CHAPTER 7

Anti-discriminatory and anti-oppressive practice with children and families

Objectives

After reading this chapter you should have a clearer understanding of the difference between anti-discriminatory practice and anti-oppressive practice as they apply to work with children and families. You will be introduced to a number of factors that may select certain children and young people for social disadvantage (for example, race, disability, use of drugs, HIV status, homelessness, sexual orientation). These will then be considered in relation to looked-after children, before a discussion of the issue of children's rights.

Anti-discriminatory and anti-oppressive practice

Issues of discrimination and oppression began to receive serious attention in social work from the mid-1980s (Ahmed, 1986, 1994; Dalrymple and

Burke, 1995; Owusu-Bempah, 1997; Thompson, 1997). According to Thompson (1997, p. 238), we are now 'much more aware of the need to see the individual in his or her social context', and 'to see that context in a fuller and richer sense than is traditionally the case in the social work literature'.

The term 'anti-discriminatory practice' is widely used in social-work training and practice to refer to attempts to reduce both 'individual and institutional discrimination, particularly on the grounds of race, gender, disability, social class and sexual orientation' (Thomas and Pierson, 1995, cited in Thompson, 1997, p. 238). Thompson (1997, p. 239) argues that a basic feature of anti-discriminatory practice is the ability/willingness to see that discrimination and oppression are so often central to the situations that social workers encounter. In his view, social workers must develop a sensitivity to the existence of discrimination and oppression all around them and recognise that there is no middle ground; they are either part of the solution or a part of the problem. The three 'key imperatives' of justice, equality and participation must be addressed, and traditional forms of social-work practice must be revisited and amended to ensure they are anti-discriminatory. The achievement of such practice begins with non-discriminatory practice and anti-oppressive assessment.

Dalrymple and Burke (1995, p. 3) argue that it is important to distinguish between anti-oppressive and anti-discriminatory practice, 'as all too often the terms are used interchangeably without thought being given to the impact of both terms'. For these authors, anti-oppressive practice is concerned with minimising the power differences in society. They quote Phillipson (1992) who considers that anti-oppressive practice 'works with a model of empowerment and liberation and requires a fundamental rethinking of values, institutions and relationships'. By contrast, 'legislation which deals with issues of discrimination – such as the Race Relations Act or the Sex Discrimination Act – is *specific* and aimed at addressing unfair treatment faced, for example, by black people or women. Anti-discriminatory practice uses particular legislation to *challenge* the discrimination faced by some groups of people' (Dalrymple and Burke, 1995, p. 3).

Whilst not denying the usefulness of anti-discriminatory practice, Dalrymple and Burke (1995, p. 3) feel it is limited in its 'potential to challenge power differentials'. Moreover, they believe that it is 'important for us to develop a practice which ultimately addresses structural inequalities'.

In what follows, we examine categories of children who have emerged as major concerns for child-welfare agencies. Some of these children belong to communities or groups who are victims of discrimination and oppression; some are the focus of moral panics, and are perceived as threats to moral and social order; others are variously perceived as both victims and threats.

Changing populations in child welfare

Black children

Children from black and ethnic minority communities in Britain are victims of the racism which permeates all levels of British society (Ahmed, 1994; Owusu-Bempah, 1997). Ahmed (1994) states: 'it is a fact that racism operates at an ideological, structural, systemic and interpersonal level within contemporary British society'. Ruxton (1996, p. 13) notes that an increase in xenophobia and racism has been widely reported across the European Union, 'leading to far greater fear and uncertainty among ethnic minority populations. In many cases children and their families have been repeatedly subjected to harassment and attacks.'

Although the proportion of people under 16 in the general population is comparatively low, the age structure of the various UK ethnic minorities varies considerably from the average. Around 3.2 million people, or roughly 6 per cent of the population, belong to an ethnic minority group, of whom 36 per cent are under 16 (NCH Action for Children, 1996, pp. 24–5). Table 7.1 shows the proportion of children under 16 belonging to each of the major ethnic groups. It can be seen that Pakistani or Bangladeshi families contain a particularly high proportion (45 per cent) of dependent children. This compares with 29 per cent for black and 21 per cent for white households.

Mean size of household also varies considerably between ethnic groups. As Table 7.2 shows, the mean size of households headed by someone of Pakistani or Bangladeshi origin is larger than in Indian households and twice that of white-headed households.

The incomes of some ethnic minority groups fall far below the national average and much of their population live in deprived areas. Black people in Britain experience disadvantage and deprivation through racism and

Table 7.1 *Children under 16 by ethnic group (per cent)*

Ethnic group	Per cent
White	21
Indian	30
Pakistani/Bangladeshi	45
Black	29
Remaining groups	42
All ethnic minorities	36
All	22

Source: NCH Action For Children (1996), p. 28.

Table 7.2 *Average household size by ethnic group of head of household*

Ethnic group	Number of persons
White	2.40
Indian	3.63
Pakistani/Bangladeshi	4.76
Black	2.59
Remaining groups	2.64
All ethnic minorities	3.22
All	2.44

Source: NCH Action For Children (1996), p. 27.

discrimination that permeate many areas of life. They are more likely than white people to be unemployed or low paid; their housing is likely to be overcrowded and lacking amenities. Access to public services, even access to schools in some areas, is more difficult for them. Infant mortality is much higher in certain ethnic groups than in the rest of the population, and some ethnic groups have their own special health problems such as sickle-cell anaemia and thalassaemia (Bradshaw, 1990).

In addition, disproportionate numbers of black children are looked after by local authorities, with less chance than white children of being reunited with their parents, and disproportionate numbers of black adolescents are in custodial establishments (Ahmed, 1994).

Traveller children

According to Dalrymple and Burke (1995, p. 110), the level of discrimination faced by travellers is so severe that 'they face insecurity and harsh living conditions and are denied access to social, educational and health services'. The Northern Gypsy Council views this as a consequence of 'the criminalisation of Gypsies through institutionalised racism'. Prior to the Children Act, travellers' contact with Social Services led to children being separated from their families and culture through the care system. The 1989 Act, however, 'offers the opportunity for practitioners to consider the context of the lives of travellers and to work with them from an anti-oppressive perspective to promote change and lessen the inequalities of their lives' (Dalrymple and Burke, 1995, p. 110).

Children with disabilities

Children with disabilities form another major group of children subjected to discrimination. The World Health Organisation defines disability as a

restriction or lack of ability to perform normal activities, resulting from an impairment to the structure or function of the body or mind (NCH Action for Children, 1996).

In the UK, the notion of social justice for people with disabilities has gained ground over recent years. In large part this reflects the growing influence of the Disability Rights Movement, which is increasingly led by disabled people themselves. Although it does not by any means go as far as many would have liked, NCH Action for Children views the Disability Discrimination Act 1995 as an important milestone in the recognition of rights for disabled people. Most of the provisions impact on adults, but those to improve access to transport and buildings will also benefit children. In addition, the Carers (Recognition and Services) Act 1995 gives carers the right to ask social services for an individual assessment of the caregiver's needs and their willingness and ability to continue providing care. The intention is that carers' needs should be recognised and that carers are not left to cope alone in very difficult and demanding circumstances. 'Carers' include those caring for a child with disabilities, and young people under 18 who provide care on a regular basis (NCH Action for Children, 1996).

Nevertheless, battles remain to be fought to ensure that the public resources required to make reality out of public rhetoric are forthcoming. While the inclusion of children with disabilities as 'children in need' under the Children Act may have helped to stimulate better provision, it is clear that service remains patchy and that families still routinely have to fight for help (Department of Health, 1994). Moreover, many disabled children are denied the educational services which are appropriate to their needs (NCH Action for Children, 1996). Ruxton (1996, pp. 10–11) reports that such children face 'considerable discrimination in all European Societies.... [This includes] ... lack of access to buildings, transport, health and social care, restrictive opportunities in relation to education, training and work, and stigma and abuse.'

Remarkably, Ruxton (1996) reports that it is not known how many disabled children there are in the EU population. The NCH Action for Children *Factfile 1996/97* reports that there are some 365,500 disabled children in the UK, which represents about 3 per cent of the population of children under the age of 16. Boys are more likely than girls to have a disability, and the most common form is a behavioural disability. Children over five are more likely than children under five to have a disability; this may in part be due to the identification of disabilities once a child starts school. Most children with disabilities are able to live in their communities; it was estimated that only 1.5 per cent were living in communal establishments.

Several studies have highlighted some of the problems and issues confronting children with disabilities and their families. These include a

national survey carried out by the Social Policy Research Unit of over 1,000 parents (Beresford, 1995). The survey explored the needs and circumstances of families caring for a severely disabled child. It found that severely disabled children of all ages are highly dependent on their parents to meet their basic care needs; older disabled children are likely to have social, communication and behavioural difficulties. One in two of the children studied were dependent on medical equipment. On average, household incomes are lower among families of children with disabilities; 90 per cent of lone parents in the study and over a third of two-parent families had no income other than benefits. Four out of ten of the families lived in unsuitable housing. Only half of those who took part in the survey described their relationships with professionals as positive and supportive. For parents, the most common unmet needs were for financial resources, help in planning for the child's future, and knowledge about available services. For the children, the most common unmet needs concerned their physical needs, learning skills, and someone to discuss their problems with. Families from ethnic minority groups, lone parents, and those caring for the most severely impaired children had particularly high levels of unmet need. They also tended to live in the poorest circumstances.

Children and HIV/AIDS

Notified cases of AIDS are increasing in all countries of the European Union. Annual rates of new cases are highest in France, Italy and Spain. At the end of 1994, the total number of AIDS cases diagnosed for the whole EU exceeded 120,000. Yet, because of the long incubation period, these figures reflect only a small part of the problem. Moreover, an estimated 560,000 people have been infected with HIV in the World Health Organisation European Region (which includes the EU and Central and Eastern Europe), 58,808 of whom have died (Ruxton, 1996).

By January 1996, there were 455 reports of HIV infection in children aged 14 or under in the United Kingdom. Some 94 per cent of these children were born to mothers infected with HIV, the majority of whom (75 per cent) were living in the Thames region of England. It has been estimated that, since 1979, a minimum of 857 children have been born to mothers with HIV infection, of whom 188 have developed AIDS (NCH Action for Children, 1996).

Roughly 85 per cent of children infected with HIV or AIDS have acquired the virus through vertical transmission from mother to child. It has been estimated that in around one in seven cases, transmission is from mother to baby during pregnancy. Some older children have been infected through blood products, others through unprotected sex and/or the sharing

of needles for injected drugs. There are also children who are not HIV positive, but live with family members who are infected (Ruxton, 1996).

Current policy and practice focuses on, first, the need to provide family-based rather than institutional care; secondly, developing a child-centred approach that recognises children's rights in relation to future care and treatment, and the right to attend school without disclosure of their HIV status. In addition, preventative measures in schools attempt to dispel myths and educate teachers, pupils and parents. Efforts are also being made to ensure that HIV prevention is a key part of health-education programmes (Ruxton, 1996).

Children and drugs

Illegal drugs are a growing problem across Europe. As many as 1 million people are estimated to use illegal drugs in the European Union. Seizures of heroin in the EU increased from 1.9 tonnes in 1987 to 5.2 tonnes in 1992, with cocaine seizures rising from 3.5 to 17 tonnes (Ruxton, 1996). Over a ten-year period from 1984 to 1994, the number of drug seizures in the United Kingdom rose from 28,560 to 108,000. Cannabis was involved in the majority of such seizures, accounting for 82 per cent in 1994 (NCH Action for Children, 1996). Alongside established drugs such as cannabis and amphetamines, there has been a recent rise in the use of Ecstasy and LSD in Britain.

Crime, including burglary and prostitution, may be a means to meet the cost of addiction. For example, Ruxton (1996) reported that property crime in Amsterdam was two or three times higher than in cities which did not share the increase in problematic opiate users. In Italy, there has been a significant increase in the numbers committed to institutions for drug-related offences. In cities such as Palermo and Naples, many children and their families are deeply embroiled in the drugs trade.

There is a paucity of reliable data on drug misuse by children. In part, this is because drug research among children frequently depends on self-reporting with all its associated problems. Despite such difficulties with data-collection methods, we do have some idea about drug misuse in children and young people in the United Kingdom. Current patterns of drug misuse in children include the use of a wide range of drugs in the younger age group, the narrowing of the gender gap, the emergence of polydrug use (the use of more than one drug at the same time) as the norm, and a decrease in the age of initiation.

In 1994, around 2 per cent of school pupils aged 11 to 12 reported taking illegal drugs or misusing solvents. The figure increases with age to 6 per cent of 12–13-year-olds, 13 per cent of 13–14-year-olds, 25 per cent of

14–15-year-olds, and 33 per cent of youngsters aged 15–16 years (NCH Action For Children, 1996).

An international comparative study appears to show that England and Wales have relatively more drug use among young people than the Netherlands, Spain and Portugal. Around one in four young people aged 14–21 in England and Wales admitted taking and/or selling drugs (Junger-Tas et al., 1994). The campaign to legalise cannabis in the UK, in line with the more liberal approach adopted in the Netherlands, has failed to find favour with any of the major political parties.

The rise in the use of illegal drugs such as cannabis, amphetamines, opiates, cocaine, and hallucinogens has been paralleled by an increase in volatile-substance abuse (VSA). 'Glue-sniffing' became popular among some young people in the mid-1970s. Since then, there has been a rise in the number of different substances inhaled to produce a 'high'. These include glues, gas-fuels, aerosols and other volatile substances. Estimates of the numbers of those involved in VSA vary between 3 per cent and 11 per cent. Between 1971 and 1993, some 921 young people died as a result of VSA (NCH Action For Children, 1996).

Teenage parents

The fertility rate among women under 20 in the United Kingdom has increased slightly over the 1990s, whereas in other European countries it has fallen. Indeed, the UK has the highest fertility rate among young women in the EU, followed by Austria, Portugal and Greece. In 1992, some 3 per cent of all 15–19-year-olds in the UK gave birth, which was five times as many as in the Netherlands (Ruxton, 1996).

The main factors contributing to the low birth rate among young women in the Netherlands are cultural openness about sexuality, successful campaigns in the popular media, widespread sex education, free contraceptive services and contraceptives, and easy access to confidential family-planning services, all of which have been underpinned by strong government support. This approach has not led to earlier sexual activity, as evidenced by the fact that the median age at first experience of intercourse is 17 in both the UK and the Netherlands. Rather, the difference between the two countries in pregnancy rates for 15–19-year-olds seems to reflect that in the Netherlands sex education is more effective and social attitudes are more open towards sexual behaviour than in the UK (Ruxton, 1996). An additional factor may be that services, such as housing, provided in the UK to single mothers with children, make pregnancy attractive to young women who see no other way to access desired services.

Runaway and homeless young people

Although homelessness among young people became a prominent issue for child-welfare agencies during the 1980s and 1990s, there is no reliable comparative data on the numbers affected across the EU. However, it seems that the problem is increasing both in the poorer regions of southern states such as Italy and Portugal, and in the large cities of northern states such as Germany and the UK (Ruxton, 1996).

In the absence of official statistics, our understanding of youth homelessness in the UK is based on research undertaken by voluntary agencies and academics. This research was summarised by NCH Action for Children (1996), who found that in 1994, it was estimated that there were over 100,000 single homeless people aged 16–24. Also, over 2,000 young people, some as young as nine, called Childline in 1994/5 because they had nowhere to stay: 34 per cent had fled from sexual or physical abuse and 33 per cent had been thrown out by their parents; 8 per cent of youngsters who rang Childline in one month because they had nowhere to stay had fled from foster or residential care. Many had done so to escape violence and bullying. Giddens (1989) reports that many runaway children turn to prostitution to live.

As mentioned earlier, local authorities in England and Wales have a duty under the Children Act 1989 to provide appropriate services for 'children in need'. Whilst the 1989 Act offers no definition as to who should be considered as children in need, campaigners against homelessness argue that homeless 16- and 17-year-olds are children in need and, as such, should be entitled to housing. However, research shows that social services departments are generally failing to fully implement the 1989 Act for homeless 16- and 17-year-olds, owing, in large part, to a lack of the requisite financial resources (NCH Action for Children, 1996).

Young lesbians and gay men

Recent years have seen the growth of knowledge about issues relating to sexuality and social work. The impetus for this has been twofold: first, recognition that sexuality is a defining characteristic for any person and, as such, has significance for social-work practice; secondly, the raising of the profile of child protection, particularly the 'discovery' of the sexual abuse of children both within families and in the care system itself (Lloyd, 1997).

In addition, there is increasing awareness of the difficulties faced by young lesbians and gay men looked after by social care agencies. Dalrymple and Burke (1995, p. 111) note that the reality of life for such young people

is that it is thought that:

- being lesbian or gay is wrong and they should be referred for treatment;
- they have to prove that they are 'really gay';
- those adults who are sympathetic find it difficult to support young lesbian or gay people as they are afraid of being labelled themselves.

Although the problem is most acute in faith-based voluntary agencies, both statutory and voluntary societies have so far failed to address the problem. Dalrymple and Burke (1995) argue that the task of service providers is hindered by discriminatory legislation. However, the guidance accompanying the Children Act 1989 does recognise that 'gay young men and women may require very sympathetic carers to enable them to accept their sexuality and to develop their own self esteem' (Department of Health, 1991c, para. 9.53). Dalrymple and Burke (1995, p. 111) consider that practitioners and carers must make use of such positive elements of legislation to combat discrimination against young lesbians and gay men. They must 'discuss sexuality with young people, ensure that their wishes and feelings are heard and that decisions are made in their best interests'.

Anti-discriminatory and anti-oppressive practice with looked-after children

In contemplating current challenges in looking after children, the ongoing struggle to forge anti-discriminatory and anti-oppressive approaches to practice should be high on everybody's list. Ahmed (1994) acknowledges that the Children Act 1989 marked a significant political shift in child-care legislation in that Section 22(5) places a new duty on local authorities to give due consideration to three important factors: a child's race, ethnic and linguistic background. A fourth factor, religion, had been part of child-care law for many years. However, Ahmed (1994, pp. 123–4) argues that the multiculturalism which underpins Section 22(5) of the 1989 Act presents the following three 'theoretical and practice challenges which have to be confronted'. First, multiculturalism lacks a power analysis; other cultures are seen as valuable and interesting but, crucially, racism is either ignored or minimised as the personal prejudices of an ignorant, misguided and intolerant few. Secondly, multiculturalism has been 'perverted by the arguments of the new right into a new form of racism, by converting cultural diversity into a deterministic theory of race'. Thirdly, it defines minority ethnic groups as being internally unified homogeneous entities with no class or gender differences or conflicts. Thus, it has done a disservice to black women's interests because black women must often deal with a

number of factors: for example, to counter the traditionalism which often lowers their status, they must deal with traditionalists within black communities as well as the racism of the dominant group, which permeates all spectrums of British society, Right and Left.

A central issue of concern for anti-racist social work is the number of black children in care. In their large-scale survey of over 9,000 placement starts and endings in six authorities, Rowe et al. (1989) found children of colour were over-represented in admissions to care; but the extent to which this occurred varied considerably between black and ethnic minority groups. For example, Asian children were under-represented in all age groups. By contrast, African and Afro-Caribbean children were over-represented. This applied with particular force in relation to the pre-school and 5 to 10 age groups, where admission rates were more than double those of white children. Yet the most striking finding on the numbers of black and ethnic minority children looked after by local authorities concerns children of mixed racial parentage. Bebbington and Miles (1989) estimated that such children were two and a half times as likely to be looked after than white children. They found a very high admission rate for children of mixed parentage in all age groups, but particularly among pre-schoolers. The latter were also the most likely to have multiple admissions.

However, it should be noted that other research studies cited in *Patterns and Outcomes* have found black boys are less likely to be fostered than whites. Studies also found that being of mixed parentage is more likely to be associated with placement breakdown (Department of Health, 1991d). In other European countries, it has been reported that one in ten children in residential care in Germany are 'foreign', and that the figure for the Netherlands is around 20 per cent (Ruxton, 1996).

Patterns and Outcomes also highlighted the need for ethnic record keeping:

> If departments do not even know how many children from black and minority ethnic groups they are looking after, or their cultural and linguistic background, it is most unlikely that they will be able to provide appropriately for them. ... There are still no national and few local authority figures on ethnicity. (Department of Health, 1991d, p. 14)

Ahmed (1986, p. 100) acknowledges that establishing systems of 'record keeping that includes ethnic origins of the clients arouses misgivings and confusion in many people'. However, he argues that such systems are essential because

> guesswork needs to be replaced with more reliable data. These data are needed to formulate policies that reflect equal opportunities for all

groups regardless of their ethnic origins. Data are also needed to monitor the implementation of equal opportunities policies.

Patterns and Outcomes laments that none of the research studies summarised 'offers data on the dominant issue of whether children must always be placed with families of the same racial background' (Department of Health, 1991d, p. 14). The question of same-race placements has also been prominent with regard to residential care. Coombe (1986) looks at how the special needs of black children could be met within a white establishment, but notes that discussion is required as to where and by whom their needs are best met. It is the belief of many in the black community that black children are best catered for by their own communities. Coombe (1986, p. 147) further argues that:

> It is imperative that social workers, when working with black clients, take note of the position in which black people find themselves. In a society where they are treated as second-class citizens, black youngsters more than ever need the support of their parents and peers. The personal conflict a black child may have about being in a white-run establishment or foster home is often denied; but such children need help to come to terms with their position, and this area of work needs to be developed.

Some progress has been made in recruiting black foster parents and residential staff during the 1990s. However, greater commitment to such recruitment efforts is required across the European Union. A survey of European organisations by the European Forum for Child Welfare in 1993 showed that relatively few children from ethnic minority groups are placed in families of the same ethnic origin. This is despite the fact that in some countries such children constitute the largest part of those entering the care system (Gambe et al., 1992; Ruxton, 1996).

Ruxton (1996, p. 343) calls for research to be undertaken in all member states of the European Union into the extent of, and reasons for, 'differential rates of admission to care from different minority ethnic groups'. He further suggests that 'residential and foster care staff should be deliberately recruited from all ethnic and religious groups represented within the [EU] and training be provided on the implications of a child's cultural background for planning and provision of services'.

More recently, Owusu-Bempah (1997, pp. 50–5) questions programmes designed to improve the self-identity of black children in care. It is argued, somewhat controversially that such programmes are inherently racist and characterised as 'sheer victim blaming'. It is ironic that some advocate them as 'a necessary anti-racist strategy for social work'. Owusu-Bempah accepts

that 'black social service users suffer discrimination on the grounds of "race"', but argues that racism damages black children's life chances rather than their self-worth. Whilst acknowledging that this 'is likely to affect their psychological functioning', the author argues that 'our efforts should be directed towards improving [black] children's life chances rather than their self-concept'.

If nothing else, this is sufficient to indicate that, as with most areas of theory and practice, anti-racist social work is a contested perspective.

Children's rights

We have examined aspects of childhood that might make children and their families vulnerable to discrimination, but we have not yet considered the extent to which children face discrimination simply by virtue of being young. In recent years much greater emphasis has been placed on the rights of children. A watershed decision in children's rights in the UK was the well-known Gillick case (*Gillick* v. *West Norfolk AHA* [1985] All ER 402). As a result of a challenge by a mother (Victoria Gillick) of her child's hypothetical ability to seek medical treatment without parental consent, the case went ultimately to the House of Lords, the highest appeal court in Britain. Although specifically about the issue of doctors prescribing contraception to under-16-year-olds without parental consent, the judgment had profound implications for consent to treatment more generally and for children's rights in relation to their parents. As a result of the judgment, several principles were firmly established. For example, Lord Fraser observed that it was not realistic to consider that a child or young person 'remains in fact under the complete control of his parents until he attains the definite age of majority, now 18 in the United Kingdom, and that on attaining that age he suddenly acquires independence'. He noted as well that the child's understanding and intelligence were important considerations. Lord Scarman noted that

> parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child. ... The underlying principle of the law ... is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.

Lord Denning described the rights of parents in relation to their children as a 'dwindling right', which 'starts with a right of control and ends with little more than advice'. These principles played an important role in the thinking behind the Children Act 1989.

Hendrick (1994, p. 283) observes that the question of 'family regulation in the liberal state only occasionally attends to children's rights *within* the family'. He argues that Parliament's decision to shift child-care legislation towards 'the family' endangers children's rights because it removes the child from the centre of child-protection policy and places it within a rather spurious domesticity. We have seen a similar shifting of focus in the education reforms, where views of the parents as consumers of the service, with increased rights of choice, and access to information about school performances ('league tables'), were taken on board as part of the political ideology. In the debates, however, there was little consideration given to the children and young people as the ultimate consumers of the education service provided. Whether of Left or Right, family-autonomy theorists of the 1980s reformulated children's rights in terms of a parental right to freedom from state supervision, based on the view that children have a right to develop and maintain unrestricted psychological ties with their parents. This is more a political theory about the correct relationship between families and the state rather than a genuine theory of children's rights. Hendrick (1994) quotes Dingwall and Eekelaar, who argue that it is impossible to 'escape from the fact that the recognition of children's interests necessarily entails the abridgement of family autonomy'. Hendrick concludes that because the 1989 Act 'rarely falls in this direction, it has little interest in furthering children's rights'.

Eekelaar and Dingwall (1990, p. 23) report that the official documents leading up to the 1989 Act said little about children's rights, despite the fact that this was a major issue among those seeking reform. The concept of children's rights was used in two ways. First, it connoted 'a general aspiration to improve the conditions of children not just in this country but throughout the world'. This aspiration is reflected in the movement that resulted in the United Nations Convention on the Rights of the Child 1989 (see Franklin, 1995; Ruxton, 1996; Newell, 1991). The UN Convention and European Charter on children's rights catalogue entitlements that represent political programmes expressing certain ideals of social justice.

The second, narrower, interpretation of the concept of children's rights distinguished by Eekelaar and Dingwall (1990, p. 23) concerns the degree to which children are recognised as having some degree of personal autonomy. For example, 'How far can a child resist a course of action that an adult (usually a parent) wishes to impose, and determine for him or herself what should happen?' According to Eekelaar and Dingwall (1990, p. 23), the 1989 Act virtually ignores such questions. To be sure, it does state that, in certain contexts, courts or welfare agencies must consider the wishes and feelings of the children concerned. Further, special provisions have been enacted allowing children 'in some circumstances to refuse to undergo medical examination'. Aside from that, however, it would appear that the decision-makers' views will usually outweigh those of the child if there is a disagreement.

Lyon and Parton (1995, p. 53) acknowledge that the 1989 Act does seem to take children's rights more seriously than previous legislation, and provides 'new opportunities for advancing the wishes, autonomy and independent actions of children and young people'. However, they argue that the Act does this in a very qualified way. The Act is highly legalistic both in the way it is framed and in the way mechanisms for addressing the central balances are operationalised. In addition, developments and legal cases since the Act came into force in October 1991 show how this is played out in practice:

> The articulation of children's rights, rather than constituting children and young persons as subjects has provided a new set of strategies and mechanisms for using the voices of children as elements in the newly constituted government of families. Rather than subjects in their own right, children have become reconstituted as legal – as opposed to welfare – objects for the purpose of governing families at a distance.
>
> (Lyon and Parton, 1995, p. 53)

The UN Convention on the Rights of the Child was formally adopted in November 1989 and has been ratified by 186 countries. By ratifying, a government signifies its intention to comply with the provisions in the Convention, and must make regular reports on its progress towards implementation to the UN Committee on the Rights of the Child. All member states of the European Union have ratified the Convention. Thus, the Convention forms a common framework of commitment to children's rights which can and should underpin the development of law, policy and practice throughout EU states.

The Convention makes it clear that children should no longer be viewed as the property of their parents, nor as objects of concern to be seen but not heard. Under the Convention, the 'best interests' of the child should be a primary consideration in all legislation and policy concerning children. The Convention sets minimum standards regarding children's civil, political, economic, social and cultural rights. These standards can be grouped into the following three major categories:

1. **Provision** – children's rights to minimum standards of health, education, social security, physical care, family life, play, recreation, culture and leisure, and adequate standards of living.

2. **Protection** – children's rights to be safe from discrimination, physical abuse, exploitation, substance abuse, injustice, and conflict.
3. **Participation** – children's rights to a name and identity, to be consulted and taken account of, to access to information, to freedom of speech and opinion, and to challenge decisions made on their behalf.

Key articles of the UN Convention include rights to freedom from discrimination (Article 2), to express views freely on all matters affecting the child (Article 12), to freedom of expression (Article 13), thought (Article 14) and association (Article 15).

Ruxton (1996, p. 22) considers that the Convention is 'a highly significant document in that it provides a comprehensive framework within which to examine the impact of all legislation, policy and practice relating to children's rights'. However, he adds that a 'key challenge for the UN Committee is ... to establish clear interpretations of each of the articles in the Convention so that legislation and policy develop coherently'.

The European Union Charter on the Rights of the Child 1990 seeks to promote the adoption of the UN Convention in a way that is appropriate to Europe's legal, economic and demographic situation (see Ruxton, 1996). In January 1996, the Council of Europe's Parliamentary Assembly adopted a Strategy for Children 1996, which advocates measures to make children's rights a political priority in member states of the Council of Europe.

In practice, it seems that greater attempts have been made in Scandinavia than in other parts of the EU, including not least the United Kingdom, to address children's rights. However, the appointment of a Children's Commissioner for Wales, an action so far resisted in England, is likely to be a major step forward in the development of children's rights. Ruxton (1996, p. 18) argues that to meet the challenges of today's Europe – which include the single market and the removal of border controls – there needs to be 'competence' on children at the level of the European Union. This would accord the lives of children greater priority by allowing for improved information collecting about their circumstances, and wider consideration of the legislation, policies and practices that affect their lives. As a result, action could be taken based on the framework recommended in the Council of Europe's Strategy for Children. Thus, the rights and interests of children could be effectively represented throughout Europe in line with the UN Convention on the Rights of the Child.

The UN Convention on the Rights of the Child attempts to address the problem of discrimination against children simply on the grounds that they are young. In this chapter we have also looked at some specific groups of

children who suffer from discrimination and oppression: black children; traveller children; children with disabilities; children who live with HIV/AIDS; children who misuse drugs or whose families are involved in the drug trade; teenage parents; runaway and homeless children; and lesbian and gay children. We have seen that anti-racist social work is strewn about with thorns: interventions intended to be helpful such as trying to raise the self-esteem of black children may be seen as a denial of the reality that if black children were not discriminated against, their self-esteem would not be low. It is sometimes difficult for social workers trying to improve the lot of individual children and families to keep in mind that discrimination against the individual occurs in the context of institutionalised oppression. Power differences in society – the fuel driving the engine of oppression – occur because some groups of people are valued more highly than others: whites over blacks, men over women, heterosexuals over homosexuals, and so forth. Social workers cannot change this – or not immediately at any rate – but they can be aware of it, they can examine their own values in the light of it, and they can view their clients in a social context which includes organised oppression.

Now that we have examined some of the issues relating to discrimination and oppression and seen how those issues affect looked-after children, the next, and last, chapter will consider some final thoughts.

Case examples

Case example 7.1 Rifat's story

Rifat is the 32-year-old mother of three children: Amina (12), Ahmed (10) and Rashid (8). She is Muslim and her family originated from Pakistan. She was born in Britain, and grew up in a relatively well-to-do part of Cardiff. When she was 13 she was sent back to Pakistan in order for her adolescence not to be undermined by Western living, and a marriage was subsequently arranged. Although academically able, she was consequently not able to extend her education into secondary schooling. She and her husband returned to Cardiff before the birth of her first child. Soon after the birth, he began to be violent towards her. She never told anyone, either within the community (because of the stigma she felt she would attract) or outside the community, because she was afraid the children would be removed from her.

When her husband began to turn his aggression towards the youngest child, Rashid, she decided to leave him. Despite considerable community and family pressure to return to her husband, she maintained her separation. Because of an injury inflicted on Rashid, which was observed at

school, a child-protection conference was arranged. Between the time of the injury being reported, and the conference, the mother had left the family home, taking the three children with her.

Questions

1. Consider how racism may contribute to the difficulties being faced by the family at the point of referral to the social services department.
2. Consider how racist assumptions and/or practices may underlie an assessment of the family.
3. How can the social worker integrate anti-discriminatory practice into her intervention? Be specific. Consider what barriers or obstacles there might be.

Case example 7.2 Sharon's story

Sharon Jones (25), originally from the Welsh valleys, lives in Swansea with her husband Lee, and their two sons, Tyrone (20 months) and Kyle (10 months). It is a 'traditional' marriage; Lee controls the family finances, and gives Sharon some money every week to buy the food. She considers the amount insufficient, but he says that she needs to manage it better. He works in a furniture warehouse. He provides virtually no support to Sharon with the care of the children. He will not get up when Kyle is having a disturbed night, as he maintains he needs his sleep because of his work. Kyle had severe colic during his first thirteen weeks, and with the older child also making demands, Sharon felt almost unable to cope. Lee considers that she was making too much of it. On Saturdays Lee spends the whole of the day in the betting shop, and on Sunday he is in the pub until dinner. He takes little interest in how the children are developing. He expects Sharon to keep them quiet in the evenings so that his television viewing is not disturbed.

At a routine developmental check, Sharon raised her concern with the health visitor that Tyrone had an unusual gait ever since he had broken his leg and was admitted to hospital some months previously. She maintained that he had fallen from an armchair. The health visitor was also concerned about Kyle, whose pattern of weight gain and loss since birth, fluctuating at or below the third centile, suggested 'failure to thrive'. The health visitor referred both children to the paediatrician, who ascertained that Tyrone had a healed spiral fracture of the femur (causing his unusual gait). Because of the nature of the injury, both children were referred to the social services with a suggestion that a child-protection conference be convened.

Questions

1. Consider how the operation of sexism may contribute to Sharon's difficulties up until, and including, the point of referral to the social services department.
2. Consider how sexist assumptions may underlie an assessment of the family.
3. How can the social worker integrate anti-discriminatory practice into her intervention? Be specific. Consider what barriers or obstacles there might be.

Case example 7.3 Lorna's story

Lorna (14) is the last of three children born to Mr and Mrs Wates. Her older brother (Tim, 20) and sister Jane (19) have since left the home and live locally. Tim is working (as a trainee manager for a local supermarket) and Jane is at university studying psychology. Mr Wates left the family eight years ago when Lorna was 6 years old and emigrated to Canada, having virtually no contact with the three children other than cards at Christmas and birthdays. The divorce was finalised four years ago. A year after the divorce, Mrs Wates met Mr Hunt, and after a period of six months they were married. He moved in to live with Mrs Wates and the two girls. Tim was already living away from home.

Lorna was born with a congenital hearing difficulty (resulting in a severe degree of hearing impairment) and attends a special school for deaf pupils. It is a boarding school and she attends as a weekly boarder, coming home every weekend and during holidays. The school originally had a policy of teaching lip-reading, but recently began teaching Sign Supported English. Lorna has become quite proficient using it.

After a year of consultations and hospital outpatient appointments, Mrs Wates has been diagnosed as having multiple sclerosis. This has placed a great strain on the couple and on the family, but they are beginning to adjust to it.

Recently, as a school holiday period approached, Lorna confided in a school teacher that her stepfather had been doing things to her that she did not like, which to the teacher sounded sexual in nature. Lorna indicated that she had tried to tell people before, but either they did not understand or they did not believe her; she was not sure which. The teacher did not probe further, but referred the matter to the head, and the head referred it to social services. Arrangements were made for Lorna to go and stay with her grandmother during the school holiday period, whilst the matter was investigated further.

Questions

1. Consider how the operation of 'disablism' might influence the events leading up to the referral, either in relation to information above or more generally.
2. Consider the practical difficulties the social worker might encounter in undertaking a child-protection investigation.

Final thoughts

In the first chapter of this book, we looked at the origins and key elements of the Children Act 1989. We learned that the Act gives paramount consideration to the rights of children to be protected against abuse and to be brought up in a safe environment where their physical, psychological, social, spiritual and cultural needs can be met. Parents have responsibilities rather than rights: indeed, their major right under the Act is to be given assistance by the local authority to meet the needs of their children. Similarly, local authorities have a responsibility to facilitate parents bringing up their children, according to the philosophy that children are best looked after within the family. The local authority has the right to intervene with the family only in so far as is necessary to safeguard the welfare of the child, and even then the authority has a duty to enhance and support parental responsibility as far as possible.

This sounds appropriately child-centred. However, in practice, the emphasis still seems to be very much on child protection (protecting the child from abuse) rather than on family support (enhancing the child's welfare in a family context). Despite the fact that support for vulnerable families lies at the core of the Act, it is evident that much more work remains to be done to create an effective system of family support in England and Wales. Insufficient resources are devoted to the kind of preventive work with families that would avert the need for more serious and more costly interventions.

The pressures on vulnerable families have significantly increased over the last two decades. During that period, the extent of child poverty was allowed to increase threefold, despite the fact that it is a key factor precipitating crises within families. We have discussed poverty at some length in this book, noting that a proactive approach to child welfare is undermined in a society where there is an increasing gap between rich and poor. Poverty exists not just at an individual level but also across communities and entire regions. Many poor areas include large numbers of people from ethnic minority communities for whom the barriers of racism preclude an adequate education and well-paid work. Other communities have been marginalised because the industries that provided them with employment

have been relocated, cut in size, or closed. In the valleys of South Wales, for example, many young people depend on income support as their parents did before them. They have no work, few prospects, minimal education, and a great deal of 'leisure' time. Thus, it is hardly surprising that some of them smash things, assault each other; and bear children whose prospects are not much better and whose involvement with child-welfare agencies tends to be high.

Those who leave in search of work may then find themselves cut off from the support systems of family, friends and familiar neighbours, and thus obliged to try to bring up their children essentially alone. Increasingly, the network of extended family is too far flung to be of any practical assistance in the day-to-day tasks of child rearing and household management. As we learned in Chapter 1, there has been a dramatic rise in the proportion of lone-parent households over the last 30 years. More women (many of whom are lone parents) are working and in need of affordable, good quality child care. They are also often in need of emotional and practical support, which they will probably not get from their communities because the type of close-knit community where neighbours routinely support each is other fast disappearing. Overburdened and unsupported parents are among those most often seen on child-welfare caseloads.

As we have seen, the Children Act 1989 substantially enlarged local authorities' duties towards children in need and their families, but the necessary corresponding increase in resources was not provided. An effective family-support system requires a comprehensive approach embracing primary, secondary and tertiary prevention. With regard to the first of these, there is no substitute for action on the part of central government to combat social exclusion. Equally, action by government is essential to ensure that social-welfare personnel have the attitudes, skills and resources to enable them to carry out their duties in relation to the second and third levels of prevention. The organisation, structure and delivery of services must be conducive to the full implementation of Part III of the Children Act. Policy and practice must reflect the provisions contained in the Act, and the linguistic, cultural and ethnic diversity of England and Wales.

The current emphasis on protection on the part of local authorities owes a good deal to the fact that local authorities have been obliged to prioritise against a background of severe resource constraint, coupled with relentless, and often unfair, criticism in relation to child-abuse tragedies. From the point of view of individual social workers, the fact that they adopt a reactive rather than a proactive approach may be related to the increasing number and complexity of their cases. The natural response of an overburdened worker is to deal reactively with the crises first (child protection) rather than proactively working with other families to prevent their crises from

occurring (family support). Whatever the cause, studies (Gibbons et al., 1995; Farmer and Owen, 1995) have suggested that large numbers of children in need are inappropriately drawn into the child-protection system, and even then do not receive the services they require.

In effect, local authorities are undertaking a 'social policing' role, which tends to create antagonism between child-welfare workers and the families they serve. A formidable task confronting child-welfare workers, therefore, is to find ways to reduce this discord by positively redefining their relationships with vulnerable families and communities. One way is to develop practical intervention methods that draw on the strengths of communities, and identify the social-support systems of clients or service users from the latter's own perspective. In Chapter 4, for example, we mentioned network analysis and the now seemingly forgotten Barclay Report, which urged social workers to create, stimulate and support social networks among people in the community, and proposed the establishment of a 'community social-worker' role. Child-welfare workers cannot take on the task of building networks within communities at the meso- and macro-levels, but it might be possible for them, at the micro-level, to bring together service users with similar experiences into informal support groups, to link users with volunteers who have the necessary skills to help them solve problems, or even to focus on building and strengthening the user's existing social networks.

Child-welfare workers also face significant challenges in relation to children placed away from home. Indeed, at the time of writing, provision for such children is the greatest source of concern. Extensive research undertaken in the 1980s showed that the child-care system was failing badly when judged against the outcomes for children and young people. All aspects of their development were found to be more problematic than those of children cared for by their own families or adopted at a young age.

In response, the Department of Health sponsored the development of the Looking After Children (LAC) materials (see Chapter 6), which are designed to promote good parental care by identifying the experiences, concerns and expectations of children at different ages and stages together with the likely impact of different actions. In a nutshell, they introduce ideas about outcomes in social-work practice. The LAC materials have been widely acclaimed and now appear to represent the mainstream of child-care practice. However, the Assessment and Action Records are very long: on average, they take between two and four hours to complete and range from 35 pages for a child under a year old to a 58-page document with 375 questions (Garrett, 1999) for a child over 15 years. If they are properly used, to promote dialogue and sharing of information with the child and family, the time associated with their use grows even longer. Jackson (1998) points out that the length and complexity of the Records

reflect the complexity of children's lives and do not stem from a bureaucratic desire to create paperwork. And of course, dialogue and information-sharing should be part of any routine social-work interaction.

Nevertheless, research into the implementation of the materials (Bell, 1999; Jones et al., 1998) indicates that local authorities have failed to allow for the time, management and organisational requirements of filling in the forms. One might allow that the Records are a good idea, having taken into account the common arguments against the LAC materials: that they are based on and reflect white, middle-class aspirations and expectations; they reflect a Eurocentric concept of parenting; they fail to acknowledge the influence of culture, race, class and gender on child development; they fail to acknowledge economic constraints; and they represent state interference in local authority social work, resulting in the de-professionalisation of social workers, whose performance can now be more readily regulated, monitored and appraised. Given all this, it is still noteworthy that a system, which is generally accepted as fruitful, should have been launched with insufficient attention to the resources required to maintain it.

Public confidence in the care system in the United Kingdom has been profoundly shaken by numerous highly publicised controversies surrounding the abuse of children and young people, particularly those in residential institutions. A succession of official reports over a fifteen-year period chronicle how the residential-care system in all parts of the UK has failed to protect vulnerable youngsters (Colton, 2000). Most recently, the inquiry into child abuse in North Wales, chaired by Sir Ronald Waterhouse, revealed a quite shocking pattern of sexual abuse by paedophiles operating alone or in semi-organised 'rings' (House of Commons, 2000).

Wolmar (2000) argues that the abuse scandals described in the Waterhouse report are 'like the tumor which warns of a widespread cancer'. This view is supported by the fact that police forces have launched investigations into historical cases of child abuse in children's homes in every part of the country. At the time of writing, 47 of 49 mainland forces have either completed or are working on such inquiries (Wolmar, 2000).

Abuse of children and young people in residential institutions is particularly disturbing given that many such young people had already been deeply harmed prior to being placed away from home. It is estimated that between one-third and two-thirds of children in residential care homes have been abused before entry (National Commission of Inquiry into the Prevention of Child Abuse, 1996). This includes a large proportion of young people who have been sexually abused prior to placement in residential care. Thus, it appears that rather than being afforded additional care and protection, young people removed from their families – supposedly in their 'best interest' – are frequently exposed to greater risk.

The long-standing concern about the quality of our public care system is often attributed, in large part, to the lack of appropriately qualified staff. Many local authorities have discovered that it is not easy to recruit, far less to retain, suitably trained and psychologically stalwart child-welfare workers who can manage the demands of the work without growing insensitive to the needs of clients on the one hand, or burning out from an intense response to clients' pain on the other. The recent overall decline in applications to social-work qualifying programmes suggests that decreasing numbers of people are prepared to take on the challenge of professional social work.

The dilemma is perhaps most apparent in the area of residential work. Residential child and youth work in the United Kingdom might be viewed as a poor relation. Historically, the training and salaries of residential workers have been less than those accorded other social workers. The result is that the residential child-care system in the United Kingdom is one in which young people with the most severe personal and social problems are being looked after by adults with the least experience and training in child-care matters. Young, inexperienced, isolated and untrained workers are often left to tend and work with the most problematic young people. To be sure, periodic attempts have been made to improve the training, supervision, management, selection and inspection of residential social workers, but it is clear that the scale of such efforts has been inadequate to date.

The foregoing tends to paint a very dismal picture, but there is hope on the horizon. There are signs that the welfare of vulnerable children is at long last beginning to receive something approaching the priority it deserves. The present government has, by contrast with previous administrations since 1979, demonstrated a commitment to combating social exclusion, and has introduced a range of practical measures for which it deserves credit. Moreover, following the publication of Sir William Utting's review of safeguards for children living away from home (Utting, 1997), the government introduced an initiative called 'Quality Protects'. This is a major three-year programme designed to transform the management and delivery of social services for children in England. A similar programme, entitled 'Children First', was introduced in Wales. Local authorities are required to demonstrate steady improvement in the management of services and outcomes for children and young people, including those placed away from home. The government has committed itself to a series of national objectives. These include ensuring that the life chances of children looked after by local authorities are maximised by educational opportunities, health care and social care. The 'Quality Protects' initiative is accompanied by the injection of additional financial resources to help local authorities improve the quality of child-welfare services (Department of Health, 1998, 1999).

Many consider that professional registration for social workers also represents a vital safeguard for vulnerable children and young people. It is encouraging to note, therefore, that the government – as part of its attempt to improve the regulation of the personal social services – plans to establish a General Social Care Council (GSCC). This body will be responsible for setting standards for services and for individual social workers, and for the registration of all those working in the services. Welcome developments are also taking place in relation to post-qualifying training for child-welfare workers, which are designed to enhance professional competence in relation to complex child-care cases.

However, whilst improved education and training, supervision, selection systems and registration can all contribute to raising the standards in child welfare, professionalism is not a panacea for the challenges inherent in the child-welfare system. Indeed, certain aspects of professionalism can be problematic in themselves. For example, the professional ability to make decisions in the 'best interests' of the child may override any concept of children's rights or natural justice. It is, therefore, evident that efforts to ensure a better deal for vulnerable children require an increased emphasis on children's rights. The much heralded Children Act 1989 for England and Wales did seem to take children's rights more seriously than previous legislation, and provided new opportunities for advancing the wishes, autonomy and independent actions of children and young people. Nevertheless, the Act does this in a very qualified way. A broader, more creative approach is required. As a useful first step, local authorities, voluntary and private agencies should ensure that they adhere fully to the 1989 United Nations Convention on the Rights of the Child. This recognises that children are holders of a specific body of rights, which includes participation as well as the more traditional areas of prevention, protection and provision.

The quality of provision that a community makes for its vulnerable and dependent members stands as a testimony to what that community holds dear and what it rejects. Thus, the quality of child-welfare services in England and Wales, including, it must be said, the appalling abuse suffered by children in residential care homes, and the conspicuous failure to develop proactive family-support services, ultimately mirrors deeply embedded social attitudes and associated structures of social injustice and inequality. Historically, social-work clients have been drawn from the poorest strata of society. Today, right-wing commentators cruelly refer to this social group as the 'underclass' (see Murray, 1994). In the nineteenth century, welfare provision took the form of a stigmatising, deterrent, Poor Law, predicated on a mean-spirited distinction between the 'deserving' and 'undeserving' poor (Gregg, 1973; Holman, 1988). Notwithstanding over 150 years of quite awesome social, economic, political and technological

transformation, the Poor Law legacy can still be discerned in attitudes towards the dependent and powerless. With regard to children and young people placed away from home, for example, the public attitude tends toward indifference or, at best, ambivalence. Whilst people are, on the whole, sympathetic towards child victims of abuse, there is long-standing anxiety about the threat to social order represented by troubled and troublesome young people. Ambivalence is reinforced by the social class background of vulnerable children and families. Also, given the disproportionately large numbers of black children, and children with disabilities, placed away from home, ambivalence is further reinforced by factors such as racism and negative attitudes towards disability.

Given the challenges that we have highlighted, a number of rather obvious questions arise. First, why would anyone want to become a child-welfare worker? Secondly, what does it take to be a child-welfare worker? Finally, what needs to be done to ensure that we can attract and retain professionals who wish to work with children and families?

For years it has been recognised that social work with children and families is more stressful than social work with other client groups. Bennett et al. (1993) reported higher levels of job-related stress, general anxiety and depression for workers involved with children and families than for workers with other client groups. Likewise, Marshall and Barnett (1993), who looked specifically at child-protection work, found significantly greater job strain and psychological distress amongst child-protection social workers, compared with other occupational groups in both nursing and social work. Morrison (1990) explored two dimensions of the emotional impact of child-protection work on workers: the effect of clients on workers; and the response of the agency to worker distress. Morrison found that some workers react to continued exposure to clients' traumatic material by growing a sort of protective skin. They become insensitive to clients' needs because they can no longer bear to listen properly to what the client has to say. Other workers burn out and leave. Some are able to cope because they have mastered the art of self-care and have solid support systems in place for themselves both within and outside the agency. Similarly some agencies seem oblivious to the possible effects of the job on their workers: they neither take preventative measures nor provide assistance to those in distress. Other agencies facilitate peer-support systems, allow sufficient time for workers to de-brief after distressing encounters with clients, and provide counselling for workers to allow them to cope more immediately. Lack of attention to possible worker distress has obvious consequences for child-protection services: difficulty in recruiting workers (Fryer et al., 1989), difficulty in retaining them when the agency has already paid for their training, and reduced performance among workers who have 'burnt out'

(McGee, 1989) but not left. The incidence of long-term sick leave and unfilled posts in agencies tends to be high, putting additional strains on the workers who remain.

It comes as no surprise, therefore, that in recent years it has become more common to hear social-work students speaking in terms of going into child and family work for a short while, a year or two (because that's where the jobs are and because it is a good stepping stone to other work), rather than intending to specialise in child and family work over an entire career. The longer-term consequence of this trend is very worrying because, quite shortly, we will have a body of child-care social workers who are largely inexperienced, lacking the necessary skills to work with children and families, described in Chapter 3. It takes time to develop skills, and a skilled workforce requires both workers committed to children and families, and agencies committed to those workers.

So what are the rewards of working with children and families? To begin with, work with children is inherently rewarding for anyone who has an interest in children and childhood. In contact with younger children, one cannot help but be impressed by their spontaneity, their current engagement in a world of discovery, their way of seeing, which is not veiled by artificial social responses one tends to acquire with maturity. Perhaps, even, one is reminded of the best bits of one's own childhood or the pleasures of bringing up one's own children. This is essentially an approach that views childhood, not as a precursor to adulthood, but as a stage of life with a value all its own. The danger, of course, is that the worker will over-romanticise notions of childhood and see the child client through a nostalgic haze: but there is still no doubt that work with children is its own reward, bringing pleasure merely through the interaction with the child – and bringing also perhaps a determination that *this* life will be a little better because of whatever the worker can do to help.

Working with older children is more challenging but it, too, can be rewarding. Adolescence is a process of becoming, often turbulent, when the young person challenges adult values while still trying to fit into the adult world. Many adolescents coming to the attention of a child-welfare worker have been hurt in one way or another; they are frustrated and angry, and tend to reject well-meant offers of assistance because they have seen so much of the negative part of life that they have lost faith in the positive. Here is an opportunity. Here is a life on the brink that can be positively influenced by a worker who is armed not only with good intentions (remember the road to hell) but with the necessary skills developed over time. There are fascinating opportunities as well to track developments in a rapidly changing society. What is different about teenagers today compared with when you yourself were a teenager? What has changed with respect to

clothes, music, preferred foods, values, attitudes, opinions and aspirations? What do these changes mean in relation to where we are going as a society? The opportunities to learn from one's teenaged clients are endless and infinitely exciting, if one will only make the effort to engage them.

The same may be said of parents. We have seen that family forms are becoming more diverse. Gender roles within families are changing. The patterns of support networks are at the same time shrinking and becoming more far-flung. Expectations about what a marriage should be, what a 'good' parent is, what a child should do and not do, how parents and children should relate to each other, how families should relate to their communities and to the larger society – all these, the entire warp and weft of our society, are in a state of flux. No one is in a better position to watch the patterns in the fabric shift than those who are in daily contact with parents and their children.

Of course, social work with families and children is not just a learning opportunity for the worker, attractive though that is, nor is it a casual social contact. It is a planned, purposeful encounter with the aim of promoting the welfare of the child, ideally through promoting the welfare of the family system. Social workers with developed skills in this area can take immense satisfaction in using those skills and watching the results of their labours come to fruition. You may be working directly with children or parents, or you may be working with other professionals towards the provision of services, but whatever your role, you will know that a skill you have learned and taken the trouble to develop has been of use in making a positive change in someone's life. That is why evaluation (or quality-assurance strategies, or evidenced-based practice, or whatever terminology we care to use) is so important. Without some indicator or measured evidence of change, this satisfaction will be denied to workers, as it may be to families in whose lives the change has occurred.

Social workers may take pleasure from the knowledge that they have been effective, but we must never forget that social work is not really about the worker's effectiveness: it is about empowering disadvantaged people and groups so that *they* can be effective, so that they can take control over making the needed changes in their own communities and their own lives. In child protection, it is easy to see the need for empowering children – unless one views rebellious teens as threats to society whose power to destroy needs to be curtailed. It is sometimes less easy to see the need for empowering abusive parents. However, destructive and abusive behaviour both often stem from a perceived lack of power, so that the individual must compensate by demonstrating whatever power he has in whatever arena is available. You might have no other power in your life but you can make yourself powerful by hitting your child or robbing a shop. Empowerment is

therefore a basic element of social work and a fundamental skill for all those involved in work with families and children.

We seem to have moved from the rewards of working with children and families to the skills needed to do so. And, indeed, the question we asked after 'Why would anyone want to become a child-welfare worker?' was 'What does it take to be a child-welfare worker?' It is difficult to identify the qualities needed to be a child-welfare worker without implying that what we really need is superman, supermother, and the bionic person all rolled into one. Perhaps we do. However, let us try to identify some qualities which an ordinary person might possess or be able to develop.

The first is undoubtedly the capacity for self-care. Repeatedly, in this book, we have mentioned the need to take care of yourself and it will not hurt at all to mention it again. You must have a means of unwinding. You must have a private life and personal friends who are essentially separate from your work life and with whom you can engage in activities that are pleasurable and rewarding. Then, you must have a support system at work – people to laugh and cry with, to discuss cases with, to offer non-judgemental advice and support, people to feel safe with. Anderson (2000, p. 846) suggests:

> Child Protection Service workers have the same needs for emotional debriefing as law enforcement officers, fire fighters, Emergency Medical Service workers, emergency room personnel, and rape/crisis workers, many of whom would say that the hardest part of their job is working with maltreated or injured children. (Anderson, 2000, p. 846)

Interestingly, Anderson's recent study in the US (Anderson, 2000) found that child-protection service workers there are using social-support coping strategies less than did a similar group ten years earlier, as reported by Parry (1989). This points to the need for workers to actively seek out supportive peers, but it also points to the need for agencies to pay greater attention to the health of their workers.

A second necessary attribute for a child-welfare worker is the ability to work as a member of a team. Teamwork is often frustrating because other members of your team may have different perspectives and different priorities – particularly if they come from other disciplines – and they might seem to be holding up the work rather than facilitating it. The strategy here is probably a few deep breaths, a real effort to understand the other's point of view, and willingness to compromise.

Third comes assertiveness – which is different, of course, from aggression. Workers must often be assertive with clients when it is necessary to obtain compliance or to confront them with the consequences of their behaviours. Workers must be assertive with other professionals when

advocating on behalf of a client or expressing an opinion about a case. Assertiveness may be necessary too in dealing with the worker's own agency. Sometimes the policies, practices and structures of agencies do not seem to be designed with the welfare of the client in mind, and it may take a combination of assertiveness, diplomacy and patience for any change at all to be put in hand. An example here is a request for training. Farmer and Pollock's recent book (1998) gives some vivid examples of bad practice in relation to working with looked-after sexually abused children. Some of these examples are very clearly related to the lack of staff qualifications and the lack of in-service training either sought or provided. It may seem that it is not up to the worker to seek training: it is up to the agency to determine what training is needed and to provide it. In one way, this is true enough, but on the other hand, workers are in an excellent position to know what additional knowledge and skills would help them with their task, and they have a duty to their clients to be sufficiently assertive to request the necessary training.

A fourth attribute is the capacity to work while being interrupted, and a fifth related attribute is the ability to prioritise. Child-welfare workers work on a number of cases simultaneously, with situations precipitately arising, and children and co-workers in various stages of crisis. It is necessary to be able to quickly size up situations and plan appropriately, deciding at the same time what needs to be done now, what can be left until later today, and what can wait until tomorrow or even until next week. Some people thrive naturally on this kind of supercharged activity. Others wilt. Most learn to cope after practice.

Finally, you should know your limitations! There will always be things you can do well, things you can do less well, and times when you should yell for help. It is particularly important to be self-aware in the 'yell for help' scenarios, but it is also necessary in general to be able to appraise your strengths and weaknesses objectively. The strengths can be used for your clients' benefit, the weaknesses can be remedied through training, supervision and experience – but only if you know which is which.

We come now to look at what can be done to recruit and retain staff in the area of child-care work. Broadly, there are two strategies that need to be developed. First, we must think in terms of raising the profile and status of social work as a profession. Secondly, we need to consider how to reverse the trend within social work of people viewing child-welfare practice as the first rung of the ladder towards something else.

Let us consider the status of social work as a profession first. In comparison both with other professions in the UK and with social work in other European countries, social work in the UK is in decline. Concerns about the low morale within other large groups of public-service-sector workers

(teachers, nurses, and most recently the police) have brought government responses aimed at redressing the situation. With respect to teachers, the government announced policies aimed at reducing the administrative workloads of teachers, so that they could focus more of their energies on what they were trained for – teaching. With respect to nurses, the difficulty of recruiting new entrants into the occupation (seen in part as being related to the higher-level requirements introduced by the Nursing 2000 strategy) brought a swift government response – higher salary gradings for nursing staff. Most recently, measures were announced by the government to address staffing difficulties within the police service. However, despite the overall decline in applications to social work programmes in recent years, there appears to be no concerted effort on the part of the government to redress this. One might be forgiven for noting that the services of teachers, nurses and the police are used by the public in general, whereas social-work services are still largely (though not exclusively) used by the most disadvantaged sectors of society. Perhaps the degree of government attention to the respective sectors reflects the degree to which society values their users.

The engagement of social-work programmes in the ERASMUS and SOCRATES networks has provided opportunities to come together with European counterparts for the purpose of mutual learning. In comparison with social work in Europe, social work in the UK has clearly lost its therapeutic orientation over the last quarter-century. Twenty-five years ago, for example, a person qualifying as a social worker would have been assumed to be qualified as a counsellor as well. However, in recent years, counselling has become cut off from mainstream social-work practice, and given much less emphasis in training than it used to receive in the UK. In most European countries, social-work training is a three-year programme; the debate about three-year social-work training in the UK has continued for over a decade. In most European countries, working therapeutically with people in dire circumstances is an essential part of the training to become a social worker. We described the need for counselling skills in working with families and children in Chapter 3, and indeed such skills remain an important part of the child-welfare worker's repertoire. However, if one wanted to conduct therapy with people in the UK as social workers do in Europe, it would probably be necessary to think of top-up training after qualifying. The fact that social workers do not conduct therapy and are no longer adequately trained to do so certainly adds nothing to the status of the social-work profession.

The media also have a role in the way that social work is perceived by the general public. It is almost impossible to overestimate the impact that the series of inquiries into child-abuse fatalities has had on the status of social work as a profession. We can see this more clearly when we compare the British approach to child protection with that in European countries, where the vilification of professionals, by comparison, is unheard of. As described by Hetherington et al. (1997, p. 25), in a dialogue between French, Flemish, German and English social workers, for the former three, the question of child-abuse fatalities

> did not resonate with any of them in the way it does in England, because measures of serious incidents do not function as primary indicators of professional, public or political evaluations of the efficacy of their child protection systems. However, child death in the context of delivery of public child welfare services is by no means unknown or unrecognised in these countries.

So what is required to redress the balance? First, social-work practitioners must always be prepared to advocate for the profession. It is imperative in the face of the small number of cases that go disastrously wrong to remind people of the overwhelmingly large number of cases that go right. Secondly, it is important to ensure that social-work education programmes produce critically reflective practitioners whose practice is soundly based on theory and evidence from empirical research. Thirdly, it is vital to develop more positive relations with the media. This is a challenging area because social workers themselves do not speak with a single voice but have different perspectives on issues and different agendas. One thing they do seem to have in common is that they adopt a primarily defensive stance, reacting to criticism, and this is a less than helpful approach. It is important to be able to engage the media proactively on issues of common concern. For example, consider a recent article about the role of the media in the development and implementation of a national child-abuse secondary prevention programme, coming from the Netherlands (Hoefnagels and Mudde, 2000). There is no reason why similar initiatives could not be undertaken in the United Kingdom.

Let us make one final point. In order to rise to the challenges we have highlighted, it is essential that child-welfare workers maintain a clear sense of mission. Social work with children in need and their families requires those who undertake it to see their task as one of service to the cause of social justice. Hence, the child-welfare worker is so much more than a mere functionary within a welfare bureaucracy. This sense of mission is a prerequisite if we want to develop an integrated and coherent system of child welfare, characterised by pro-active, preventive, help for vulnerable children and families; if we want highly skilled, intelligently targeted protection for children at risk of abuse and neglect; and if we want competent, imaginative, child-centred care and after-care for children and young people.

Nothing that we have said concerning the challenges confronting child-welfare workers should detract from their achievements. Much important and successful work is accomplished in extremely testing circumstances. Despite the impression conveyed by an often hostile mass media, child-welfare workers invariably strive with sensitivity, integrity and courage to provide high standards of service for vulnerable children, young people and their families. Their work makes a vital contribution to the well-being of the whole society.