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Relative Foster Care: Practice Implications Arising from the 1995 Relative and Foster Care Regulations.

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Irish Social Worker, Jan. 1997
Relative Foster Care: Practice implications arising from the 1995 Relative and Foster Care Regulations.

Introduction

The 1995 Foster Care and Relative Placement Regulations made by Minister for Health, Michael Noonan under the Child Care Act, 1991 will shape foster and relative placements in Ireland into the next century. While undoubtedly there are reservations about aspects of the regulations, and the implementation is bringing forth both anticipated and unanticipated difficulties, these new regulations are generally to be welcomed. The publication of separate regulations for relatives and non-relatives fostering children is of particular significance. This article examines the history that led to two separate sets of regulations, the difference and similarity between the regulations, and the implications arising out of the changed framework for relative placements. It focusses particularly on the practice implications arising from emergency placement of children with relatives, and the process of conducting assessments when the child is already placed in the home. The article is drawn from the author’s PhD research study, which examines the evolution of relative care networks/placements, and the characteristics of the families and children involved in relative care in the Eastern Health Board.

Positive Aspects of the New Regulations

Significant improvements have been made in replacing the 1983 Boarding Out Regulations. Both sets of new regulations include promotion of the welfare of the child, pre-placement procedures, monitoring of placements and removal of children from placements. They provide a clearer and more concise structure for those involved in the care system. The main changes from the 1983 to the 1995 foster regulations, which have been welcomed by people involved in foster care are:

- The **best interest of the child** is identified as priority. (Article 4)
- A **care plan is required** for each child. (Article 11)
The duties of foster parents and relatives are clearly specified. (Article 16)

The introduction of mandatory support services, pre-placement and in-service training recognises foster parents and relatives need for services. (Article 15)

The re-emphasis on review meetings as a forum for making and evaluating care plans with provision for the active invitation of all involved in the child’s life to attend. (Article 18)

The extension of ministerial inspection powers to monitor the system. (Article 25)

The overall partnership ethos underlying the regulations, designed to support “the best interest of the child” and “the inclusion of the child’s view”.

Comparison Of The Two Sets Of Regulations.

It is the similarity in the layout, content and language of both relative and non-relative regulations that is most striking on comparing the two sets of regulations. The minor differences that exist in the regulations are set out in Table 1.

**TABLE 1: Differences in Foster Care and Relative Care Regulations.**

<table>
<thead>
<tr>
<th>Article</th>
<th>Regulations</th>
<th>Subject</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Relative</td>
<td>Definition of relative</td>
<td>Omitted in foster care regulations</td>
</tr>
<tr>
<td>6</td>
<td>Relative</td>
<td>Emergency placement and assessment</td>
<td>Omitted in foster care regulations</td>
</tr>
<tr>
<td>5, 5</td>
<td>Foster care</td>
<td>People with training and expertise to be included on committee, generally accepted to mean foster parent.</td>
<td>Omitted in relative regulations</td>
</tr>
<tr>
<td>7</td>
<td>Foster care</td>
<td>Capacity to meet needs of child/matching</td>
<td>Omitted in relative regulations</td>
</tr>
<tr>
<td>27</td>
<td>Foster care</td>
<td>Placement of child with person on panel of other Health Boards.</td>
<td>Omitted in relative regulations</td>
</tr>
<tr>
<td>14</td>
<td>Foster care</td>
<td>Foster and financial allowance</td>
<td>Same allowance, different name</td>
</tr>
<tr>
<td></td>
<td>Relative</td>
<td>Foster and financial allowance</td>
<td>Same allowance, different name</td>
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With only the above minor differences in regulations which extend to twenty five sections each, and which deal with what many consider to be the same subject matter, the question may then be posed as to what purpose is served by having separate regulations for relatives
and foster parents? The formulation of the 1991 Child Care Act provides the context for understanding the difference and demarcation between foster parent and relative, which although apparently minor, could have major implications.

Section 36 (2) of the Child Care Act, 1991 is central to understanding the publication of the two separate sets of similar regulations. This section states:

In this Act, “foster parent” means a person other than a relative of a child who is taking care of the child on behalf of a health board in accordance with regulations made under section 39 and “foster care” shall be construed accordingly.

The reports of the Dail debates in 1990 pertaining to the Child Care Bill, 1988 give an understanding of the insertion of the distinction between foster parent and relative in Section 36 (2), and the subsequent evolution of separate regulations. There was recognition in the contributions that relatives offered an option for children unable to live with their own parents. The debate occurred at a time when limited research was available regarding relative care as an option for children requiring formal state care. Strongly-held views were expressed, welcoming it as a care option but reservations were raised as to the potential impact on the provision of informal care-giving, and the resultant potential cost for the state. These views were due in part to a long tradition in Irish society of informal care within families, which was shaped by our particular economic, social and cultural history.

1Research was limited and the studies of Thornton (1987); Dubowitz (1991); and Rowe (1984) are generally referenced as the early influential studies in the field. Research is still rather limited with the majority of studies conducted in USA where this care option is being used in increasing numbers since the late1980’s.

2A small number of relative placements would have formed part of the regular care system up until this time, but the extent of the practice is unknown as separate statistics were not kept separating relatives form regular foster placements. The failure to collate separate statistics causes difficulties in identifying specific trends in relation to this placement option where it was being used.

3Up until the early nineties in Eastern Health Board, the Community Welfare Service was used to finance a number of relative caring for children. Financial help was generally provided until such time as a formal fostering assessment was completed. The relatives would then be incorporated into the foster care system. The community welfare service was also used for providing financial help to some relatives if it was considered by the board that the relatives may not satisfy the necessary conditions to be approved as a foster parent. Two major difficulties were associated for relatives if financed through this service. One they had to satisfy a standard means test to be eligible for supplementary benefit and secondly if eligible the maximum allowance available under the community welfare scheme was substantially less than the fostering allowance. The community welfare service withdrew from financing relatives in the nineties as they saw it as more the responsibility of the child care service within the health board.
The financial implications of introducing placements with relatives as a care option remained central to the debate. This aspect of the debate reflected an underlying ambivalence surrounding the financial consequences for the state of legitimising relative care as a placement option within the care system. The ambivalence centred on the reluctance of the state to encourage unnecessary dependency, or to finance informal family arrangements made in respect of child rearing, while recognising that some children needed to be cared for by the state (Dail Report, 1990: 662). Further evidence of the ambivalence towards relative care was demonstrated in the attempts made to devise structures outside the foster care system to finance relative placement. The community welfare service, administered by the Health Board on behalf of the Dept. of Social Welfare, was examined as an alternative to including relative care as part of child care system within the health boards. This proposal was not however incorporated in the final draft of the Child Care Act, 1991 and the decision was made to administer foster care and relative placements within the Dept. of Health / Health Boards. The strong emphasis in the debate on financial considerations was identified by the politicians, though it was stressed by speakers that the reason for the distinction between relative and foster parent was not for “financial reasons ......but for sound practical reasons”, and to avoid unworkable and cumbersome regulations, particularly in relation to assessment. (p 662). While the inclusion of relatives was eventually seen “as an enlightened approach” (p. 655), attempts made to prioritise placement with relatives over other care options failed to get adequate support to be accepted, though this was not pushed forcibly at the time.(p 663). Therefore the separation of “relative” and "foster parent” in the Child Care Act, 1991, and the subsequent making of two sets of regulations can be seen to reflect the ambivalence surrounding the placement of children with relatives.

Nonetheless, based on preliminary findings from my research study, financial considerations and the underlying ambivalence surrounding the financing of family members to look after their own are a central feature of the current relative care system. The implications of not fully taking into account the potential effects of this separation, together with an examination of the extent of achievement of the intention of greater flexibility are explored more fully in the remaining sections of this article.
How well has the vision of flexible relative regulations translated into practice?

Articles (6) relating to emergency placements in relative care, and the broad definition of relative in article (3) of the Relative Care Regulations, 1995 reflects the spirit of flexibility which the 1991 Act contained. However, in advance of the making of these regulations, an opportunity was lost by the Department of Health to ascertain what flexibility was required to facilitate this placement option. The failure to consult more fully with relatives, practitioners and other stakeholders involved in relative foster care, or to circulate the draft relative guidelines prior to publication was regrettable. To have done so would have provided first-hand accounts of the flexibility required to ensure the regulations would provide a framework for the successful operation of relative foster care.

The opportunity was also missed to draw more fully on the experience of other countries and the debate as to what system of evaluation support and supervision was needed for relative care (Thornton, 1987; CWLA,1994). If this had occurred, the importance of consultation and the need to address the practice changes arising within relative placements would probably have been reflected more in both the relative regulations and the accompanying guidance documentation. The lack of any identifiable group representing the interests of relatives involved in relative care, as well as the pressures under which the Department of Health were operating because of the high profile occupied by child care as one disclosure of child abuse after another hit the headlines, would tend to explain this failure.

While some the spirit of flexibility was incorporated, perhaps if more consultation had occurred the following shortcomings, which have particular practice implications, would have been identified.

- The lack of acknowledgement of the central position of families in relative care resulting in a more peripheral role for the health board.
- The twelve weeks time period within which to conduct the assessment following an emergency placement. (Article 6)
• The implication of removing any reference of “foster parent” to relative placement.  
  (Section 36(2) of the Child Care Act 1991)

General Trends

Despite the limitations raised above, the identification of relative care as a viable care option, whether part or separate from foster care, is to be welcomed. While exact figures are not available in Ireland to show the extent of the practice prior to the 1995 regulations, based on international trends, it is suggested that this placement option will be used increasingly over the next decade. The 1995 regulations now require the collation of separate statistics for foster and relative placements which will undoubtedly help in the formulation of policy and practice into the future. 4 Factors to account for the international move towards relative care, and which undoubtedly also affect child care practice in Ireland, are the following.

• The shift from residential care to foster care in general, (Triseliotis 1989; Colton 1988)
• an emphasis on partnership as a central principle in child care, (Ryburn, 1993; Thoburn, 1988)
• demographic changes effecting the availability of foster parents, (Gilligan 1990)
• increase in serious drug addiction giving rise to increased numbers of children requiring alternative care, (Thornton 1987; Wulczyn 1995) and
• outcome studies on relative care indicating lower disruption rates and more security for children placed (Rowe 1984, Dubowitz 1993).

The Practice Implications of differentiating Relative Care.

The implications for practice arising out of the differentiation of relative care is explored in the following sections, with particular reference to the definition of relative, financial assistance, emergency placements and assessment and training.

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4 Differences currently exist throughout health boards as to how the statistics are collected and the definition of relative that is employed. Attention is drawn to the broad definition of relative used in regulation guidance. It is hoped that this definition will be used in all health boards, with relative placements subdivided into relative based on blood and marriage, and friends/neighbours. Collation of this information is vital if future policies and practice developments are to reflect the reality in the ground.
Article 3: Definition of Relative.

The 1995 regulations do not include a specific definition of “relative”, other than a reference to spouse and loco parentis. In the guidance accompanying the regulations however, a broader definition of relative is included. Relative is described as a relationship “through marriage, cohabitation, adoption or friendship i.e. an existing relationship (p.3)” This definition provides scope for practitioners to place a child in need of alternative care with a significant person in the child’s life, and thus offers the broadest possibility for minimising the trauma for children of being placed with strangers when entering care. However, while recognising the advantages which the broad definition of relative offers, questions regarding the definition of “relative” and its relationship to “foster parent” need to be addressed, as follows.

- What are the implication of defining relatives caring for children in the care system as “relatives” rather than “foster parents” and would it have been better if this rigid demarcation was avoided?
- Are there specific implications in removing all references to foster care from the practice of children received into the formal child care system and subsequently placed with relatives?

Relative carers are not a homogenous group, and arising from my research different meanings may be attached to caring for a child within the extended family. For some relatives, particularly if they are involved in an adversarial relationship with the birth parents of the child, the identity of “foster parent.” would be welcomed. Viewing themselves as foster parents, and having that reinforced by the agency, represents a separation and demarcation of roles that, in their view, contributes to the long term stability of the placement. Other relatives saw the activity of looking after a niece, nephew or grandchild as looking after “family”, regardless of the level of conflict in the broader network of relationships. The making of the distinction between foster parent and relative in the legislation and subsequent regulations failed to recognise these implications in practice.

Does the marked distinction in the definitions result in an over-emphasis on the differences between relatives and foster parents, and in the process negate the expertise built up over the years in the foster care system? Similarly knowledge and expertise arising from experience of informal caring within families may also be negated. Separating “relatives” from “foster
parents” fails to recognise that the experiences of participants in both may be more similar than different, and therefore the opportunity to learn from and support each other is hampered.

Equally the demarcation may have implications for support for relative care. The growing sector of relative carers are in something of a limbo, without any representative body or pressure group, such as the Foster Care Organisation provides for foster parents. It makes practical and ideological sense that the support needs of relatives should be embraced within the umbrella of the Irish Foster Care Organisation.

In conclusion on this point, it is my view that the distinctive characteristics and nature of relative placements must be validated, and at the same time we must anchor this similar but different service firmly within the foster care system. Otherwise the knowledge and expertise acquired over the years may be lost. The spirit of flexibility underpinning the legislation will need to be used creatively to achieve this purpose.

**Article 14: Financial and Other Assistance.**

A continuation of the distinction between relative and foster care is seen in the sections which deal with financial arrangements. The language used in respect of finance in the two sets of regulations is identical, apart from the name given to the sections. In the foster regulations, financial help is referred to as the “fostering allowance”, whereas for relatives it is referred to in Article 14 as “financial and other assistance.” Both refer to the flat allowance and discretionary payment permissible.

- What is the implication of this distinction in naming payment?
- Does it reflect again the hesitation to ascribe the description of fostering to the placement of children with relatives, or does it create scope for a differential payment to be introduced at a latter date?

Research shows relatives approved as foster parents in the USA received less services than unrelated foster parents (Gleeson 1994; LeProhn 1994). The relatives in the studies were dependent on low incomes, and could ill afford the differential service provision. Preliminary findings in my own study reflects a similar socio-economic profile of Irish relative carers as
those in the international research. Less access to services may occur as service providers may see children placed with relatives as being less in need of services than those placed with regular foster parents. Equally the relatives may be reluctant to avail of a range of available services in case their motive for fostering may be mis-interpreted. Regardless of the motive for the distinction in the title used to describe financial assistance, safeguards are needed to ensure that relatives in the formal care system do not end up disadvantaged, or not fully availing of the appropriate range of services. While this situation should not arise if the regulations are adhered to, in times of scarce resources, increasing workloads and change arising from implementing new legislation, relatives may be marginalised without strong representation. The commitment to ensuring that relatives financial needs are met must be prioritised.

**Article 7: Capacity to meet the needs of the child.**

In the Foster Care Regulations, 1995 Article 7 states that the board “in selecting persons from the panel .... shall endeavour to ensure that the persons have the capacity to meet the needs of the child concerned”. There is no corresponding section in the relatives regulations. What does this omission suggest? Is it assumed that this is an intrinsic component of the assessment with relatives, and therefore it was decided to exclude it from the relative regulations?. Or was it intended to re-iterate the importance of matching between foster parent and foster child at a time when there is an acute shortage of foster placements, and to avoid children being placed with families irrespective of risk factors associated with foster breakdown? It is essential that the capacity of relatives to meet the needs of children placed with them is examined thoroughly. Attention is needed to the question of how this examination is perceived by both the practitioners and relatives. This has particular significance, as preliminary findings indicate an overwhelming majority of relative placements commence through the use of article 6 (1), which provides for emergency placements. This fact has serious implications for assessment and support services, which are discussed in the final sections of this article.

**Article 6 (1): Emergency Placements.**
Article 6 (1) of the relative regulations provides practitioners and families with enormous opportunity to make arrangements for children in need of care within their extended family and community at a time of crisis. This regulation grants the health board discretionary powers to make emergency placements, provided it is in the board's opinion that this placement is suitable and in the best interest of the child. The board is sanctioned to do this without having satisfied “one or more of the provisions of article 5” covering the assessment of relatives. Emergency placements involve an initial interview with the family, and “such other enquiries that are practicable”. The decision to make an emergency placement is made at local level, and does not have to go to the placement committee for approval until the full assessment is completed. This regulation legitimised a practice already in existence, and was an example of regulations following a practice development.  

Despite this regulation being welcomed, certain reservations were expressed by social workers in my research, in particular about the feasibility of operating the twelve week timeframe for conducting the assessment following the emergency placement. Equally for many relatives, the availability of 75% only of the fostering allowance until the completion of the assessment caused difficulties. It is generally accepted that costs are high at the initial stage of setting up fostering placements. Therefore unless relatives have access to a good range of discretionary allowances, unnecessary hardship may be caused. The initial stages of placement involves trying to get children to settle, while also working out the complex relationships both within the family and with the health board, and thus it is apparent that this is a period to avoid unnecessary financial worries.

The regulations stipulate a twelve week timeframe for conducting the assessment after emergency placement has occurred. The twelve week timeframe is used also in the UK foster care regulations following emergency placements, and at the time of drafting the 1995 regulations, the difficulties with this timeframe were already identified.  

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5 A scheme was introduced in the Eastern Health Board in 1993 to facilitate the emergency placement of children with “friends, neighbours and relatives”. Such a scheme had been proposed to management prior to 1993 by social work practitioners but it wasn’t until the acute shortage of care placements connected with the closure of Madonna, that it was implemented. The reluctance to introduce it prior to this date was due largely to perceived barriers of the boarding out regulation 1983.

6 Personal communication with Social Service Inspectorate London and Ass. Director of Tower Hamlets, Social Services Dept. London.
section is to be fully realised. Based on my clinical and research experience, the principal questions connected with the time scale are as follows:

- What are the constraints preventing health boards from meeting the twelve week requirement?
- Are there existing features of the system that needs to be streamlined to facilitate this requirement?
- Which features need to streamlined at administrative and professional levels, e.g. secretarial services, waiting lists, frequency of committee meetings, as well as the content and structure of the process of assessment currently undertaken?
- Is the purpose of the assessment process clearly understood at both agency and relative carer level?
- In the event of the twelve week time-frame not been adhered to, what happens individual health boards in terms of accountability when regulations are breached?

These questions need to be fully addressed by both individual health boards and the Department of Health, if the benefits of the emergency provision in Article 6 are to be realised. It is my view that, while administrative resources and influences need to be examined, it is the impact of the regulations on current assessment practice that is of critical importance.

**Assessing relatives: Models of assessment and practice implications**

The significant difference between relative care and regular fostering is that assessment and providing training for relatives occurs where the child is in most cases already in the care of the relatives. This reflects the developing practice of placing the child in the care of relatives at the time of the crisis, and then subsequently carrying out the assessment and training. Thus the practice of preparing and assessing prospective foster parents for a hypothetical future with an imagined child is fundamentally different than working with a relative towards meeting the regulation requirements. In this context social workers are challenged to examine both the applicability of current models of assessments for relatives and the general premises on which assessment models are based.
Models of assessment practice

The theoretical and practice shifts in assessing the suitability of families for the fostering task are outlined in the following section. Assessment models span three different time-frames - 1960-1970, 1970-1985, 1984-1996. These are recognized as arbitrary distinctions, as changes in theory and practice occurs at different rates from area to area, as shown by American, English and Irish literature (George, 1970; Smith, 1984; Triseliotis, 1988;). Practice models governing assessment have however followed similar trends in the three countries.

Separate assessment models have not been developed to date for relatives, though the type of assessment most suitable for relatives carers is a pressing question in all countries where this care option is developing. In general, the models currently used in assessing non-related foster parents are super-imposed on relative assessment. The applicability of this approach, and the consequences for the participants, needs to be examined. A brief outline of the development of general assessment models provides a context for understanding many of the current difficulties of both conducting a relative assessment, and being obliged to complete it in twelve weeks.

Assessment models

The three distinct phases in the development of models for assessing prospective foster parents (and adoptive parents) are:

The traditional approach (1960-1970)

The traditional model was dominant up to 1970 (Dubois, 1987; Smith, 1984; Hartman, 1979). This model was built on the premise that "applicants either have or do not have the necessary characteristics and qualities to make successful foster 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). The social worker makes the choice.

The educational/preparation approach (1970-1985)

The second broad time frame, from the early 1970s to the mid 1980s, was largely concerned with exploring an assessment model based on both education and preparation. Smith (1984...
argued increasingly against the traditional model, urging instead that “assessment and selection should be discarded in favour of an approach which prepares prospective substitute parents for their distinctive role”. This model favored an approach in which, if people were given adequate information regarding role and agency expectations, they could then choose if they have the resources to undertake the task. Within this model the emphasis on an assessment role for social workers remained important. The social work role as assessor co-existed 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 foster parents were developed, such as “parenting plus” and “the challenge of foster care” (NFCA, 1988). Professional practice in agencies in the UK was altered by the shift in emphasis, and different workers were allocated to fulfill the assessment and educational role (Rhodes 1992). Agencies in Ireland began to implement this development from the mid-eighties onwards.

**Self-selection 1987-1996 : The impact of social constructionism**

The model of practice which has been developing from the middle 1980’s to the present is known as self-selection. (Ryburn, 1991; Cain, 1993; Laird and Hartman, 1985). The shift in interest to self-selection arose from a questioning of the assessment process by social workers and applicants. In tracing this development, Ryburn argues that the more traditional assessment practice was deeply dis-empowering 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 referenced social constructionist thinking as influential in questioning if “through some skill assessment process professionals can decide who is and who’s not suitable to become a foster carer” (Ryburn 1995: 37). According to Ryburn the central issue to be addressed is the belief “there is an independent objective reality against which, through a process of enquiry, prospective adopters or foster carers for that matter can be measured and appropriate placements can be made” (1991: 20). The social work role in the self-selection model is seen as one of facilitator. The interest in a self-selection model of assessment is better understood when placed against the growing influence of social

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7 Crowley, 1982 describes how Parenting Plus was first introduced in the UK in 1979 having been devised by the Child Welfare League of America. Different health board areas in Ireland adapted it to suit their particular needs from the eighties onwards.
constructionism and post-modernism. The implications of a self selection approach, utilising a social constructionist position has far reaching consequences, connected with power, partnership, empowerment, marginalisation and normalisation. 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 1992, Ryburn, 1991).

**Assessment of Relatives**

It is against this background of developing assessment models that relative assessments are currently being conducted. The arguments raised by the proponents of self-selection, as outlined above, are mirrored by the participants interviewed in my study. From my own research, the assessment process as it is currently constituted is presenting difficulties for both social workers and relatives. Part of the difficulties centre on the depth of the background information required. This is accentuated by an interweaving of multiple roles for social workers and relatives, and unclear expectations as to the agendas and the purpose of the conversations between the participants involved.

Relatives are confused as to the role they have now taken on. This confusion centres on a lack of understanding of the health board’s expectation of them. However given the general confusion surrounding the role of foster parent, it is not surprising that the confusion is even more pronounced for relatives. The confusion for relatives, who are already embedded in a complex extended family network, is exaggerated when jettisoned into a working relationship with health boards. They join a system which is not particularly characterised by clarity. This lack of clarity in due in part to the complex nature of the task of child placement, and the multiple relationships involved. In this context of multiple roles and task confusion it is not surprising that the assessment process takes longer than the twelve week allocated to complete, and in the assessment process a relationship based on uncertainty, mis-trust and lack of understanding of each others position may be set up, with subsequent implications for the development of the placement.

The current difficulties shared by both relatives and social workers in respect of the assessment can be summarised as follows:
• confusion as to the purpose and process of assessment when the child is already in the home leads to a paradoxical situation for both relatives and social workers, who are both concerned with child protection and the wish to respect family privacy.

• the superimposing of assessment models from fostering on relatives which are in themselves been questioned by practitioners.

• the delays in completing the assessments leads to increased financial and psychological burden for the relatives caring for the child, and intensifies the role confusion for the social workers who are trying to both support and assess the relatives simultaneously.

• the unworkability of the twelve week time limit.\(^8\)

Preparing and assessing relatives for fostering is a complex task, which occurs in a context of conflicting demands for the participants involved. The need to protect children, while at the same time respecting the privacy of families offering themselves as service providers will remain as a central dilemma. The following questions needs to be addressed at this stage:

• Is the current practice of having separate workers for the child and foster parent the best model at this time, when a detailed assessment of the situation is required\(^9\).

• Does this model add to the confusion of already confused participants?

• How is a balance between the needs, expectations and agendas of the multiple participants involved in relative care to be achieved.

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\(^8\) Based on an examination of time scale of relatives assessments in the study, only a small percentage were completed in the twelve week time scale with the majority taking nine months plus to complete.

\(^9\) In most health boards, two social workers work with each case, one worker for the child and the other for the relatives or foster parents. This structure is used also in UK
**Towards a new model of working**

As part of my research study I have been developing a new model of working with relative networks. I would pose the question if there is benefit in working during the assessment stage in particular towards a system where the two workers would work conjointly with all the participants: birth parents, child and relatives and other interested parties. A structure using a combination of network, family, and individual meetings would be necessary. The structure of the family group conference would be adapted to carry out this work. These conversations would then form the basis of the report presented to the committee, and depending on the needs of the participants, services and social work input could then be arranged. Review meetings, of the type described in the regulations to include all participants with an interest in the child, would be used to examine the needs of all the participants on an ongoing basis.

This proposal is designed to provide practitioners with a framework for dealing with many of the current difficulties being experienced in conducting training, support, supervision and assessment of relatives. It is hoped that a complete model of working, following the above general outlines and developed from my research project, can be made available in 1997 to assist workers in this area.

**Conclusion**

In this article I have attempted to review the growingly significant area of relative care for children in the formal care system. I have shown how the 1995 Regulations, not withstanding some reservations, provide a context within which this option can develop. The challenges for all involved are significant, but a spirit of openness and flexibility can see the development of an effective child-centred placement option, which will take us into the new millenium.

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10 The regular parenting plus courses used with foster parents is not entirely suitable for relatives as it fails to account for the children already being in situ. Specific training is being developed as part of the ongoing research. Separate training for relatives has also been provided through the fostering resource group in the Eastern Health Board.
Acknowledgements. The author would like to acknowledge the support of the Eastern Health Board in the relative foster care research referred to throughout this article. Particular gratitude is extended to Dr. Nollaig Byrne and Dr. Valerie Richardson, supervisors of the research and to Dr. Imelda McCarthy, Director of the Ph.D. programme in Families and Systemic Therapies at University College Dublin for her helpful comments on earlier drafts of this paper.

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