HEALTH SERVICES RESOURCE CENTRE

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on

THE 1988 CHILDCARE BILL

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The 1988 Child Care Bill was at Committee stage when the general election was called. The Bill was restored to the Order Paper after the election, on 20 July 1989. The Committee stage commenced in November 1989 and about 200 amendments were put down on the Order Paper. Agreement was reached to refer the Bill to a Special Committee of the Dail to continue the Committee Stage. In a speech on the Bill in the Seanad on 8 November, Noel Treacy TD, Minister of State at the Department of Health, emphasised the Government's commitment to ensuring 'the earliest possible passage of the Child Care Bill'.

Introduction

The purpose of this paper is to provide a guide to the 1988 Child Care Bill and by extension to the current state of thinking and legislation on child care in Ireland. The style adopted is one which combines information on the Bill itself with commentary and analysis. The intention is to clarify the implications of the various provisions of the Bill for health boards in the delivery and development of their child care services.

The 1988 Bill has now lapsed due to the 1989 general election but it is probable that any new Child Care Bill will be very similar in content to the 1988 Bill. Indeed, in spite of some significant differences, there were many similarities between the 1988 Bill and the Coalition Government's 1983 Children (Care and Protection) Bill, which also lapsed with the demise of the Dail.

Many of the comments made below will probably apply also to any future legislative initiative in the child care area. An additional briefing paper on such legislation will be circulated at the time by the IPA's Health Services Resource Centre.

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1. BACKGROUND TO THE PROBLEM OF FAMILY BREAKDOWN AND INCREASES IN THE NUMBER OF CHILDREN AT RISK.

Ireland's relatively rapid industrialisation in the early 1960s brought in its wake equally radical social change particularly in family formation patterns and in the values and beliefs pertaining to marriage and family life. The most objective indicators of these changes are the demographic data over the period 1960-1986. A brief review of this data is a useful reminder of the major structural changes which have taken place and also helps to identify the factors which account for the vulnerability of the family in modern Irish society.

The rapid growth in population which occurred in the mid 1960s was largely due to an increase in the marriage rate and a very substantial reduction in the age of marriages for both males and females. Early marriages and more marriages were facilitated by economic growth and job creation. On the negative side, rapid urbanisation and increased social and geographical mobility brought about a weakening of kinship ties and increased the isolation of the family. This problem was in many instances compounded by the decision of many local authorities to give priority (understandably in the context of rapid population growth) to house building at the expense of more thoughtful planning of population mix and amenities for the new estates. What emerged in many urban areas in consequence were single cohort housing estates populated by young married couples with young children and few social support networks or adequate community facilities. The growth in unemployment in the intervening period has added to the vulnerability of such families and intensified the risk of family breakdown. The number of child dependants of unemployment payment recipients has risen substantially in the recent period: in 1986 there were 235,000 child dependants - a growth of 45%

since 1981 (McCashin, 1988, p.17). One fifth of the children of the state are in fact dependants of unemployment payment recipients. The link between family breakdown and poverty and unemployment is now well established (ESRI 1988 O'Higgins and Boyle).

The increasing incidence of marital breakdown and the growth in illegitimacy rates over the last few decades have resulted in family units which are more vulnerable to breakdown. In the period 1981-1986 the number of lone parent households increased by 16% in comparison with a 7% increase for all households. Lone parent families now account for 10% of all households (Blackwell 1988). Children in these households have a disproportionately higher risk of ending up in care given that about 40% of children placed in care are there because they were being cared for by one parent who is unable to cope (Relate Vol. No.9 June 1985). The reasons why these children are at greater risk may be related to their equally high risk of poverty as the recent ESRI research has demonstrated. Callan and Nolan identified sub groups within the Irish population who are particularly at risk. Among those groups they referred to were:

> "Households consisting solely of a woman with children: almost all households with a single adult plus children comprise a woman with children, and at the 50% line their risk of being in poverty is 66%. For most of these at low incomes the woman is aged under 35, and most are deserted/separated wives or single mothers rather than widows" (Callan & Nolan 1988).

The fact that the typical reason given for these children being taken into care is 'parents unable to cope' further suggests that the material circumstances of such families may be the major underlying cause of breakdown.

2. INTRODUCTION TO 1988 CHILD CARE BILL

The last government introduced the Children (Care and Protection) Bill but it was never enacted. Certain provisions of the 1985 Bill proved to be particularly controversial and raised doubts about the constitutionality of certain aspects of the Bill. In introducing the 1988 Bill to the Dail, the Minister for Health said that a recent Supreme Court case cast doubt on two proposed provisions of the 1985 Bill - the proposal to make it easier for children to be placed in health board care and the provisions which would have allowed the courts to grant custody rights to foster parents.

The overall approach to child care policy underpinning the 1988 Bill is different in some respects to that of the 1985 Bill. When introducing the 1985 Bill, the Minister for Health outlined the three basic principles on which it was based. These were:

(1) that the best place for a child to grow up is in his family, but where this is not possible, in a substitute family

(2) that there should be the minimum intervention in the lives of children and their families. The state and its agencies should only intervene where there are compelling reasons for doing so in the child's interests and where intervention is necessary, the rights of parents and guardians must be safeguarded

(3) that children have rights and these may sometimes conflict with the rights of parents. In cases of conflict, the child's rights are to be regarded as paramount.

The third point above, more so than either 1 or 2, provided the key to the orientation of the 1985 Bill. Children's rights in certain circumstances were to take precedence over the rights of their parents and following on from this the duties and responsibilities of health boards were to be strengthened to make it easier for them to intervene and take a child at risk into care. In fact, the provision of the 1985 Bill which gave greater recognition to the rights of children as individuals, also explains Mr. Desmond's admission in the Dail that his Bill was probably in conflict with the Constitution which gives priority to parental rights.

The Minister for Health, when introducing the 1988 Bill in the Dail strongly emphasised the role and rights of families but was more cautious on the question of children's rights as individuals. He said:

> "while the state and its agencies must have the power and resources to protect those children whose health or well being is in jeopardy, it is equally important to protect children and families from unwarranted or excessive interference. I would see children being taken into care against the wishes of their parents only in exceptional cases where, for example, they have been ill treated or sexually abused or where there are compelling reasons why their welfare demands that they be removed from their family. The bill has been drafted on this basis ...."

The 1988 Bill, unlike its predecessor, does not allow children suspected of being at risk, to be taken into care. In fact the 1988 Bill gives much stronger recognition to parental rights by making it much more difficult for health boards to take children into care.

3. MAIN PROVISIONS OF THE 1988 CHILD CARE BILL

The 1988 Child Care Bill was, in part, a response to the deliberations of the 1980 Task Force report on Child Care, which called for a new comprehensive children's act covering the following matters:

(i) the designation of health boards as child care authorities in the provision of services for deprived children

(ii) safeguarding the interests and promoting the welfare of children, particularly deprived children

(iii) reform of the juvenile justice system

(iv) the provision of ministerial powers to make appropriate regulations in relation to service provision

However, as far back as 1970 there was a growing concern, particularly among professionals and experts in child care, about the needs of deprived children and the adequacy of the statutory services response to these needs. The Kennedy Report (1970) also highlighted the need for comprehensive legislation in the whole area of child care. The slow pace of change since then, in this important area of policy, must in itself be a cause for concern especially when one considers that the 1908 Children's Act is the last major piece of legislation in this crucial area of public policy.

The purpose of the 1988 Bill is to update the law in relation to the care of children, particularly children who have been assaulted, ill treated, seriously neglected

or sexually abused or who are at risk.
The main provisions of the Bill are:-

(1) the health boards will have a statutory duty to promote the welfare of children who are not receiving adequate care and attention

(2) the health boards' powers to provide child care and family support services will be strengthened

(3) there will be improved procedures to enable health boards and the Gardai to intervene where children are in serious danger

(4) the procedures for placing children in care by the courts will be changed

(5) there will be arrangements for the inspection and supervision of pre-schools

(6) the provisions relating to the inspection and appraisal of residential centres for children will be changed.

Who is the child?

For the purposes of the Bill a "child" is defined as any person up to 18 years (other than a married person). This means that children may be placed in health board care up to the age of 18 if unmarried.

3.1 Functions and responsibilities of health boards

The Bill states that it is the function of every health board to promote the welfare of children in its area who are not receiving adequate care. In operational terms the

Bill requires a health board to:-

- identify children who are not receiving adequate care and protection

- be mindful of the principle that it is generally in the best interests of a child to be brought up in his own family. In this section reference is also made to the rights and duties of parents under the Constitution

- provide health care and family support services and provide and maintain premises and make such other provision as it considers necessary

- insofar as it is practicable, before making a decision or taking action in relation to a child, give consideration to the wishes of the child while taking account of his age and maturity.

Comment:

In reply to a query about support services, Mr. Leyden, Minister of State at the Department of Health, clarified the reference in the Bill to support services as follows:

> "The boards will be required to provide child care and family support services, such as social work support for families at risk, counselling services, child guidance, day fostering, family resource centres and out reach projects for the young homeless".

The financial implications of developing an appropriate infrastructure of support services at health board level is an issue which merits further attention. Some additional resources are to be made available but it is

unclear at this stage how this money will be used. There is however little doubt but that the Bill's provisions, relating to support services in particular, will have significant resource implications.

In relation to the personal social services provided by health boards for children and families, the 1987 NESC review of community care services, had this to say:

> "The development of these services is uneven and no community care area has a comprehensive range of services. This is associated with a pattern of piecemeal development in response to immediate need, rather than a planned development based on the range of services needed in individual areas" (p 119).

The inadequacy of existing services, NESC also point out, is largely due to the limitation of resources.

3.2 Voluntary Care

Health boards will be obliged to provide care for a child who resides in its area and who is unlikely to receive the care and protection he needs. This section however stipulates that the wishes of the parents of such a child/children or any person acting in loco parentis will be paramount, and therefore care in these circumstances will mean voluntary care i.e. with the consent of parents or guardians.

The above provision was designed especially to cater for orphans and abandoned children and for children whose parents agree to their being taken into care because they are unable to cope due to illness or family problems. When such a child is taken into care the health board will be

obliged to maintain that child for as long as his welfare requires it. (Currently about 80% of children in care are there on a voluntary basis).

3.3 Child Care Advisory Committees

Health boards will be obliged to establish Child Care Advisory Committees to advise on the performance of their functions. These committees will be composed of representatives of voluntary bodies providing child care and family support services and persons with a special expertise or interest in child care. The minister may also have a say in the composition of these committees. Under the act, health boards will be required to "consider and have regard to any advice" from the Child Care Committees.

Comment:

The establishment of locally based Child Care Committees will facilitate much better coordination of service provision by bringing together statutory and voluntary service providers. The Committees will also provide a useful source of expert advice and support to health board child care professionals. The Child Care Committees are not however a substitute for a National Children's Council, the establishment of which was recommended by CARE, the Kennedy Report and the Task Force Report on Child Care (1988). A National Children's Council, it was envisaged, would act as a lobby on behalf of deprived children and would provide an expert input into the policy process at national level. However Child Care Committees will nonetheless be in a position to highlight issues relating to the implementation of policy and may in this respect provide important feedback on policy implementation at local level.

3.4 Review of Services

Health boards will be required as soon as the Bill is enacted, to produce a report on the adequacy of the family support and child care services in their areas. In the preparation of the review, health boards will be obliged to assess the needs of:

(a) children whose parents are dead or missing.

(b) children whose parents have deserted or abandoned them.

(c) children who are at risk of being neglected or ill treated.

(d) children whose parents are unable to care for them due to ill health or for any other reasons.

The Bill also obliges health boards to consult with their Child Care Committees and seek the views of voluntary bodies who are providing child care and family support services.

Comment:

It is unclear from the Bill how health boards are to assess the needs of children in categories (c) and (d). If this information is to be based only on existing information on the numbers of such children in health board care or under the supervision of health board child care professionals, then there is a danger that service needs will be seriously underestimated as unmet need in the community will not be assessed. Close cooperation with voluntary organisations

who are also working with families and children will however help improve the accuracy of the assessment but may not, in the absence of some additional research reveal the real extent of unmet need in the community.

3.5 Provision of Services by Voluntary Bodies or Other Persons

The Bill enables health boards to involve voluntary organisations or other persons in the provision of child care and family support services. Assistance towards the provision of services by voluntary bodies and other persons may be by way of grants, periodic funding or assistance in kind.

Comment:

This section of the Bill will strengthen the relationship between the voluntary sector and health boards. It is also a recognition of the importance of nurturing community support networks and will facilitate a more flexible approach to service provision in this important area of policy. This section at the same time emphasises the statutory duties and responsibilities of health boards.

3.6 Place of Safety

The new 'Place of Safety' provisions are much more restrictive than those contained in the 1985 Bill. The 1985 Bill included a provision whereby a child could be taken into care 'if he is receiving inadequate care such as to cause or be likely to cause him physical or mental suffering or impair substantially his proper development' 33 (2). This section of the Bill was seen as giving health boards unjustified powers of intervention and in the Dail it was argued that it was unconstitutional and would

seriously undermine the rights of parents.

The 1988 Bill enables a member of the Gardai to remove a child to a place of safety if he has reasonable cause to believe that:

"(a) a child has been assaulted, ill treated, neglected or sexually abused, and

(b) there is an immediate and serious risk to the health and well being of the child".

A Garda does not require a warrant to remove a child in such circumstances. The child may be kept in a place of safety pending the application for an emergency care order. This must be made as soon as possible and not later than 24 hours after the child was placed there.

The wording of the 1988 Bill is more mindful of the constitutional rights of parents, and this is underlined in legal terms by the use of the words <u>immediate</u> and <u>serious</u> in regard to the risk to the health of a child.

3.7 <u>Emergency Care Order</u>

A health board or any other person may apply for an emergency care order to a district justice. This order authorises the health board to keep a child in a place of safety for a period of 8 days. Any district justice may grant an emergency care order, an application for which can, if necessary, be made at night or at the weekend.

Health boards will be obliged to ensure that there are enough places of safety in children's residential centres or other suitable places for the purpose of emergency care orders.

Comment:

It is unlikely, given the restrictive nature of the provision relating to the application for an emergency care order, that there will be a significant increase in the number of children in emergency care.

This section of the Bill is very mindful of the rights of the parents and is likely to avoid any situation where doubt is likely to be cast on the grounds for the granting of a care order. It will also, in the spirit of the Task Force Report of 1980, ensure that only a very small minority of children will end up in care. The success of these provisions will depend very much upon the infrastructure of support services and personnel available in the community: but in general child care expert opinion would welcome the residual role envisaged here for emergency care. These comments are also applicable to the section on care proceedings which follows.

3.8 Care Proceedings

The grounds for an application for a care order are the same as those outlined above. The Bill obliges health boards to apply for a care or supervision order if these conditions exist. At present the health boards are not required to apply for Fit Person Orders and it has been suggested that in fact they have no legal authority to do so (even though in practice, they apply for and get them). Care orders will replace the present Fit Person Orders.

A care order may last for as long as the child remains a child or for what ever shorter period the court specifies. While the order is in operation, the health board will assume responsibility for the child or it may allow the child to be under the charge and control of a parent or

other suitable person.

When making a care order, a court may require parents to contribute to the cost of maintaining the child. The court may also make orders regarding access by parents or other persons to the child.

3.9 Supervision Orders

If the same conditions exist as in the case of a care order and it is thought desirable that the child be visited from time to time by or on behalf of the health board, the court may make a supervision order.

A supervision order will require the health board to have the child visited periodically in order to provide any necessary advice to the parents or guardians of the child as to his/her care. The court may also make an order requiring the parents of the child to take him for treatment to a hospital, clinic or other place specified by the court.

Persons who fail to comply with the terms of a supervision order or who try to prevent an authorised person visiting a child on behalf of a health board will be guilty of an offence and will be liable on conviction to a fine of not more than £250. Supervision orders will apply for a 12 month period but a health board may apply to the court for an extension of an order.

Comment:

The imposition of fines may prove counterproductive if they work against efforts by child care workers to rehabilitate and support parents. This is a view which was expressed by social workers when the 1985 Bill was

published, though in fact the fines were much higher and prison sentences were also to be imposed under the terms of the 1985 Bill. The 1988 Bill is less punitive in its approach.

3.10 Foster Care:

The 1985 Bill gave preference to foster care as the most appropriate form of care. This reflected the view of the Task Force Report (Minority and Majority); no such preference is expressed in the 1988 Bill.

The 1988 Bill will allow the Minister to make regulations in regard to foster care. These regulations may:

- fix the conditions under which children may be placed in foster care.

- prescribe the form of contract to be entered into between health boards and foster parents.

- provide for the supervision and visiting by the health board of children in foster care.
- provide for regular reviews of the case of each child in foster care.

The health board will have the power to remove a child from the custody of his foster parents at any time. Once a child is removed from the custody of foster parents the contract between the foster parents and the health board terminates. If foster parents refuse to hand over a child the board may apply to the district court for a custody order.

3.11 Residential Care

The Minister may also make regulations in regard to the placing of children in residential care (whether in approved children's residential centres or in other institutions). Regulations may cover the following:

(a) the conditions under which children may be placed in residential care,

(b) the contract between the health board and the residential centre

(c) the supervision and visiting of children in care by the health board,

(d) the review of the care of each child in residential care, by health boards.

The Bill also enables the Minister to make regulations as to the conduct of residential centres. The regulations may cover the following aspects of care in residential centres:

- design, maintenance, repair, ventilation, heating and lighting of centres,

- equipment

- ratio of children to staff,

- record keeping.

Comment:

This provision may have staffing and resource implications if inspection and regulation become a routine part of the health board's duties. These new regulations, coupled with the power to withdraw approval for residential centres, are a welcome development and their very existence may help raise consciousness of the need to continually maintain and improve standards of care.

NESC in its 1987 report on Community Care Services highlighted some concern regarding the current provision of residential services. The report drew attention to the fact that it is now mostly children with special needs who are placed in residential care and therefore there will be greater need for staff training and support. They also mentioned the problem of an uneven geographical distribution of residential facilities and in the interests of ensuring easy access to residential centres this problem must be addressed. Finally they refer to the shortage of residential facilities.

3.12 Aftercare

This section enables a health board to continue if necessary, to assist a child who has been in its care.

beyond the age of 18 up to the age of 21 and beyond, if he is completing a course of education.
Assistance may take the form of visits, paying for training or education or arranging accommodation for him.

3.13 Pre School Services:

The Bill provides for the supervision and inspection of pre-schools, including play groups, day nurseries, or creches. The Minister for Health will have power to make regulations for the purposes of promoting the health, safety and development of children attending pre school services. These regulations may:

- set standards regarding the physical conditions including: heating, lighting, ventilation, cleanliness, repair and maintenance of premises and equipment.

- provide for the enforcement of the regulations by health boards.

- set annual fees payable to health boards by providers of pre-school services to cover the cost of inspection.

This section also requires persons providing pre-school services to advise health boards of their service.

Health Boards will be obliged to visit all pre-school facilities in its area to ensure that the regulations are being complied with.

The Bill enables health boards to provide pre-school services themselves. They will also be obliged to provide information on pre-school services in their areas whether

provided by the board or otherwise.

Comment:

The increase in the labour force participation rate of married women from 7.3% in 1972 to 23.4% in 1988 with an even more marked increase in participation rates for younger married women would suggest a growing demand for and use of pre-school services in Ireland today. In line with other European societies, it is appropriate that the state take some responsibility for ensuring that minimum standards are met. The introduction of regulations and fees may however inadvertently increase the cost of pre-school services for many parents and this may force women to involuntarily withdraw from the labour force. The provision of more pre- school services by health boards may however offset this trend and facilitate greater choice for lower income families.

It is important to note that this provision is likely to have serious resource implications for health boards as section 36 (e) clearly provides for the enforcement and execution of the regulations by health boards.

3.14 Other Provisions

The Bill will abolish the death sentence for crimes committed by persons under eighteen years of age.

The sale or provision of solvent to persons under eighteen years of age will be an offence. Fines of up to £1,000 or a prison sentence of up to 12 months or both may apply if someone is convicted under this section.

4. CONCLUDING REMARKS

Overall the 1988 Child Care Bill does strike a good balance between the objectives of rescuing children from physically and psychologically damaging situations and supporting families at risk, in their own homes and communities. The general orientation of the Bill would appear to be in line with modern expert opinion on what constitutes good child care practice. However the success of the Bill, on its own terms, will very much depend upon the extent to which resources will be made available to develop an appropriate infrastructure of child and family support services nationally. The inadequacy and uneven spread of the existing services has been highlighted by NESC, the Task Force Report, and many child care professionals. If substantial funds are not made available for the development of these services it will be impossible for health boards to support families and prevent family breakdown which is the role the Bill envisages for them. It is likely that any future legislative initiative in the child care area will also emphasise the role of the child care services in preventing family breakdown and the same issue of resources for support services is therefore bound to emerge as a major concern. It is difficult at this stage to speculate on the shape or form of a future child care Bill but it would seem likely that the present Bill, which appears to have been well received by many of those involved in child care, may well form the framework for future legislation.

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