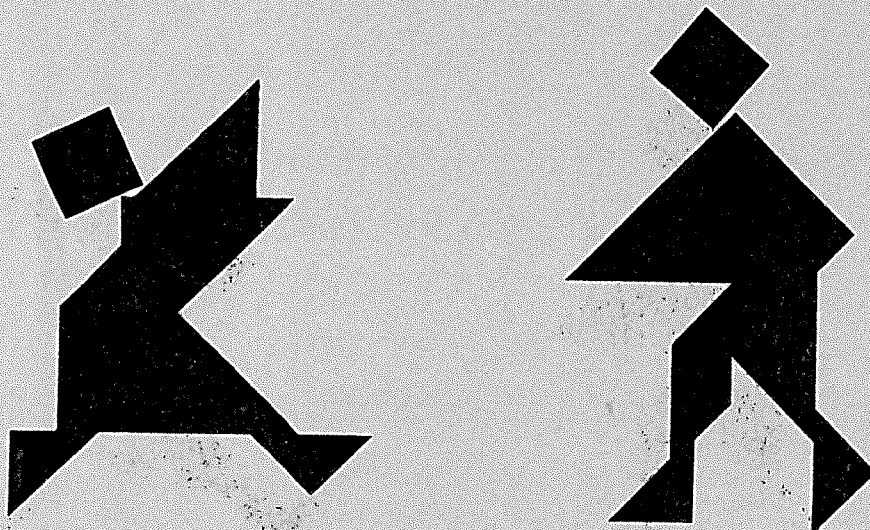




NATIONAL CHILDREN'S RESOURCE CENTRE

Training Manual
Child Care Act 1991
Parts II to VI



Reference Pack 2

PROMOTION OF WELFARE OF CHILDREN

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CHILD CARE ACT 1991

FUNCTIONS OF HEALTH BOARDS

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

Section 3 (1)

CHILD CARE ACT 1991

FUNCTIONS OF HEALTH BOARDS

In the performance of this function, a health board shall -

- (a) take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area;**
- (b) having regard to the rights and duties of parents, whether under the Constitution or otherwise -
 - (i) regard the welfare of the child as the first and paramount consideration, and
 - (ii) in so far as is practicable, give due consideration, having regard to this age and understanding, to the wishes of the child; and
- (c) have regard to the principle that it is generally in the best interests of a child to be brought up in his own family.

Section 3 (2)

CHILD CARE ACT 1991

FUNCTIONS OF HEALTH BOARDS

In the performance of this function, a health board shall -

- (a) take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area;
- (b) having regard to the rights and duties of parents, whether under the Constitution or otherwise -**
 - (i) regard the welfare of the child as the first and paramount consideration, and**
 - (ii) in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child; and**
- (c) have regard to the principle that it is generally in the best interests of a child to be brought up in his own family.**

Section 3 (2)

CHILD CARE ACT 1991

FUNCTIONS OF HEALTH BOARDS

A health board shall, in addition to any function assigned to it under this Act or any other enactment, provide child care and family support services, and may provide and maintain premises and make such other provision as it considers necessary or desirable for such purposes, subject to any general directions given by the Minister under section 69.

Section 3 (3)

CHILD CARE ACT 1991

VOLUNTARY CARE

Where it appears to a health board that a child who resides or is found in its area requires care or protection that he is unlikely to receive unless he is taken into its care, it shall be the duty of the health board to take him into its care under this section.

Section 4 (1)

Without prejudice to the provisions of Parts III, IV and VI, nothing in this section shall authorise a health board to take a child into its care against the wishes of a parent having custody of him or of any person acting *in loco parentis* or to maintain him in its care under this section if that parent or any such person wishes to resume care of him.

Section 4 (2)

CHILD CARE ACT 1991

VOLUNTARY CARE

Where a health board has taken a child into its care under this section, it shall be the duty of the board-

- (a) subject to the provisions of this section, to maintain the child in its care so long as his welfare appears to the board to require it and while he remains a child, and
- (b) to have regard to the wishes of a parent having custody of him or of any person acting *in loco parentis* in the provision of such care.

Section 4 (3) (a)(b)

CHILD CARE ACT 1991

VOLUNTARY CARE

Without prejudice to the provisions of Parts III, IV and VI, where a health board takes a child into its care because it appears that he is lost or that a parent having custody of him is missing or that he has been deserted or abandoned, the board shall endeavour to reunite him with that parent where this appears to the board to be in his best interests.

Section 4 (4)

CHILD CARE ACT 1991

ACCOMMODATION FOR HOMELESS CHILDREN

Where it appears to a health board that a child in its area is homeless, the board shall enquire into the child's circumstances, and if the board is satisfied that there is no accommodation available to him which he can reasonably occupy, then, unless the child is received into the care of the board under the provisions of this Act, the board shall take such steps as are reasonable to make available suitable accommodation for him.

Section 5

)

CHILD CARE ACT 1991

PROVISION OF ADOPTION SERVICE

Each health board shall provide or ensure the provision in its area of a service for the adoption of children in accordance with the Adoption Acts, 1952 to 1988.

For the purpose of this section, a health board may enter into arrangements with any adoption society for the time being registered in the Adoption Societies Register maintained by An Bord Uchtála under Part IV of the Adoption Act, 1952.

A health board may take a child into its care with a view to his adoption and may maintain him in such care in accordance with the provisions of this Act until he is placed for adoption.

Section 6 (1) (2) (3)

CHILD CARE ACT 1991

PROVISION OF ADOPTION SERVICE

Without prejudice to Parts III, IV and VI, nothing in this section shall authorise a health board to take a child into its care against the wishes of a parent having custody of him or of any person acting *in loco parentis* or to maintain him in its care under this section if that parent or any such person wishes to resume care of him.

The provision of section 10 shall apply with any necessary modifications in relation to any arrangement made under subsection (2).

Section 6 (4) (5)

CHILD CARE ACT 1991

CHILD CARE ADVISORY COMMITTEES

A health board shall establish a child care advisory committee to advise the health board on the performance of its functions under this Act and the health board shall consider and have regard to any advice so tendered to it.

A child care advisory committee shall be composed of persons with a special interest or expertise in matters affecting the welfare of children, including representatives of voluntary bodies providing child care and family support services.

A person shall not receive any remuneration for acting as a member of a child care advisory committee, but a health board may make payments to any such member in respect of travelling and subsistence expenses incurred by him in relation to the business of the committee.

Section 7 (1) (2) (3)

CHILD CARE ACT 1991

CHILD CARE ADVISORY COMMITTEES

Payments under this section shall be in accordance with a scale determined by the Minister, with the consent of the Minister for Finance.

The Minister shall give general directions in relation to child care advisory committees which may include directions on any matter relating to the membership, constitution or business of committees (including a provision empowering a committee to co-opt one or more members) and each health board and child care advisory committee shall comply with any such directions.

A health board may, with the consent of the Minister, and shall, if so directed by the Minister, establish more than one child care advisory committee for its area and where more than one committee is established the provisions of subsection (1) shall apply with the necessary modifications.

Section 7 (4) (5) (6)

CHILD CARE ACT 1991

CHILD CARE ADVISORY COMMITTEES

Each child care advisory committee shall -

- (a) have access to non-personal information in relation to child care and family support services in its area,
- (b) consult with voluntary bodies providing child care and family support services in its area,
- (c) report on child care and family support services in its area, either on its own initiative or when so requested by the health board,
- (d) review the needs of children in its area who are not receiving adequate care and protection,

and where more than one child care advisory committee is established in a health board area, the provisions of this subsection shall apply with the necessary modifications.

Section 7 (7) (a)(b)(c)(d)

CHILD CARE ACT 1991

REVIEW OF SERVICES

A health board shall, within 12 months of the commencement of this Part and annually thereafter, have a report prepared on the adequacy of the child care and family support services available in its area.

Section 8 (1)

CHILD CARE ACT 1991

REVIEW OF SERVICES

Without prejudice to the generality of subsection (1), a health board in preparing a report under this section shall have regard to the needs of children who are not receiving adequate care and protection and, in particular -

- (a) children whose parents are dead or missing,
- (b) children whose parents have deserted or abandoned them,
- (c) children who are in the care of the board,
- (d) children who are homeless,
- (e) children who are at risk of being neglected or ill-treated, and
- (f) children whose parents are unable to care for them due to ill-health or for any other reason.

Section 8 (2) (a)-(f)

CHILD CARE ACT 1991

Review of services

A health board shall give notice of the preparation of a report under subsection (1) to -

- (a) any child care advisory committee in its area;
- (b) such bodies as the board sees fit whose purposes include the provision of child care and family support services;

and shall have regard to any views or information furnished by such committee or bodies in the preparation of the report.

A health board shall submit a copy of any report prepared under this section to the Minister and may make copies of any such report available to such bodies as are mentioned in subsection (3) (b).

Section 8 (3)(4)

CHILD CARE ACT 1991

PROVISION OF SERVICES BY VOLUNTARY BODIES AND OTHER PERSONS

A health board may, subject to any general directions given by the Minister and on such terms or conditions as it sees fit, make arrangements with voluntary bodies or other persons for the provision by those bodies or other persons on behalf of the health board of child care and family support services which the board is empowered to provide under this Act.

Nothing in this section shall empower a health board to delegate to a voluntary body or any other person the duty conferred on it under section 4 to receive certain children into care or the power to apply for an order under Part III, IV or VI.

Section 9 (1)(2)

CHILD CARE ACT 1991

ASSISTANCE FOR VOLUNTARY BODIES AND OTHER PERSONS

A health board may, subject to any general directions given by the Minister and on such terms or conditions as it thinks fit, assist a voluntary body or any other person who provides or proposes to provide a child care or family support service similar or ancillary to a service which the health board may provide under this Act-

- (a) by a periodic contribution to funds of the body or person;
- (b) by a grant;
- (c) by a contribution in kind (whether by way of materials or labour or any other service).

Section 10 (a)(b)(c)

CHILD CARE ACT 1991

RESEARCH

The Minister may conduct or assist other persons in conducting research into any matter connected with the care and protection of children or the provision of child care and family support services.

A health board may conduct or assist other persons in conducting research into any matter connected with the functions assigned to the board under this Act.

Section 11 (1)(2)

SUMMARY OF PART II, CHILD CARE ACT, 1991

HEALTH BOARDS ARE UNDER A DUTY TO:^{f 1)}

① Promote the Welfare of Children

In doing this they must:

- identify children in need
- co-ordinate information from all sources
- balance different interests in accordance with the Act
- Provide child care and family support services

② Provide Services

- Child care and family support services
- Voluntary care
- Accommodation for homeless children
- Adoption Service

③ Develop and Review Services

- Child care advisory committees
- Annual review of services and publication of section 8 reports
- Arrangements with voluntary bodies and other persons to provide services
- Research

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To facilitate participants to identify the needs of children.
- Exercise:** Participants are asked to identify generally the physical, emotional, social and intellectual needs of children during the following developmental stages
- 0 - 1 year
 - 1 - 4 years
 - 5 - 7 years
 - 8 - 11 years
 - 12 years +
- Method:** Working in small groups or pairs.
- Participants work in small groups or pairs to complete the exercise. Each small group is allocated a different developmental stage. The trainer then facilitates feedback and a full group discussion. Appendix 1 may be distributed as a hand-out.
- Materials Required:** Flip chart
Markers
Pens and paper
Appendix 1

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To enable participants to consider the problems and issues facing children.
- Exercise:** Participants are asked to identify the key issues and problems facing children of all ages, with whom they come into contact, in their own working environment(s). (including children with disabilities, children who are travellers, child victims of abuse, child refugees etc...)
- Method:** Brainstorm
The full group participate in a brainstorm exercise. The feedback is recorded on flip chart by the trainer who sums up.
- Materials Required:** Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To encourage participants to examine whether the Act provides for the promotion of the welfare of all categories of children who are not receiving adequate care and protection.
- Exercise:** Section 8 (2) of the Child Care Act 1991 describes who might be included in the category of children "not receiving adequate care and protection".
- With reference to this section of the Act, participants in small groups consider the list offered. Is it exhaustive? If not, what other categories could be added?
- Method:** Small Groups
- The trainer displays Acetate 11 of this module which presents section 8 (2) of the Act.
- Participants work in small groups and answer the questions posed. Their responses can be recorded on a flip chart. The full group can then discuss the list.
- Materials Required:** Acetate 11
Overhead projector
Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To assist participants to consider the type of information a health board may need to gather concerning children in its area.
- Exercise:** Participants are asked to identify the type of information a health board might require:
- (a) concerning an individual child who has been referred directly to the health board as not receiving adequate care and protection
 - or
 - (b) the wider demographic information on children in its area.
- Method:** Small groups/pairs
- Participants list on a flip chart sheet the data they consider relevant to the task allocated.
- Materials Required:** Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

Purpose: To assist participants consider how the health board can implement its function under Section 3 (2)(a) of the Act and to explore how this impacts on participants day to day work.

Exercise: The following questions are posed:

- (1) What steps can a health board take to meet its responsibilities to
 - (i) identify children who are not receiving adequate care and protection
 - and
 - (ii) co-ordinate information?
- (2) How does the implementation of this section impact on participants' day to day work?

Method: Brainstorm

The full group participates in a brainstorm exercise and the feedback is recorded on a flip chart.

Materials Required: Acetate 2
Overhead projector
Flip chart
Markers
Appendices 2 and 3

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To encourage participants identify the key elements of a comprehensive child and family support service.
- Exercise:** Participants are asked to identify the key elements of a child and family support service.
- Method:** Brainstorm
- In the full group the participants brainstorm their responses. The feedback is recorded on a flipchart by the trainer and discussed with the full group.
- Materials Required:** Flip chart
Markers
Appendices 4 and 5

PROMOTION OF WELFARE OF CHILDREN

Purpose: To assist participants develop the debate concerning the potential conflict between prevention and protection in childcare.

Exercise: The following scenario is presented to the participants:

The management team of a community family support service is approached by the programme manager of the local health board requesting that 5 places in the day nursery be allocated to children subject to supervision orders under section 19 of the Act. The health board provides eighty per cent of the funding for the service. A follow up meeting is organised. The health board team meets with the management of the family support service and discusses the request.

Method: Role play

The trainer seeks three volunteers to take on the role of the health board team, three to take on the role of the management team and one to act as a neutral chairperson. Adequate time is allocated to each team to prepare for the meeting. The role play is staged for 10 minutes. The task of the remaining participants is to evaluate the arguments used during the meeting. For added interest the observers can also be asked to vote on whether or not the family support service should meet the request of the health board. A full group discussion is then facilitated by the trainer.

Materials Required: Copy of exercise for each participant
Pens and paper
Voting slips

PROMOTION OF WELFARE OF CHILDREN

Purpose: To assist participants identify the services that are available for children and families in their area and to identify any gaps in the provision of those services.

Exercise: Full group
The trainer asks the full group to list the services available to children and families in their area. They can be categorised under the following headings:

- Health
- Welfare
- Social
- Advice and counselling
- Information services

The trainer then poses the question: Are there any gaps?

Method: Brainstorm

The trainer facilitates the full group in a discussion of the list of services compiled and also any identified gaps in local service provision. (The list can be typed and circulated to each participant at the end of the course).

Materials Required: Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

Purpose: To provide participants with an opportunity to explore the provisions of the Act in relation to voluntary care.

Exercise: The following case study is presented to the participants.

Case Study

Jean is six years old. Her mother Mary (23 years) who is a lone parent has a history of alcohol abuse. She says she wants to stop drinking and to this end is attending counselling. Her counsellor reports that Mary would benefit from a period of treatment in a residential centre. The teachers at Jean's school are concerned about her. She presents at school unkempt and withdrawn. She is frequently enuretic at school and appears to be sleepy. The other children call her names and shun her. "She looks thin, small and unhappy" says the teacher. The teacher has discussed her concerns with the social worker.

Mary has visited the social worker twice recently saying she is finding it impossible to cope and to make ends met. She owes rent and electricity money and is in debt to several friends. Jean needs shoes and Mary says she finds Jean "won't do anything she is told, even when I slap her".

On Monday morning, Mary comes down to the duty social worker to ask that Jean be taken into care.

The tasks of the participants are:

- (1) To consider
 - (a) whether this case scenario would be best dealt with by receiving Jean into voluntary care and to give reasons for the decision.
 - (b) what work would need to be undertaken with Mary and Jean to ensure a positive outcome.
- (2) Participants are requested to draw up an intervention plan and allocate tasks and goals. This should be presented in a format suitable for consideration by the chief executive officer. The full group can be brought together to compare their findings.

cont'd...

MODULE 2 - STEP 4 (CONT'D)

EXERCISE 9

Method:

Small groups/Role play

Stage 1 Participants are divided into three small groups to undertake the tasks outlined. The trainer then facilitates feedback and a full group discussion.

Stage 2 Three volunteers (one from each group) are invited to participate in a role play. Two take on the role of health board professionals eg social worker, public health nurse, child care worker etc.. and the third person takes on the role of the chief executive officer, as outlined in section 72, (1)(c) of the Act. (which is presented on Acetate 13 Module 1 Step 5). The remaining participants take of the role of observers.

The health board professionals present their case to the chief executive officer in support of the child, Jean, being received into voluntary care. The issues raised are discussed and debated. In conclusion, the trainer facilitates a full group discussion.

Materials Required:

Acetate 13 Module 1 Step 5
Overhead projector
Copies of case studies
Flip chart
Markers
Pens and paper

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To encourage participants examine the reasons why children may be homeless.
- Exercise:** The full group are invited to consider the circumstances that may lead to children presenting as homeless.
- Method:** Brainstorm
- In a brainstorm session the participants respond to the above exercise. Their findings are recorded on flip chart by the trainer who facilitates a full group discussion.
- Materials Required:** Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

Purpose: To enable the participants see how section 5 of the Act could be applied to their day to day work.

Exercise: The trainer displays Acetate 8 which presents section 5 of the Act. Then one or both of the following case studies are presented to the participants.

Case Study (1) Johnny

The local hospital has phoned you about a young man, Johnny, (he won't give his full name), who is, they say 16 years old approximately. He is currently in casualty awaiting medical attention for a broken wrist. He is very reluctant to give any information about himself and is unaccompanied. He says he does not live with his parents and is staying with friends but now after a fight (which resulted in his injury) he cannot return there. He refused to give his parents or relatives address and says he will find a hostel. Sister says he looks unkempt. She is ringing you for advice.

Task: As a health board duty officer how would you proceed with this referral?

Case Study II - Sineád

The sister in the outpatients maternity unit contacts the duty social worker. Sineád (sixteen and a half years old) has presented herself at the outpatients without an appointment. She is 7 months pregnant and says she has nowhere to go. She has been told to leave home because of her pregnancy. Sister suspects she may be abusing substances. The doctor on duty does not think she needs to be admitted to hospital.

Task: As a health board duty officer how would you proceed with this referral?

Method: Small groups

The participants are divided into small groups. A case study is allocated to each group. The findings can be recorded on flip chart and reported back to the full group. A full group discussion is then facilitated by the trainer.

Materials Required: Acetate 8
Overhead projector
Flip chart
Copies of case studies

PROMOTION OF WELFARE OF CHILDREN

Purpose: To assist participants explore the main issues concerning the provision of the adoption service.

Exercise: Depending on the composition of the training group one or all of the following questions can be posed:

- What are the elements of a good adoption service?
- In post adoption work - does an adopted person's need for information conflict with confidentiality for birth mothers who placed children for adoption?
- Where couples are considering intercountry adoption what additional issues would need to be covered with them during the assessment?
- The 1996 Adoption (no.2) bill sets out how fathers are to be consulted during the adoption process. What are the issues that could arise for the child, the mother and the adoptive parents as a result of this legislation?

Method: Brainstorm

(a) All or a selection of the above questions are posed to the full group who discuss and record their views. The trainer sums up the discussion.

(b) Small groups

The group is divided into smaller groups who take all or a selection of above questions. They feed-back their views to the full group.

Materials Required: Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To assist participants consider the operation of a child care advisory committee.
- Exercise:** The trainer displays Acetate 10 which presents section 7 of the Act. Based on the functions of the child care advisory committee as outlined in the Act the participants are asked the following questions:
- How are the functions of the child care advisory committee implemented in their area?
 - What, if any, reports on aspects of child care and family support services have been published by the child care advisory committee?
 - Do the staff of the health board and voluntary agencies have access to the members of the committee?
 - Do clients of the health board have access to members of the committee who are charged with reviewing the needs of children in their area under Section 7 (7) (d).
 - How can workers in the health board area positively influence and support the work of the child care advisory committee?
- Method:** Small groups.
- Participants are split into small groups. Each group is allocated one or more of the questions posed. They record their views on flip chart for feedback to the full group. A full group discussion is facilitated by the trainer.
- Materials Required:** Acetate 10
Overhead projector
Flip chart
Markers

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To assist participants consider whether or not section 8 reports, as presently available, can contribute to national policy and planning in a comprehensive way.
- Exercise:** Section 8 reports from three or more health boards are examined and presented to a panel of participants who have assumed responsibility for national planning and policy in child care.
- The group is divided into two working panels.
- Group 1** is provided with the contents page of three or four section 8 reports to examine from different health boards. Their task is to compare and contrast the content of the reports outlining similarities and differences.
- Group 2** takes on the role of a policy and planning unit with national responsibility for child care and family support services. Their task is to suggest a framework for section 8 reports that would aid their work.
- Method:** Small groups
- Each group is allocated a specified time period to complete its work. Group 1 presents its findings to the full group and group 2 comment on the findings based on the framework they have developed. The trainer facilitates a full group discussion and sums up the issues raised.
- Materials Required:** Photocopies of 3 or more Section 8 reports.
Pens and paper.

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To enable the group consider the implications of voluntary bodies providing services both from the health board perspective and the voluntary perspective.
- Exercise:** The participants are asked to identify the advantages and disadvantages of voluntary provision in the child care area from three perspectives:
- Health board
 - Voluntary bodies
 - Families using the service
- Method:** Small groups
- In three groups the participants complete the above tasks. Group 1 assumes the role of a health board and group 2 takes on the role of a voluntary body. Group 3 assumes the role of families using the service. Each group views the exercise from its own perspective and reports its findings to the full group where the trainer facilitates a discussion.
- Materials Required:** Flip chart
Markers
Pens and paper

PROMOTION OF WELFARE OF CHILDREN

- Purpose:** To assist participants consider how research can contribute to the development of appropriate services for children and families.
- Exercise:** Participants discuss and consider the role of research in child care by examining some or all of the following:
- What Irish research concerning child care can participants identify?
 - Is any research being currently undertaken in the local health board area?
 - Identify areas of research suggested by the Child Care Act 1991 e.g. the outcome of the Supervision Order provision, how consumers views can be collected and used to influence service design etc..
- Method:** Brainstorm
- The full group is asked to comment on one or all of the above points. Their views are recorded. The trainer can sum up the discussion and/or suggest other areas of research. In relation to research in the area of the views of consumers the trainer may wish to refer to chapter 4 of the Health Strategy compiled by the Department of Health.
- Materials Required:** Flip chart
Markers

WHAT CHILDREN NEED

PHYSICAL

- Adequate housing
- Safety
- Good nutrition
- Hunger satisfied
- Regular medical care
- Immunizations
- Exercise
- Cleanliness

EMOTIONAL

- Feeling loved
- Basic needs met
- Security, reliability
- Respect and recognition
- Support for self-esteem
- Acceptance for who they are
- Appropriate limits
- Protection from hurts and dangers
- Patience, as much as possible
- Praise and encouragement for what they do well
- Affection
- Attention

cont..

SOCIAL

Parents who talk with them

Playing with other children

Being around adults who respect them

Guidance in trusting

Encouragement to respect others' differences and rights and to negotiate when there are differences and problems

INTELLECTUAL

Freedom to explore

Questions respected and answered

Encouragement to be curious and interested in new things and ideas

Discussion

Encouragement to think and express own ideas and imagination and develop skills

Stimulation of going places

Books and toys

Regular school attendance

These needs have to be met from the very beginning of life. The ways in which these needs are met change during the different developmental stages.

Adapted from: Mia Kellmer Pringle

SAMPLE LIST OF INQUIRY REPORTS

(A) IRISH CONTEXT

1. Report of the Kilkenny Incest Investigation McGuinness, C. The Stationary Office (1993) Available from Government Publications
2. 'Kelly - A Child is Dead' Report of a Committee of Inquiry (Chaired by Keenan, Owen) Houses of the Oireachtas 1996 Available from Government Publications
3. Report of the Inquiry into the Operation of Madonna House Department of Health (1996) Available from the Government Publications Office.
4. International Missionary Training Hospital, Drogheda, Report of an Independent Review Group, June 1996

(B) U.K. CONTEXT

1. The Doreen Aston report; Lewisham Social Services Department, London, 1989
2. A Child in Trust: the report of the panel of inquiry into the circumstances surrounding the death of Jasmine Beckford, London Borough of Brent, 1985
3. A Child in Mind: protection of children in a responsible society - The report of the commission of inquiry into the circumstances surrounding the death of Kimberley Carlile, London Borough of Greenwich, 1987
4. Lester Chapman: inquiry report, Oct. 1979 Available from Berkshire Shire Hall
5. Report of the committee of inquiry into the care and supervision provided in relation to Maria Colwell, H.M.S.O. London 1974
6. Whose Child? The Report of the Public Inquiry into the death of Tyra Henry, London Borough of Lambeth, 1987
7. Malcome Page: Report by the panel appointed by the Essex Area Review Committee, 1981
8. Report of the Inquiry into Child Abuse in Cleveland 1987 Her Majesty's Stationery Office (HMSO), 1988
9. Sukina: by John Fitzgerald, The Bridge Child Care Consultancy Service, 1991
10. Paul - A Child is Dead The Bridge Child Care Consultancy Service, 1995

CO-ORDINATION OF INFORMATION BY HEALTH BOARDS

PROPOSED INITIATIVES

The proposed initiatives are:

- (i) Designated officers in the health boards to co-ordinate inter-agency approaches to child protection at community care level,
- (ii) Regional and local child protection committees, operating at health board and community care area level, to enhance inter-agency and inter-professional approaches to child protection,

Details of the proposed initiatives:

- (i) Designated officers in the health boards to co-ordinate the inter-agency and inter-professional response to individual cases at community care level

To insure inter-agency and inter-professional co-operation at community care level, it is proposed that designated officers be appointed in each community care area by each health board, to co-ordinate the response of all agencies, statutory and voluntary, to individual cases of child abuse or protection. The designated officer would be either the child care manager or the senior social worker.

Responsibilities designated officers would have include:

- ensuring inter-agency co-operation in relation to child protection and welfare,
- ensuring inter-professional and inter-programme co-operation in relation to child protection and welfare,

- (ii) Child protection committees at health board and community care level

It is proposed that a regional child protection committee be established at health board level to facilitate co-ordination on a regional basis, and a child protection committee in each community care area to foster co-operation locally. The proposed structure therefore allows for a regional committee, which will develop policies to improve inter-agency and inter-professional co-operation, and a more local committee to provide a forum at local level for the sharing of knowledge and experience in relation to the protection of children.

(Extracts from Department of Health publication 'Putting Children First', 1997, p.14 - 17)

KEY PRINCIPLES OF FAMILY SUPPORT

Family support involves recognising and responding to the needs of families, especially when they are under stress. To be effective, family support must be responsive and accessible: above all, it must connect with the families who need the support when they need it. To be effective, family support must address the family's definition of the need or problem concerned (Dunst and Trivette, 1990, p. 327).

Family support must be supportive: it must not be experienced as threatening, alienating or demeaning. Family support must be offered and available on terms that make sense within the lived reality of its target users. In practice, this will mean emphasising a low-key, local, non-clinical, unfussy 'user friendly' approach. To be effective, it must generally be offered in or near the child's home, certainly within 'pram -pushing' distance. To succeed, family support must operate fundamentally on the principle of consent rather than coercion. It must be presented and perceived as enticing and attractive. Parents, guardians and children must be left with a clear sense of benefiting from their involvement with family support activities. Family support should aim to enhance rather than diminish the confidence of those being helped. It requires an orientation on the part of professionals which is one of respectful ally rather than patronising expert. It also needs to 'wrap around' the particular circumstances and child-rearing stage of the family (Whittaker, 1993,p.9).

Family support services need to have the capacity not just to work in crisis. They must also be available over the long haul. To use Harris' metaphor, 'milk-van support' (daily, low-key, routine) is likely to be more helpful than 'fire-brigade support' (once-off, emergency, dramatic) (1993,p.99). While just 'being there' may be important at certain times, it is also sometimes important that family support work has a purposeful and focused quality. Where necessary, family support work, especially in its protective mode, should be focused on a particular targeted problem or set of problems, for a specific time period, and with specific and measurable outcomes in mind. The work should be geared to searching for what works best in a particular set of circumstances, or across a set of cases belonging to a particular category of problem. This entails a strong evaluative component to the work, a clear obligation in a context of scarce resources and infinite need. Ultimately, however, support to families must be available on the basis of need rather than the prospect of success. While the work should be as effective as possible, the guarantee of success must not become a condition of help being offered. Family support should proceed from an ethic of care, the spirit of which is captured well in the fifteenth century french adage, to cure sometimes, to relieve often, to comfort always' (Schneiderman et al., 1994,p.113).

*(Extract from article by Gilligan, R. 'Family Support and Child Welfare': Realising the Promise of the C.C.A., 1991 in Ferguson, H. & Kenny, P. (eds) 'On Behalf of the Child', (1995)
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FAMILY SUPPORT SERVICES

'Family support services' is the collective title given to a broad range of provisions developed by a combination of statutory and voluntary agencies to promote the welfare of children in their own homes and communities. These services are provided mainly to particularly vulnerable children in disadvantaged areas and often include pre-school, parental education, development, and support activities, as well as home-maker and visiting schemes and youth education and training projects.

Current assumptions that prevention and family support services are synonymous need to be challenged on the following grounds. Families cannot be understood separately from the economic, political and social systems of which they are a part. Emphasising the social significance of family is a deeply embedded, politically conservative stance. Even the enlargement of the definition to include the diversity of forms currently gaining ground, such as lone parent and reconstituted families, points to the importance for the status quo of preserving an ideology of family. Thus, as the market demands, family can be reworked, as in the neoliberal thesis of Thatcherite Britain. Family, in this context, becomes the key issue in retrenchment of public activities and the privatisation of welfare (see Barrett and McIntosh, 1982; Williams 1989). In meeting the needs of its members, therefore, it is compared, to its advantage, with inflexible welfare bureaucracies; where it fails its members usually the women members, are 'pathologized', blamed and seen to be in need of treatment, if not of punishment. Is it a coincidence that Sweden, one of the most socially developed welfare states in the world has, as Popenoe characterises it, 'taken a world-leading move away from nuclear family ideology' as well as an enviable record in its public child care policies? (Popenoe 1987, p.159). Sweden, although short on the rhetoric of family values familiar to citizens of Britain, Ireland and the US, has a majority of couples living in monogamous dyads most of whom have children, and whose social life revolves around gatherings of relatives. Significantly, these parents are facilitated in spending state-supported time with their young children through extensive paternal, maternal and parental leave. Challenging family ideology entails primary prevention in the form of radical income redistribution policies and work place structures. Providing limited family supports is not even in the same league!

Family support seems to imply that families are unitary wholes where conflicts of interests do not occur. It carries connotations of a warm private world where members share a standard of living, class position and mutual sharing of assets and power as well as care and protection. The disaggregation of individual interests within families by feminists has demonstrated the patent untruth of this proposition, at least for women. Unfortunately, as Alanen points out, it has largely failed to extend the analysis to children, and she suggests, has remained just as functionalist and adult-centred as malestream/main social science' (Alanen 1994, pp.27-42). However, feminist analysis and process does, she suggests, point a way forward for addressing children's interests. In doing so we become aware that just as patriarchal family forms serve the interests of men more than women, so too women and children's interests are not always compatible, as intergenerational patterns of power place women with men in 'apparatuses of ruling' (Ibid).

Children are indeed 'familiarised' to the extent that they are physically, emotionally and intellectually dependant on adult carers for survival and it will usually be within the context

of such child/adult relationships that these dependencies are met. However, if the family is seen to be the only or even major unit of societal observation or indeed intervention concerning children, this will extend the inter-generational inequities brought about by the fact that adults are the powerful actors in families and children the powerless.

Sgritta's analysis of income distribution in Europe shows how this relegates children to the lowest income level, by comparison with all other groups (Sgritta's 1994, pp.335-63). This suggests that policy and practice need to consider means by which children's interests are given at least equal rating with those of adults and this analysis suggests that disaggregation is the only way to ensure this - a notion bound to be unpopular in a romantically paternalistic Ireland!

In Ireland, as in other countries, family support services have mainly tended to reach mothers. Whilst this acknowledges the extent of the child care burden carried by women and thus their need of such support, it obscures two important features of children's lives in modernity. These suggest that supports to child carers need to be proactively offered to a wider constituency than mothers. The first is what has been termed the 'feminisation of childhood', which refers to the relegation of child care work to the 'no or low-pay' status of women. Women of higher occupational status can continue to enjoy this status and income only by handing over the less societally valued work of caring for their children to women who are paid at lower rates, often in the 'black economy'. For these women, as for others, such as the high numbers of inner-city grandmothers caring for children whose parents have died from Aids or drug overdosage, there are few supports.

The second strand of this argument is the absence of fathers from sites of support such as family centres and playgroups, even in areas of high male unemployment. There are a few notable exceptions to this but the report of the Kilkenny incest investigation pointed out that proactive measures need to be taken to involve men in such services (McGuinness 1993,p.111). An analysis focusing on how best to provide relevant supports to all carers is needed to address both these issues. They will be even more relevant in a post-divorce Ireland.

The above factors need to be borne in mind when considering the main conceptual categories of children's experience and thus potential disadvantage. These can be identified as physical care/neglect and abuse, educational need/disadvantage and emotional nurturance/neglect. These are interlinked at several levels but for conceptual clarity and consideration of intervention strategies it is useful to discuss them separately.

(Extract from article by Marion Murphy, Prevention to Family Support and Beyond: Promoting the Welfare of Irish Children. In Ferguson,H. & McNamara,T. Administration, Protecting Irish Children Vol 44, No 2, 1996, p.76-80)

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PROPOSED INITIATIVES

That regional and local child protection committees be established operating at health board and community care area level, to enhance inter-agency and inter-professional approaches to child protection.

It is proposed that the regional child protection committee be established by a direction from the Minister for Health to child care advisory committees which have been established under Section 7 of the Child Care Act, 1991. The Minister may give general directions to child care advisory committees under section 7 (5) of the Child Care Act, 1991. Given the highly sensitive nature of the issues which will need to be reviewed in detail before such committees, and that their primary focus will be on inter-disciplinary and inter-agency co-operation, it is envisaged that the regional child protection committees will be composed of health board management and relevant professionals. However, regional child protection committees will operate as a sub-committee of the child care advisory committees, focusing on professional and technical matters and reporting to the child care advisory committee, as appropriate, on matters of general policy.

The regional child protection committee will issue guidance on inter-disciplinary and inter-agency procedures, review annually the child protection work in the region, develop a work plan for the incoming year and produce a report to go to the head of each constituent agency and the child care advisory committee.

The membership of the regional committees will consist of representatives of health board management and professional staff, educational interests, the gardai, the probation and welfare service, the Department of Social Welfare, general practitioners and the voluntary child care sector. The membership of child protection committees at community care level will mirror the membership of the regional committees to ensure local implementation of co-ordinated initiatives.

(Extracts from the Department of Health Publication, *Putting Children First*, 1997, p.16-17)