an adopted child.

The purpose and approach to the home study should be explained to the applicants at the preparation stage. This should be repeated at the beginning of the home study. There has to be clarity about the process involved for it to work, with openness and transparency on both parts. It is important that there is sensitivity and mutual respect between the worker and the applicants. A framework, which highlights the rights and responsibilities of different parties, is essential.

The Assessment Method

Systemic theory should inform the methods used to undertake the recommended self-selection approach to assessment in inter-country adoption.

Scheduling Home Study Interviews

The home study should be undertaken as a regular scheduled process.

The process should be fully prepared, so the worker goes in with specific topics or issues to discuss for each meeting. The interviews should have an opening, where the intended areas are outlined, the interview itself, and a closing. The applicants should be told before what is intended in each session, and checked back with at the end of the process. At the end of each session, items should be summarised and clarified. If there is something, which is not clear, it should be checked over.

Interruptions to Assessment

Where a major issue emerges early in the process which leads the worker to conclude that a negative recommendation will be made, this fact should be worked through with the applicants, who may decide to withdraw. If they do not, the worker should prepare a report, without having explored the full range of issues, detailing the conclusion and the basis for this, and submit it through the normal decision-making process.

Where an issue emerges, such as infertility, and where it appears that applicants are not in a position to proceed at the time, this should be discussed, and there should be flexibility to suspend the process until the applicants are ready to proceed.

Duration, Frequency and Location of Interviews

The duration of each interview, as is generally the case, should not exceed more than an hour and a half to two hours.

Once started, the interviews of the home study should proceed at scheduled intervals of two weeks, subject to scheduled holidays, etc. The allocated workload of the social worker should enable them to follow such a schedule, and should allow for preparation for the interview, and analysis and updating of the file after each interview.

Provided the applicants have undertaken a preparation course, the areas to be covered in the interview process should generally be dealt with in six to seven interviews. This should include a visit to the referees and discussion of the final report.

Nine to ten hours of contact should, in normal circumstances, enable an appropriate assessment to be made. This indicates that the process should be completed within a twelve (six by two week intervals) to fourteen (seven by two week intervals) week time band. Where, as happens, it is necessary to deviate from the above-expected norms, (or to stop the clock) this fact and the reasons should be mutually agreed by worker and applicant, and recorded.

The venue for the interview should be a balance between the home and the office. There is a need to consider how an increase in the number of office based interviews can be achieved, by having suitable offices or interview spaces. It is suggested that one interview be held in the applicants home so that an assessment of the surroundings for the child can be made. After that agencies should strive towards the remainder of interviews being office-based. This would facilitate co-working and supervision, as well as efficiency.

Handling Intrusive Issues

The applicants have to be clear from the outset of the process that there are valid issues of a sensitive nature, which should be explored, in terms of parenting somebody else's child. It should be clearly stated at the information and preparation stage, and repeated at the start of each relevant session why there is a need to know about the stability of the relationship, sexuality, or about infertility, if this is an issue;

A therapy role is not part of the Social Worker's brief in conducting the ICA assessment. However, it may emerge that therapeutic conversations are required. The possibility that this may emerge should be highlighted at the information stage, before applicants launch into the process. If issues arise which, in the worker's and agency view, needs resolution, applicants should be advised to suspend the process while this is resolved. The applicants should be facilitated in every way possible, and the assessment should re-commence at the couple's request.

Use social work and systemic principles and ethics to help position the worker to deal with applicants in an open, respectful manner. Preparation for these sessions is essential and training and practice in use of different styles of questioning for dealing with issues in a sensitive manner is required.

The Areas to be Covered

The current conditions in the applicants' lives

Relationship stability

Motives for adoption

Knowledge and experience of young children

Capacity for parenting role

Expectations concerning the child

Identity and culture,

Attitude to birth parents

Impact of infertility

Background

Relations and other social networks

Personality and interests

Religion and attitude to life

Openness to individual differences

The Report

A good report should have the following characteristics

- Analytical, rather than a descriptive account

- Thoroughness, not to be confused with including all details

- All headings explored and documented

- Issues identified, followed and concluded

- Evidence that process followed

- Balance

- Clearly argued recommendation

- Be presented well, under main headings, avoiding too many sub-headings

The Adoption Board in consultation with interest groups should develop guidance for final reports. The following is a suggested outline that can be adapted and includes

- Background**, inclusive of childhood, education, occupation, current relationship with family members and other social networks

- Current conditions**, inclusive of housing, occupation

Health**Stability of the marital relationship** inclusive of brief history**Personality** and interests / religion and attitude to life**Motives for adoption** including deliberations regarding the process**Attitude towards children** and expectations concerning the child including identity and culture and attitude to natural/ birth parents and opennessKnowledge and **experience of young children**, ideals of parenting and preparation for parenthood, capacity for parenting role**References****Recommendation and summarise** basis on which decision is made

The final report should be compiled within four weeks of the completion of the assessment.

Sharing Contents with applicants

Applicants should be given a full opportunity to review the contents of the report, and to raise issues with which they do not concur. The worker should consider these, and if agreed the report should be amended. If there is not agreement, after mediation by the supervisor, the applicants should be afforded an opportunity to provide written comment on the matters in dispute and this should be submitted with the report to the placement committee for consideration.

Decision-Making

The basis for decision-making has to be set down clearly in writing, and applicants have to be given an opportunity to challenge aspects with which they disagree. The language of the recommendation should be clear, factual and objective.

The role and procedures surrounding decision-making in the Adoption Board should be examined carefully to ensure they comply with the principles of fairness and openness.

Appeals

At each stage of the decision-making, from workers recommendation to the Adoption Board, the applicants should be afforded an opportunity to see the documentation being used in the consideration of their case, and have a right to make their own submission for consideration.

File Keeping/ Recording

All contact and correspondence should be logged on the front of file

Contemporary records should be made of all significant matters related to the processing of the file. These should be in a standard format, dated and signed.

A genogram should be constructed to illustrate family composition and connections

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APPENDIX A

Age Distribution of Applicants in 1998

Age of Male Applicant

Age	Frequency	%
25 < 30	3	1.8%
31 < 35	24	14.5%
36 < 39	49	29.5%
39 < 43	45	27.1%
43 < 47	23	13.9%
47 < 50	11	6.6%
50 < 54	5	3%
54 < 57	2	1.2%
57 < 60	1	.6%
60+	3	1.8%
Total	166	100%

Age of Female Applicant

Age	Frequency	%
25 < 30	5	3%
31 < 35	32	19.3%
36 < 39	55	33.1%
39 < 43	36	21.7%
43 < 47	25	15.1%
47 < 50	7	4.2%
50 < 54	2	1.2%
54 < 57	1	.6%
57 < 60	3	1.8%
60+	Total	100%

Age Differential Between the Applicants

Age Differential	Frequency	%
0 < 3	99	59.6%
3 < 6	39	23.5%
6 < 9	16	9.6%
9 < 12	7	4.2%
12 < 15	1	.6%
> 15	1	.6%
Total	163	100%

(3 missing cases)