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Disadvantage or Disadvantaging - Conceptualising Class Differences in Education as a Disease or as a Process?

**Disadvantage or Disadvantaging - Conceptualising Class Differences in
Education as a Disease or as a Process?**

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Abstract

Much of the writing on differences in educational attainment by different social classes in Ireland has started by accepting the use of the term 'educational disadvantage' and trying to define it afterwards (Kellaghan *et al.*, 1995; Boldt and Devine, 1998). Others, like Drudy and Lynch have simply dismissed the use of the terms out of hand, preferring instead to write about social class differences in education (1993, p 52). Far from discouraging the use of the term, this latter sort of intervention seems to have had no effect and the use of the term has continued to proliferate in this decade. The term is now widely used by agencies from the Conference of Religious in Ireland (CORI) to the Combat Poverty Agency (CPA) to the Government of Ireland. It is used by researchers, teachers, policy makers and those who fund research. It appears that the term is here to stay.

Despite a recent comprehensive review of research in the area (Boldt and Devine, 1998), it is still far from clear what is meant by educational disadvantage. In this paper I will look at the different definitions of educational disadvantage proposed. I will argue that the use of the term in Ireland has many similarities with the use of the term "at-risk" in the US and has similar problems. The at-risk model understands educational disadvantage as akin to a disease or a condition - it is something the individual has. I will

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argue that educational disadvantage should be seen as a series of active processes, rather than a condition. Such an approach to educational disadvantage has serious consequences for our attempts to research and to measure the phenomenon.

Introduction: Competing Understandings of 'Educational Disadvantage'

The term 'educational disadvantage' is used in at least two distinct ways. I refer to these two as the disease model and the process model. In general practice these two are not entirely separate, (i.e., many of the writers who use one approach encapsulate aspects of the other in their approach), however, instead of giving definitions greater scope, this mixing of models simply tends to confuse the issue. Most of those writing in Ireland today have tended to work within, or be heavily influenced by, the disease model. I suggest that this model is not very useful for understanding educational disadvantage. Rather a process model makes more sense.

Disease Model: With this model, educational disadvantage is understood as a condition of a person or a group. The word "disadvantage" is used to describe the person or group, (i.e., the group is said to be disadvantaged). Just as if the group has a disease, they can be said to have educational disadvantage. When the term is used in this way there is generally also an implication that some groups of people are "at-risk" of catching educational disadvantage. In fact the

two terms, “at-risk” and “educational disadvantage” are sometimes used interchangeably (Kellaghan *et al.*, 1995, p 2; Boldt and Devine, 1998, p 9). Therefore, in order to better understand the debate on educational disadvantage in Ireland, it makes sense to understand the debate on at-risk children in the US.

The term “at-risk”, which has become popularised in the US, is borrowed from epidemiology (Richardson *et al.* 1989) and is ‘identified by defining and measuring probabilistic outcomes, and is defined in relation to a specific event (e.g., at risk of contracting a specific disease or of being involved in an automobile accident)’ (Tompkin and Deloney, 1995, p 3). In other words research shows that there is a statistical relationship between being an intravenous drug user and catching HIV, therefore this group are identified as being ‘at-risk’. While intravenous drug use does not cause HIV it is still an “at-risk” factor. A similar conception of risk has also been applied to studies of poverty (e.g., Nolan and Whelan, 1996). One recent study (Nolan *et al.*, 1998, p 24) found a statistical association between living in public sector housing and poverty. Therefore people living in such houses could be said to be at-risk of poverty. Again, there is no suggestion implied that living in public sector housing causes poverty. The same thinking is applied to the area of education. We find out who is ‘at-risk’ of educational disadvantage by identifying

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variables which correlate with educational disadvantage. In Ireland, such factors as unemployment, low farm income, ownership of a medical card, local authority housing, living in a lone-parent household, and low educational attainment of parents are used as indicators of a child's at-risk status (An Roinn Oideachais, 1995, p 6). There is no suggestion that owning a medical card is a factor in making someone educationally disadvantaged. Someone who is not educationally disadvantaged is not going to become educationally disadvantaged if we give their parents a medical card. Association between variables, does not imply causation.

One of the problems with the idea of someone being at-risk of educational disadvantage is that it is not clear exactly what the specific event which one is at risk of, is (Wehlage et al., 1989). For some, it is to be at risk of not achieving full potential. For example, Boyd notes that:

Family background, personal characteristics of the child, the school context and the social behaviour of children interact to create conditions that place children at risk of failing to achieve their academic potential, dropping out of school, and/or having limits placed on their ability to function as productive adults in society. (1992 quoted in Tompkins and Deloney, 1995, p 3 - 4).

As I will show, this definition has a lot of similarities with some of the better Irish definitions of educational disadvantage. However, as Tompkins and Deloney, (1995) point out, from a 'risk' perspective, it is problematic. They note that 'although dropping out of school is generally a discrete event which can be measured, future success in adult life or limited functioning as productive adults are difficult concepts to define in ways which facilitate assessment of "at-risk" status' (1995, p 4). One could add educational participation and attainment below the level of which one was capable to this list of intangibles. Therefore, while it is easy to say that educational disadvantage is about educational failure due to social factors, it is nigh on impossible to measure it. The response of some is to abandon the attempts to measure statistically. Unfortunately most place measurement ahead of clarity, and end up defining educational disadvantage in terms which facilitate measurement - a process which leads to both poor definitions and poor measurement.

The Irish literature on educational disadvantage contains many of the same elements as can be seen in the US debates. While the Irish literature agrees on few things, it is generally agreed that educational disadvantage is a complex phenomenon (Boldt and Devine, 1998, p 9; Kellaghan *et al.*, 1995, p 2). While almost all regard educational disadvantage as relating primarily to social class

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differences in educational attainment (Drudy and Lynch, 1993, p 52) (alternatively conceived of as a relationship between poverty and poor attainment), others wish to include those who suffer learning disabilities (Fine Gael, 1998, p 5), other suggest that ethnic and gender based differences in educational attainment should be included (Boldt and Devine, p 10), and others suggest that children in schools which are geographically remote from educational services are educationally disadvantaged (INTO, 1994; Prendeville, 1998). It seems there is tendency in some of the research to equate educational disadvantage with educational failure. This “tacking-on” of every process which could lead to educational failure to the core concept of educational disadvantage serves only to obscure the issue. If educational disadvantage becomes synonymous with educational failure then there is no added-value in using the term. For that reason, I follow the core of the concept of educational disadvantage, implicit in most of the research, as relating to comparatively poor attainment and participation in formal education by the working class (a group which roughly correlates with the poor).

Although the term “educationally disadvantaged” is normally used in Ireland without the pre-fix “at-risk”, the pre-fix is implied in the use of the term. Like a disease, educational disadvantage is generally seen as being a condition of the individual or the group. The focus of attention is generally on measuring

who “has” educational disadvantage and who is “at-risk” of developing it. Yet the same critique which applied to the US literature applies here: once someone tries to identify the nature of educational disadvantage in measurable terms they lose sight of the nature of the issue.

The most comprehensive attempt to measure educational disadvantage in Ireland is that of Kellaghan *et al.*, (1995). They note in relation to the Irish literature ‘although the term educational disadvantage is widely used, there have been remarkably few efforts to define it’ (1995, p 5). They follow this tradition, by opting out of a specific definition of the term which is the core concept of their research. However, they do offer a rough definition of the term, as follows:

We will define disadvantage in terms of measures of achievement and of poverty. . . For the purposes of our analyses to examine the distribution of educational disadvantage, pupils who came from a home that possessed a medical card were identified in the National Reading Survey data. Then the lowest scorers on the achievement test were identified to the point at which 16% of all pupils in the sample were identified (1995, p 45 - 46).

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There are many problems with this definition. First, only one measure of educational attainment is used. Scores for other subjects such as maths or practical subjects, general engagement and participation in school, even dropping out without qualifications, are all ignored. Any conception of multiple forms of intelligence (Gardner, 1983) is absent. While Kellaghan *et al.* point out that their single measure is a useful one, it is still limited to exploring only one aspect of educational attainment and participation. Secondly, it uses a cut off figure of 16%. This is a magic number, whose arbitrariness is recognised by Kellaghan *et al.* (1995, p 44). It does not represent a serious attempt to estimate the extent of educational disadvantage. Finally, the measure of educational attainment contains no sense of the child's potential. Therefore particularly bright children from poor, unemployed or working class families who may be under-achieving compared to their potential but may be achieving about average compared to other children are, by definition, excluded from this working model of educational disadvantage.

The rationale for limiting the numbers of educational disadvantaged to 16% of the population is that there is a need to provide a high quality service for those most in need (1995, p 43). In other words this is not so much an estimation of the numbers of educationally disadvantaged as a means of identifying those most educationally disadvantaged. While many of their recommendations

follow on from their belief that the problem relates to individuals, they do note that in the majority of cases they identified as educationally disadvantaged (the 60.7% living in rural areas) any intervention would need to include a focus on system wide responses, including teacher in-service training, and access to other support services. (1995, p 71). This suggests that some of the problem of educational disadvantage resides, not in the individual, but in the nature of schooling in Ireland. I will return to this question later.

The definition offered by, and measured by, Kellaghan *et al.* does not correspond to the accepted understanding of educational disadvantage. However, they do at least try to move beyond the more traditional, more limited, attempts to quantify the size of the issue. The example of Crooks, who, in his working model, equates early school leaving with educational disadvantage, is typical of many. He identifies disadvantaged young people as those who 'leave schools at or near the minimum school-leaving age (15) with no 'effective' formal qualifications' (Crooks and Stokes, 1987, p 65). Similarly, studies of early school leaving by McCoy and Whelan (1996) and the European Social Fund Programme Evaluation Unit are commonly understood as measurements of educational disadvantage (e.g., Boldt and Devine, 1998; Fine Gael, 1998). Such studies focus primarily on children who leave school without attempting any examination, those who leave without receiving any

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qualification, and those who leave without a Leaving Certificate qualification. Again, this is distinct and measurable, as required under the at-risk model, however, like the definitions discussed above, it does not measure that which is commonly understood as educational disadvantage - unrealised potential.

It is possible that there is more than just a concern for having a clearly measurable entity at work in some of these approaches. Another rationale for these models is that they focus on qualification and consequent employability of the individual. In some respects, this means that educational disadvantage is understood primarily as a problem for society and only second as a problem for the individual. If our primary focus is on the employability of individuals (and, implicitly, keeping them off social welfare) then the fact that some people do not receive any qualifications is the primary concern. If a working class child does not fulfil her/his potential and ends up in a reasonably low paid job, instead of fulfilling his/her potential and ending up in a well paid or high status job, then that is all right according to this conception of disadvantage. They are, at least, employable. However, if our concern is with the individual then anyone who under-achieves due to their social class heritage, even if they do get a qualification, should be our concern. These writers seem to be less concerned with educational disadvantage in general and more concerned specifically with vocational training disadvantage.

Boldt and Devine in their review of the literature recognise the limitations of the existing research when they note that Irish research ‘has failed to produce precise explanations of educational disadvantage, its nature and characteristics’ (1998, p 8). However, they go on to re-iterate the old certainty that a definition of educational disadvantage should be measurable in so far as they note that ‘[t]o a large extent, what is most important is to specify the term and set criteria which are agreed upon, *which are measurable*, and which serve the purposes for determining the extent of educational disadvantage’ (*Italics added - not in the original*). (1998, p 8).

Despite their concern with understanding the nature and characteristics of educational disadvantage their own definition ends up combining this with elements of a disease model (i.e., understanding educational disadvantage as condition someone *has*).

- In relation to a student in the formal education system, educational disadvantage may be considered to be a limited ability to derive an equitable benefit from schooling compared to one’s peers by age as a result of school demands, approaches, assessments and expectations which do not correspond to the student’s knowledge, skills, attitudes

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and behaviours into which (s)he has been socialised (as opposed to those to which (s)he is naturally endowed).

- In relation to people who have left formal schooling, educational disadvantage may be considered to be the condition of possessing minimal or no formal educational qualifications and/or being inadequately trained or without knowledge, skills, attitudes and behaviours associated with the demands of available employment, so that one's likelihood of securing stable employment is disproportionately limited as compared to one's peers by age.

(Boldt and Devine 1998, p 10).

In this definition educational disadvantage is defined as 'a limited ability' and as a 'condition'. In other words the term fits the medical model by describing something the individual has. At the same time, their concern with the nature and characteristics of educational disadvantage means that they are left with a definition of something which is far from distinct and measurable. Since the measurement of naturally endowed talents (as opposed to social acquired skills) is very problematic (Drudy and Lynch, 1993, p 60), quantifying the numbers of educationally disadvantaged is next to impossible using this definition. The only measurable component of the definition relates to those who have left formal schooling. Again, this relates specifically to vocational training

disadvantage rather than the generality of educational disadvantage. In trying to deal with both the processes of educational disadvantage and the measurement of educational disadvantage Boldt and Devine have fallen between the two stools. In fact, in looking at the extent of educational disadvantage Boldt and Devine uncritically accept the model of measurement proposed by Kellaghan *et al.*, claiming it gives a 'good indication of the incidence and distribution of educational disadvantage in Ireland' (1998, p 14). (As I have already shown, Kellaghan *et al.*'s figures for the incidence of educational disadvantage in Ireland are based on the selection of a magic number which even they describe arbitrary.)

Overall then, disease based models of educational disadvantage attempt to define something which is clearly measurable in order that its correlates can be identified. As Boldt and Devine note, (1998, p 8) this has led to a lack of research on the processes, the nature and the characteristics of educational disadvantage. It has also led to researchers measuring something which is clearly not educational disadvantage as it is generally understood. Instead, researchers have tended to define vague proxies for educational disadvantage as educational disadvantage and proceed on this basis. Such a procedure can only lead to unsatisfactory results.

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Process Model: One of the central tenets of Underdevelopment theorists in their assault on the conceptualisation of the Third World was to change the use of the term “underdevelopment” from an adjective to a verb. Underdevelopment was no longer understood as a condition but as an active process. The Third World, they argued, was not just underdeveloped, it was *being actively underdeveloped*. (Hoogevelt, 1982; Regan, 1996). A similar conceptual shift is overdue in relation to educational disadvantage. Rather than being concerned with measuring the extent of it as a condition, we need to conceptualise it as an active series of processes through which people *are actively disadvantaged*. This change in understanding necessitates a switch in focus to the processes through which people are disadvantaged, rather than simply on risk factors. While the term ‘educational disadvantaged’ is still applied to those who suffer due to the operation of these processes, disadvantage is not understood primarily as a condition of the individual. In order to emphasise this, I will refer not to educational disadvantage, but to *processes of educational disadvantaging*. This implies that the disadvantaged are those who have been actively disadvantaged. Using a process model then, educational disadvantaging can be described as a series of processes which combine to bring about comparatively low attainment and participation in formal education by working class children. Those who are affected by these processes are identified as the educationally disadvantaged.

Research has identified a number of suggested processes through which children from working class homes do not achieve their potential in schooling. Tizard and Hughes (1984) suggest that discontinuities between home and school inhibit the performance of working class children during the early years of schooling. The balance of the research into teacher expectancy effects (e.g., Rosenthal and Jacobsen [1968] Rist [1970]) suggest that teacher's social expectations of children are likely to have effects on children's attainment (Rogers, 1986, p 177). Other research has suggested that there is likely to be a social class basis to the development of anti-school cultures among pupils (Willis, 1977). Boldt suggest that pupils choice to leave school early is related to what the pupils see as a failure on behalf of the teachers to relate to them, to understand them, to help them learn and to make classes interesting (1994, p 47). Other possible processes include a failure to build a sufficient bridge between children's primary school experience and their secondary schooling (Boldt, 1994, p 58), a lack of knowledge on behalf of parents as to how to get the most out of schooling due to fact that they only experienced limited schooling themselves (Whyte, 1997, p 43), and a lack of income to maximise the advantages the system could offer (Drudy and Lynch, 1993, p 161).

These are some of the distinctive processes which have been identified in education systems in Ireland and internationally which contribute to the

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comparatively poor performance of working class children in our education system. This list is far from exhaustive. Each of them are a process of disadvantaging, together with others they constitute the processes of educational disadvantaging of working class children.

While the existing Irish literature on educational disadvantage does not identify the distinction between identifying disadvantage as a condition and identifying it as a series of processes, some of the available literature does try to make sense of educational disadvantage in process terms. The Conference of Major Religious Superiors (CMRS, now CORI) emphasise the processes of educational disadvantaging when they note that '[underlying the concept of educational disadvantage is the idea that there is a discontinuity between the school and the non-school experiences of children who are poor]' (1992, p xvii). Furthermore they note that some children are ill-equipped to cope with the demands of schooling and that the school, the teachers and the curriculum are unable to cope with some of the children who are presented for education.

Other Irish literature also emphasises the process-based, active nature of educational disadvantaging. Much of Boldt's own work on early school leaving (1994; 1997; 1998) emphasises the need to understand the processes, rather than simply the correlates of disadvantaging. For example, he notes that

'early school leaving should be seen as a process involving a series of interrelated circumstances and variables which result ultimately in a pupil deciding to leave the school system with no formal qualification. . [It is possible and necessary to understand and record the meanings and importance which early school leavers attach to their experiences in order to gain an awareness and appreciation of the intricacies of this process' (1994, p 51). The reason for understanding the process of early school leaving (one of the processes of educational disadvantaging) is that, without understanding it, we will be hard pressed to do something about it.

Some of this awareness of the importance of process carries over, as I have already indicated, into the definition of educational disadvantage offered by Boldt and Devine. Like the CMRS, they note that educational disadvantage derives from a specified series of processes. The first half of their definition of educational disadvantage is almost precisely a process based definition. However, the concern with process remains mixed with disease based understandings of educational disadvantage.

Overall then we can see that the Irish literature on educational disadvantage has tended to work within the assumptions of the disease, at-risk model, even when trying to broaden the model to recognise the processes of disadvantaging. The

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domination of the debate by the epidemiological model and its consequent focus on disadvantage as a characteristic of a person or group have not previously been properly confronted in the existing Irish literature.

Conclusions

Irish attempts to define educational disadvantage have tended to be based on an epidemiological model of disadvantage, similar to the concept of the educationally at-risk as used in the US. This means a greater concern with looking for the correlates of a measurable entity than looking for the causes disadvantage. Since the crucial aspect of any such definition is the measurability of the concept, the intangibility of human potential is lost. Such definitions end up identifying something that may be a proxy for educational disadvantage, but is not educational disadvantage as is generally understood. A more constructive definition of educational disadvantaging is one which emphasises the process-based nature of educational disadvantaging, rather than simply the condition of being disadvantaged. Therefore, I suggest that educational disadvantaging can usefully be described as a series of processes which combine to bring about comparatively low attainment and participation in formal education by working class children. Those who are affected by these processes are identified as the educationally disadvantaged. This is similar to the definition offered by the CMRS, and to the first half of the

definition offered by Boldt and Devine, though the case of Boldt and Devine they widen the definition to include socialisation processes other than those relating to social class.

This focus on the processes of educational disadvantaging has a number of benefits.

1. It recognises educational disadvantage as it is commonly understood. It does not confuse educational disadvantage with educational failure more generally, nor with vocational training disadvantage more specifically. Nor does it try to cobble together inadequate measurable proxies of educational disadvantage and then confuse the proxies with the core concept.
2. It recognises that, while there are proxy measures, the extent of educational disadvantage itself cannot be measured. Therefore it focuses attention on the causes of working class children's comparatively poor educational attainment and participation, rather than on simply identifying those at risk by looking for correlates of educational disadvantage.
3. Most importantly, it focuses attention on the models of intervention we currently use. As Kellaghan *et al.* note, Irish government policy claims to focus on those most in need (1995, p 43). This then forms part of their rationale for choosing a figure of 16% in their estimate of the educationally disadvantaged: a relatively small figure allows resources to be focused on those

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most in need. Of course there is some contradiction in the fact that interventions and funding to target this group are directed, not at individuals, but at schools. While this was recognised by Kellaghan *et al.* they sidelined this issue by noting that schemes focusing on the individual 'would not be unproblematic and is something which requires further consideration' (1995, p 51). However, this issue of the level at which intervention is needed is raised again in their conclusions where they note that, given the dispersed nature of those they identified as educationally disadvantaged, interventions will need to be targeted at individuals and system wide, as well as simply on schools (1995, p 71). A focus on process also focuses attention on the inadequacies of the current model of intervention. If the problem is recognised as being the processes rather than the person, then the solution is to target the processes rather than the person. This requires some work with schools, some work with teachers and teacher training, some work with individual pupils and families, and substantial work on our education system itself. As long as we continue to see educational disadvantage as being primarily a condition of the person, this valuable insight will be obscured.

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***Mental Health, Adolescents and Children - A Comparative
Analysis of the Practice/Policy Interface***

**Mental Health, Adolescents and Children - A Comparative Analysis of the
Practice/Policy Interface**

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Abstract

Mental health services for children and adolescents in Ireland exist in a state of ambiguity. Services operate within a context of resource constraints and increasing demand. The result is that practitioners have to prioritise the client groups according to policy dictates. In Ireland the policy priority is children at risk of physical and sexual abuse. Utilising current literature in the field, this paper discusses the potential consequences of such a focus for clients, practitioners and policy through a comparative analysis with the United Kingdom. It is argued that a lack of legislative clarity, combined with a focus on abuse has led to the neglect of older adolescents with psychological problems non-consequent of abuse. The implications of such neglect are indicated and discussed.

Introduction

One of the striking features of the 1980s and 1990s is the growth in the awareness of child exploitation issues in western countries [see Lalor, 1998]. This is driven by the revelation of child sexual abuse within and outside the family, accompanied by an increased focus on the emotional abuse and neglect that can be inflicted upon children [Ferguson, 1998; O'Doherty, 1996]. In recent times it has also come to encompass issues such as the economic exploitation of children in the first, second and third worlds [McKechnie and Lynch, 1998], issues of adoption [Borland, 1998], social and economic exclusion and the general rights of children to be consulted and listened to by

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the adult world [UN Convention on the Rights of the Child,1989]. This latter development can be seen as a feature of a general trend in western society towards a consumerist and individualist perspective on citizenship through the growth in the influence of ideas around rights and responsibilities which stem from the economic liberalism of the 1980s [see for example, Savage, 1992].

At the same time that society is more focused on the welfare and rights of children there is a "moral panic" that the child poses a threat to civil society [Cleary, 1998; Shortall, 1996]. This "fear" of children manifests itself in concern about what children are exposed to via the media and how it may affect behaviour [McElwee, 1997]; and a public perception that there is an underclass of children and adolescents beyond the normal rules that govern civil society, out of control through the interaction of drugs and crime [Shortall, 1996; Powell, 1995]. The public cry is that these need to be either employed, treated or contained [Shortall, 1996; McElwee,1997].

This paper explores some of the contradictions and issues that arise for mental health practitioners dealing with children and adolescents as a result of the combination of this double bind societal attitude and a working environment in which resources are short and policy guidance is unclear. It contrasts Irish practice and policy experience in this area with that in the UK, both as a contextual measure and to highlight that though there may be certain similarities between the two there are also many differences.

There are a number of factors why it is important to examine difficulties in mental health practice and the population of children and adolescents. First, Ireland is experiencing enormous economic and social change and this, it may be argued, has some bearing on the sense of crisis that exists in Irish society with regard particularly the adolescent population. Second, Irish mental health legislation remains largely unreformed, relying on a mental health act originally drafted in 1945, (A White Paper for a new mental health act was produced in 1995, but little has occurred to pass this into law [Department of Health and Children, 1995]). Fourthly, Irish society's concerns about the risks posed to and by children and adolescents in recent years has a unique aspect that mental health professionals may need to consider in their practice [McELwee, 1998; Ferguson, 1998]. Finally, there is a need to initiate the collection of data in relation to child and adolescent mental health issues in Ireland as there is little at national level and wide variance in the degree and depth of information available from the various health boards at present. Necessarily, therefore, a number of observations are anecdotal in nature.

The Context

Ireland is uniquely different to the United Kingdom in a number of ways. Firstly, it has a written constitution [Bunreacht na hi-Eirean,1937] which guarantees the citizen certain rights. Thus any legislation passed by the Irish Parliament can be subject to test in the courts against the constitution. Practitioners, therefore, have to pay heed to issues beyond the immediate

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legislation that they are required to implement. This is very different to the British situation, where the concept of citizens' rights in relation to statutory agencies is rarely considered by practitioners.

It is a common cliché that Ireland is the "tiger" economy of Europe. Outside of what was formerly known as the Eastern Bloc, Ireland is experiencing more rapid social and economic change than any other country in Europe. Certainly, its economic growth rate since the 1990s is phenomenal, with an average of 8% compared to an average growth rate for the UK of 2% [OECD,1997]. In 1997 it overtook the UK in terms of per capita income [Tutt,1997].

Most of the dynamic for the economy is focused around Dublin and its environs. This has resulted in a large population shift, both in terms of demography (the capital now holds over one third of the total population, including 31% of all those under 18; nationally those under 18 make up 32.5% of the population [Eastern Health Board, 1995]); and in employment, which has changed from an agrarian to industrial base [OECD,1997].

Naturally such dramatic changes in such a short time have had political and social consequences. For example, there is a crisis of confidence in Irish society focused around the Catholic Church and its traditional role in welfare provision, particularly in relation to the exposure of a number of child abuse cases, such as that of Father Brendan Smyth [Ferguson, 1997; McElwee,

1998a]. This latter case actually led to the fall of a government. These developments have had a profound effect on services for children and adolescents in general and mental health in particular.

The Interaction Between Public Attitude and Service Practice

International epidemiological evidence would suggest a prevalence of mental illness among children and adolescents ranging from 8 to 21%, with higher rates in adolescence than in childhood. Urban rates are higher than rural ones [Barker,1997]. Accurate epidemiological data for the level of mental illness in the Irish child and adolescent population is not available, though some authors estimate it to lie between 10 and 15%, [McDwyer, 1995].

Major psychiatric disorders such as depression and suicide become more common during adolescence, whilst conduct disorders are often exacerbated with the onset of puberty. In one study, children who were most aggressive at age 8 to 10 were found to be particularly at risk of becoming violent delinquents [Farrington, 1978], whilst the range and degree of anti-social activities carried out by adolescents is greater than in earlier childhood [Shapland, 1978]. Of particular significance in the Irish context is that research in the UK has highlighted that 80% of children diagnosed with a conduct disorder experience premature death (suicide, road traffic accidents etc.) by early adulthood [Neeleman, 1998].

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In Ireland practitioners are confronted in the mental health field with three main issues that have a particularly high profile amongst children and adolescents. Firstly, an alarmingly high and increasing rate of suicide amongst adolescent boys, accounting for over 25% of all suicides in Ireland [Department of Health and Children, 1997]. Secondly, high rates of drug abuse. For example the South Eastern Health Board [1996] reported that 42% of young people in their area had taken illicit drugs. The most commonly used drugs being cannabis and solvents. Needless to say however, along with the rest of western Europe and the United States the main focus of public concern is the vulnerability of children to sexual and physical abuse [Thorpe, 1997].

The difficulty for practitioners is that this concern, and consequent public reaction, is often emotionally charged, single case focused and irrational. However, this reaction can have an enormous political impact, which then drives policy in undesirable directions for which practitioners are largely held accountable and therefore can affect their professional judgement. Two well known examples from the UK illustrate the point, that of the murders of Jason Swift and Jamie Bulger.

If we look at the example of Jason Swift, we find that public concern is not focused on how a boy of 14 came to be sexually involved with a group of adults, (For example, In England and Wales between the years 1989 and 1993, there were 1500 prosecutions involving children for offenses relating to

prostitution [McElwee and Lalor,1997]), but rather on the perpetrators of the crime. The public discourse and reaction, as each one of the offenders is released, has clearly driven UK Home Office policy. It has also had the effect of making both statutory and non-statutory agencies reluctant to assume responsibility for them, for fear of the public consequences should there be an incident. Proposals that these men become the responsibility of mental health services have found an unwilling response from professionals in that discipline.

A similar trend can be seen in Ireland. There is a case in which a health board has been ordered by the courts to provide a paedophile with accommodation in a psychiatric hospital whilst he sees a therapist in the community. The hospital psychiatric staff are quite clear that they are not responsible for his behaviour outside of hospital, whilst the therapist is of the opinion that they are.

The case of James Bulger, in which two boys aged 10 were convicted of the murder of a two year old infant in Liverpool, highlights both the fear of children and the role public pressure has in determining practice responses [Tutt, 1997]. The boys were found guilty of murder and sentenced to 8 years detention. This was later increased by the Home Secretary, Michael Howard, in response to a public campaign, to 15 years (The Law Lords found the Home Secretary's action to be ultra vires). Though it was made clear at the trial that these two individuals were extremely damaged children, public attitudes have determined that they be looked upon as criminals. The Inspector of Prisons has

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said that he finds great disquiet within the service at their impending transfer into adult oriented establishments [HC Select Committee Home Affairs, 1998].

From a mental health perspective of course, even a cursory reading of the case histories of these two boys would suggest that they are in need of a psychological rather than penal responses in their rehabilitation. However, it is unlikely in the current climate that that is what they will receive. The fate of these two boys became a totem of public fear that children were out of control and committing horrendous crimes because society had been too lenient. Indeed, one of the consequences of the Bulger case was to increase pressure to reduce the age of criminal responsibility. It currently stands at 10 years in the UK. It is note worthy that in Ireland the age has been increased from 7 to 10. However, the original intention was to raise it to 12 [Ring,1997:14]. However statistics indicate that there is not a significant increase in the criminal activity of youth under 12 {BCCLA, 1998} and in Ireland most youth crime is property related [Ring, 1997] .

How does this public and political reaction translate into individual practice response in the clinical field? This serves to reinforce restrictions on what practitioners are prepared to do, and the degree of risk they are prepared to countenance with particular clients and the type of client group they are prepared to take on [Wells, 1998]. Secondly, they focus on what is prioritised by the State whilst deflecting those types of cases which do not attract as high a

concern [Lipsky,1980]. Finally, it has been noted by Ferguson and Kenny [1997] that the practice of psychiatrists, public health workers, psychologists and social workers has become more legalistic and focused on procedure. This is something which is not unfamiliar to those working in mental health in the UK [Wells, 1997].

The two British examples illustrate these broad points and are relevant to the Irish situation because both had a high media profile and received wide coverage in the Republic. Indeed, it is well known that the media has played a prominent role in pushing the agenda in child care policy in both countries [Ferguson, 1997]. That is not to say of course that this issue is just all media hype. For example McElwee [1998a] states that there are 3 million children and adolescents abused each year in the USA alone.

In the Irish context, the Kilkenny incest inquiry in 1993 was seminal. This case was a catalogue of sexual and physical abuse perpetrated by a father on his daughter from the age of 10 to 26 years. What so enraged public opinion was the revelation that practitioners were aware of these events and had actually had contact with the victim and her family.

The subsequent report resulted in an immediate commitment from the government to release 35 million pounds over three years to implement in full the Child Care Act (1991) [Ferguson,1997]. It is to this Act and the amending

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legislation that I now turn, since it carries a number of implications for mental health services for children and adolescents.

The Child Care Act

In 1989 170 states ratified the UN Convention on the Rights of the Child. Ireland ratified the Convention in 1992. The charter placed an onus on signatory states to put in place measures to ensure the protection of children from physical and psychological abuse. Ireland's response was the Child Care Act in 1991, which defined a child as anyone on or below 18 years, as stipulated in the Convention [UN Convention on the Rights of the Child, 1989].

An important difference between Ireland and the UK is that in Ireland social and health services are both administered by a single authority - the regional Health Boards, whereas in the UK a difficulty for practitioners is the administrative separation of these two services. The Irish Child Care Act is similar to its UK counterparts in England and Scotland [See for example. The Scottish Office, 1996]. The Act put in place a number of measures which served to extend Health Boards legal liabilities and powers, clarifying their role in child protection [Ferguson, 1997]. Indeed, the Act is primarily concerned with this issue above all others, in particular it is focused on children who are deemed at "risk", which it appears is being primarily defined at practice level of physical and sexual terms. In this regard the Act places a duty of care on

health boards for those children already in its care and for those whose parents are incapable of providing care [Ferguson & Kenny,1997].

However, a number of legal judgments highlighted a major deficiency in the Act, namely that the Board's power of detention of children of behaviourally disturbed children was weak [Durcan,1997] and that there was a question as to whether they were obliged to contain such children. The result has been to amend the Child Care Act by passing further legislation in the form of the Child Care Bill, 1996, which is due to come into operation this year [Ring, 1997].

Within this Bill clauses have been inserted to provide for a special care order which must be applied for by a Health Board. If the court is satisfied that the behaviour of the child is such that it poses "a real and substantial risk to his or her health, safety, development or welfare, and the child requires care or protection which he or she is unlikely to receive unless the court makes an order ..." [Department of Health and Children,1997] then it will be granted. This order entitles the Board to detain a child in a special care unit for between six months to twelve months. This can then be periodically renewed on further application to the court.

There are a number of problems from a mental health perspective with this amending legislation. Firstly, it has been incorporated within an Act whose

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primary purpose is to reform the law surrounding juvenile justice, and the detention order can be used against juveniles who are “out of control” as well as those who may have substantial mental health problems. This creates the impression that detention can be a punitive rather than therapeutic act.

Now from the point of view of the detained one may argue that this would always be the case. However, such issues are important from the view of practice, for they can influence the determining criteria used by professionals in deciding whether or not to make an application for detention. For example, because an application has to be heard by a judge and the vagaries that this involves, Health Board officials may apply for orders only when a child or young person becomes a nuisance to the wider community or will wait for very extreme behaviour to manifest itself so as to be sure of a strong legal case. Indeed concern has been expressed that the general nature of special care orders has in effect left a policy vacuum at ground level because all applications will be decided upon a case by case basis [Durcan, 1997].

The State itself has provided little in the way of clear guidelines. Thus in effect policy and guidance will be in a constant state of flux in response to each judgment. The implications for practitioners is that of course they will need to pay constant attention to individual cases and their results as the only means of providing guidance to both their legal obligations and the criteria that they can apply. In effect, therefore, practitioners will be creating reactive policies at

grassroots level to fill the vacuum at national level [Lipsky,1980]. As such this leaves them exposed to criticism in the court. Their response will inevitably be defensive in terms of practice, as some commentators have begun to notice [Ferguson,1997].

Furthermore, because the special care order is part of juvenile justice it criminalises children (Children's Legal Aid Centre, 1997) who have deep rooted psychological problems, associating them in the public mind as being responsible for their predicament. It has been argued elsewhere that this is a growing trend in relation to adults who are mentally ill [Wells, 1998] and in this context will serve to confirm public prejudices with regard the danger posed by the adolescent. It is therefore paradoxical, as others have pointed out [Children's Legal Aid Centre, 1997], that these detention clauses should appear in legislation which, in its preamble, declares that the detention of children within the criminal justice system should only be employed in the very last instance [Children's Legal Aid Centre, 1997].

The Interaction of Resource Shortage with Practice

This legislation is likely to exacerbate resource issues in the child care system in general and child and adolescent psychiatric services in particular. Concern has already been voiced about the level of resources provided to cope with the level of need identified through the implementation of the Child Care Act [Walsh, 1997]. For example, the increase in the age of criminal responsibility

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from 7 to 10 will inevitably transfer a number of children from the criminal justice system into the welfare system. Furthermore, the availability of secure accommodation is extremely limited and in some cases totally inappropriate. Already, there have been cases involving children with severe psychiatric problems being sent into secure units, whilst the courts have stated that health boards are constitutionally obliged to provide more appropriate accommodation to meet the needs of these mentally ill adolescents. However, these units have yet to be established and will be unlikely to meet demand [Walsh,1997]. Furthermore, it is very unlikely that they will be solely devoted to children and adolescents separately and to the mentally ill. At the time of writing there are only two secure units with a specific psychiatric remit.

This shortage has been further exacerbated by the fact that the religious orders, which previously provided the bulk of secure care have been largely discredited as providers of the same, due to the exposure of widespread sexual abuse. Indeed, recently one order, the Christian Brothers, took out a newspaper advertisement to apologise to all its victims. Partly because of this, the Catholic Church is in the process of closing down such establishments and largely withdrawing from providing such services [Tutt, 1997:]. Also the clergy now feel that their resources need to be re-directed, as the State becomes more dominant in this area [McElwee, 1997].

Even where secure units have been opened they experience severe staffing difficulties because few are attracted to working in an area which in recent years has generated so many scandals [Tutt 1997]. Others have criticized the fact that resources are being devoted to the establishment of such secure units when services in the community remain under developed for want of money [Ring,1997]. Furthermore, some psychiatrists have complained that the whole philosophy of their work is now family and community centred, yet the bulk of legislation is mainly focused on children in detention or care [McDwyer,1995]. The fear, of course, is that their role will be increasingly dominated by this issue, particularly if adolescents challenge orders in the courts.

However, such a response is perhaps understandable, in a climate of reduced resources and increased public concern about the perceived threat of an underclass of adolescents. Children with severe behavioural problems as part of a psychopathology are a great drain on resources, both personnel and financial. This, combined with the fear of public criticism of individual practitioners working in the community with such individuals, something which Mechanic [1995] has noted as an increasing trend in mental health in general, it is likely that practitioners will want to place individuals in these units. Others have noted, that practitioners tend to give most time to those clients that are most vulnerable but least behaviourally disturbed. Those who create trouble tend to be seen as problems who detract from more deserving cases and need to be got rid of [Repper & Perkins,1995].

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We must also bear in mind that, in the Irish context, many of those charged with working with disturbed children and adolescents - GPs and public health nurses and so on - do not have a specialist training in psychiatry or psychological interventions. Yet lack of such suitably qualified personnel means the current system is highly dependent on these genericists [Buckley et al, 1997]. Transfer to a secure unit could be seen as an attractive option, thus encouraging more children to be identified as in need of secure accommodation [O'Sullivan,1997]. However, it is likely that this will in fact encourage such units to raise the threshold of admission as increased demand comes up against limited places.

Consequent of this strained situation inter-professional and inter-agency tensions are likely to arise. One chief nursing officer of an in-patient child and adolescent psychiatric unit reported, at interview, a waiting list for assessment alone of two years, whilst children needing admission are "hot housed" in local paediatric wards until a bed is available. A phenomenon will and indeed is appearing that is common in the United States, namely getting children into such units through manipulation of the system. For example, it has been noted by a number of lawyers that cases involving children with psychiatric and behavioural problems are appearing in the criminal courts on minor charges as a means of getting an assessment for placement in an appropriate unit, following which an application can be made for a long term placement [Ring,1997].

This situation is not entirely unique to Ireland. Last year the House of Commons Health Select Committee [Select Committee on Health,1997] heard about the dire consequences that have resulted from the continued closure of adolescent units in the UK at a time when need and demand are increasing. However, in Ireland practitioners face an added pressure, in that the courts have held that it is the constitutional right of children to receive appropriate treatment to their needs [Durcan,1997]. The Mid Western Health Board [1996] reported a 28% increase in the number of referrals to their child and adolescent service on the year. One of two consultant psychiatrist, specialising in child and adolescent psychiatry in another health board region, reported that he received 308 referrals from January to September 1998. This compares with a figure of 175 in 1987 for the entire year. In addition his service has no specialist in-patient facility. One in-patient unit in Dublin caters for children and adolescents up to 16 without any division between the age groups, something which is recognised in the literature as inconducive to the therapeutic milieu, so essential to successful treatment [Wolkind and Gent,1993].

What are the practice responses in such a situation? Firstly, child and adolescent psychiatric services refuse to deal with children over the age of 16 years. This policy, of course, goes against both the spirit and letter of the Act which defines a child as or under 18 years, however increasing the age to 18 has been calculated as increasing the work load of mental health services in this area by 12% without any corresponding increase in resource [Ferguson and

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Kenny,1997]. What the practice response to this demonstrates is an example of what Michael Lipsky [1980] has termed “Street Level Bureaucracy”, that is the reality of policy being made at ground level by practitioners rather than at macro or meso level to manage limits on their resources and the consequent personal stress and anxiety (for a fuller discussion of street level bureaucracy and mental health services see Wells,1997). Research in the South East of Ireland in relation to social work and child protection has found a similar phenomenon [Buckley et al, 1997].

Secondly, such children as are over 16 years are being directed to the adult psychiatric services and if in need of in-patient treatment go on to adult wards. There are only 51 specialist psychiatric in-patient places for children and adolescents in Ireland, divided between one unit in the west and two in the Dublin area [Gilligan,1991]. They are constantly full and adolescents outside these areas or even within them who cannot gain admittance are forced to turn to adult services. For example, in 1987, 702 out of 803 young people aged 19 and under were admitted to adult psychiatric in-patient units [Gilligan,1991]. This, needless to say, stretches the spirit of Ireland’s treaty obligations under article 37 of the Convention of the Rights of the Child [1989] which states:

“every child deprived of liberty shall be separated from adults unless it is considered in the child’s best interest not to do so...and ... treated ...in a manner which takes into account the needs of persons of his or her age”

However, it in effect transfers what one might call the “twilight” children, that is those children who are physically at a stage where they can pose a major behavioural challenge to adult staff and consequently a drain on resources. They can be rationalised away as adult enough to cope with an adult environment. Many of these children need to be detained in order to receive treatment and here again we come upon a worrying aspect of the practice response; for they fall between two stools in terms of protection and detention. The Irish government chose not to integrate child and adolescent psychiatric services within mainstream adult psychiatry, therefore policy formulation to cover such children is impaired.

The result is that such patients can be seen as an extra burden, because staff are unsure whether they are governed by the provisions of the 1945 Mental Health Act and are not as familiar with the Child Care Act and its amending legislation. This uncertainty may be further exacerbated by the fact that under the 1945 Mental Health Act an adult, for the purposes of detention, is classified as over 16. This runs counter to the Children’s Act but could be seen as convenient for child and adolescent services. The issue is further compounded by the fact that the 1995 White Paper on reforming mental health legislation proposed to raise the age to 18, bringing it in line with the Child Care Act. However, to date this White Paper has not been passed into legislation.

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Thus the question arises under which legislation should we treat these *twilight children* and shouldn't they be somewhere else anyway? This is not unique to Ireland. During the course of current research on the work of generic community mental health teams in the UK, a number of staff mentioned to me the problems of having such children referred to them because of lack of suitable services. Indeed, there was great reluctance on the part of Community Psychiatric Nurses and psychiatrists to take them on as patients because of the legal issues that surrounded them. They felt that this was more the remit of social services. As one social worker recounted:

“Anything with kids goes straight to the social worker...”.

This stems from the fact that, traditionally, this age group's care has been deflected in to the judicial and special school system. In Ireland there was a recent case of an adolescent girl displaying suicidal behaviour being sent to Oberstown special school as a place of detention and treatment [Durcan, 1997].

The problem is that safeguards for such detention, whether it is a special school or in an adult psychiatric hospital is weak or non-existent. For example, the integration of child and adolescent psychiatric services into social welfare services means that dedicated psychiatric secure units are not subject to inspection, unlike their adult counterparts in Ireland. Thus the therapeutic

regimes that such children and adolescents are placed under are not subject to the same degree of scrutiny and analysis to which a mental health act inspectorate would subject them.

Overall, there are approximately 2,700 children in the care of the Health Boards in Ireland [Ferguson and Kenny,1997]. Recently the House of Commons Select Committee on Home Affairs [1998] examined the whole question of the health of children in the care of local authorities. One of their findings was that young people in residential care are four times more prone to psychiatric disturbance compared to young people in the general population and that the rate of psychiatric disorder in this residential population was 67%. The British Association of Social Workers reported that psychiatric services to this population had declined in terms of range and access. Waiting lists often stood at two years, with a number of children leaving care before they could be assessed.

Whilst data for the position in Ireland is sketchy, it would not be unreasonable to assume an equivalent rate of psychiatric pathology here amongst those detained or in care. Equally it is clear from what I have previously indicated that access is just as difficult. With limited residential placement availability, lack of rights to treatment under the mental health act and a mental health service that is over-stretched, one has to ask where are these older children going. It seems to me clear that because so many of their psychiatric problems

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have an oppositional or conduct components they are ending up in prison because they are either not receiving assessment or there is just no where therapeutic to put them. [Hanley, 1997]. This would reflect a trend that has occurred in adult mental health services in the UK. The confusions in policy in relation to the mental health of children, symbolized by the amending legislation, of the child as offender (e.g. conduct disorder, drug abuse) and the child as mentally ill have already been noted. Prison statistics in the UK for young offenders show a 30% rise from 1993 to 1996. Out of a population of 17600 in 1996 6010 were 17 or under [HC Select Committee on Home Affairs, 1998].

Ireland has the second highest rate of juvenile detention after the UK and at the same time whilst no up to date data is available, anecdotal evidence suggests adolescents from the age of 15 upwards are most likely to be placed in adult prison [Keating, 1998]. At the same time, the rise in suicide of young people in prison is causing concern [Department of Justice, 1992].

In Ireland suicide amongst young men is as major an issue as elsewhere. It is the second most common cause of death amongst males between the age of 15 to 24 and has a strong correlation to alcohol and drug abuse [Department of Health and Children, 1996a]. The National Task Force has made a number of recommendations to meet this crisis, however, so far these initiatives have not been implemented. What is clear is that by and large adolescents with

depression and other types of serious mental illness are not receiving appropriate care through statutory services. It has been estimated by Kolvin et al (1981) that only 10% of children with child psychiatric problems are seen by statutory psychiatric services. One cognitive behavioural therapist, working in the private sector, has told me that currently one third of those coming to see her are middle and older adolescents suffering from problems as wide as school phobia to mild to severe depression.

From what has been said therefore one has to ask where is the effort of practitioners in children and adolescent mental health services being directed? The answer is that practitioners in this service are responding to the policy priority, which is child protection work and especially the detection of abuse. For example, the bulk of the last Mid-western Health Board Report on Child Services was taken up with child protection, with very little on other issues such as psychiatric disturbance and issues that were non-abuse related [Mid-Western Health Board, 1996].

Ferguson [1997] argues that the level of child abuse currently extant in Ireland is an example of the how historical, social and political context shapes the identification and response to a social problem. In other words child abuse was ripe for discovery in Ireland given the changes society has experienced. It is not any worse than it ever was but practitioners have become more conscious of it, the public demand action and priority is being accorded to it consequently. For

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example, statutory requirements place a clinical responsibility on practitioners, such as doctors, social workers and public health nurses, to seek out abused children [Ferguson, 1997]. Thus a perception is created that its incidence and prevalence are increasing and this in turn creates more public pressure on professionals to expose it. The result is that large numbers of staff, time and effort is spent dealing with this one issue. One consultant child and adolescent psychiatrist reported to me that he seems to spend most of his time writing child protection reports for the courts. The Eastern Health Board [1996] have voiced concern that their child and adolescent psychiatric services are under severe strain from the demands of courts and social workers to provide reports and assessments. There is inevitably an opportunity cost phenomenon at work here, driven by insufficient resourcing to meet demands and a desire to “cover one’s back”.

The opportunity cost is of course that children with major psychological problems are finding it more difficult to get assessment and treatment, whilst adolescents are largely abandoned by specialist statutory services, short of demonstrating major anti-social behaviour necessitating detention. The policy priority was confirmed by the Green Paper on a New Mental Health Act [Department of Health and Children 1992], which justified an expansion of child, and adolescent psychiatric services on the grounds that this was needed to deal with the growth in child sex abuse and extremes of behaviour amongst

adolescents. Whilst £35 million was allocated over three years this appears to have proved barely adequate to meet these two policy priorities.

Conclusion

It is clear that practitioners in Ireland share many of the dilemmas with their counter-parts in the UK. Where they differ is that the courts have a much greater say in the activities of Irish practitioners as a consequence of the differing constitutional and legislative position. More specifically, the failure to ensure that legislation in both the field of child care and mental health is providing practitioners in the specialist child and adolescent services and general psychiatric services with dilemmas vis-a-vis operating within the system to cope with over-stretched resources and unclear policy. In the middle are, in particular, adolescents, and especially those aged 16 to 18 years, who do not fall neatly into any one policy priority. They tend to be the most willful, the least grateful and in need of psychological help. Practitioners find them hard to handle. Lear sums them up when he declares "Sharper than a serpent's tooth is an ungrateful child". To abandon them in the way services are at present justifies their ingratitude.

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