

What's wrong with child welfare?

An examination of current practices that harm children

Meredith Kiraly

This paper outlines the growing awareness of one experienced professional in the out-of-home care field regarding some of the deleterious practices of the present time. While much good practice exists in this field, it is the author's contention that entrenched attitudes which convey insensitivity and discrimination towards children and young people in care are still all too frequent; and that these attitudes continue to militate against meeting the essential needs of children and young people.

This paper outlines a group of theoretical concepts and relates them to a number of areas of current malpractice by way of an attempt to explain how these occur. In doing this, it seeks not to deny the sensitivity and skill of most current practitioners, and the excellent work that abounds in the child/youth welfare fields. Rather, the paper seeks to address those areas of practice which are still of concern, and to call for a change of attitude where needed.

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How, in the face of the sometimes arrogant certainty of professionals, do we find the humanity to acknowledge what we don't know, that what we are doing may not be effective, that it may even harm rather than help? (Scott, 1998, p.12)

Welfare workers, and the wider community, are now all too aware of the travesties of past child welfare practice in relation to the Stolen Generations and the transportation of British children to Australia. The malpractices of the present are, of course, harder to identify and face; nevertheless, most workers become aware from time to time that they are involved in practices that harm children and young people. This paper outlines the growing awareness of one professional who has spent 15 years in the out-of-home care field regarding some of the deleterious practices of the present time. While much good practice exists in child welfare organisations, it is the author's contention that entrenched attitudes which convey insensitivity and discrimination towards children and young people in care are still all too frequent; and that these attitudes continue to militate against meeting the essential needs of children and young people.

This paper will also outline a group of theoretical concepts which, it will be argued, go some way towards explaining some current malpractice. It is deliberately provocative. In so doing, it seeks not to deny the sensitivity and skill of most current practitioners, and the excellent work which abounds in the child/youth welfare field. Rather, the paper seeks to address those areas of practice which are still of concern,

and to call for a change of attitude where needed.

THEORETICAL CONCEPTS AND BARRIERS TO GOOD PRACTICE

ADULTCENTRISM

'Adultcentrism' is the tendency of adults to view children and their problems from a biased, adult perspective (Petr, 1992, p.408). It can be seen in psychiatric diagnoses of children which relate their behaviour to a set of perceived norms, where the norm relates to what the assessor considers to be deviant, eg, criteria such as 'often argues with adults', or 'often touchy or easily annoyed by others' (ibid).

In summary, the danger in practice is to overidentify with the goals and point of view of the adults. This danger is intensified by the agency context, which often emphasises social control, and by practice methodologies, which implicitly legitimise the adult point of view (ibid, p.413).

Adultcentrism contributes to the ongoing difficulty agencies experience in incorporating into their modus operandi the practice of routine consultation with children about decisions that affect their lives – even after training and policy development about children's rights and participation have taken place.

CAREISM

'Careism' is a term coined by Dr Michael Lindsay (1996) to describe discrimination on the grounds of care status, ie, of a child or young person

being in care. It is described, as all discrimination, as 'prey[ing] on irrational fears and prejudices... [and] built upon personal or shared prejudices which have a tendency to over-generalise, or even demonise, the class of people referred to' (ibid). Lindsay demonstrates how this form of discrimination has variously allowed for undue control measures to be used with children in care; for school exclusions where other young people not in care have not been excluded; for breaches of privacy and confidentiality; and for the neglect of older adolescents at ages when they would still be offered care if with their families. It may also explain why children and young people in care are rarely asked their preferences about placements or given choice in their placements, while those within their own families are more routinely asked their preferences about decisions which affect their lives. The concept of careism may explain a range of child and youth care practices which vary dramatically from community norms.

When combined with adultcentrism, careism is an even more powerful form of bias and distortion in the understanding of the needs of children.

LABELLING

Labelling theory has a long history. Essentially, it challenges the notion of deviance as a given, suggesting instead that deviance is the product of society's reaction to an act which breaks its rules, and the affixing of a deviant label to the 'actor' (Lemert, 1951). As well as potentially cementing those labelled into identifying with their label and entrenching themselves in the so-defined deviant behaviour, it has the consequence of facilitating certain favourable consequences for those who apply the label (Becker, 1966). The social rule enforcers who label individuals mostly do so as part of their occupation; this process justifies their position; the enforcer is armed with a great deal of discretion and may use their power to label an innocent person in order to gain respect (Becker, 1966).

Mental health is an area in which labelling theory has been applied popularly; Scheff (1999) suggests that people are labelled as mentally ill in order to explain rule-breaking

behaviour that society can't categorise. According to Scheff, everybody expresses the popular symptoms of mental illness at some point in their life, and labels are attached to those without power.

The concept of labelling has much relevance to child welfare, as will be seen.

MALPRACTICE OF OUR TIMES

CARE LANGUAGE

The wide gap between the language workers use to describe children in care, and children in the community – including their own children – is a key example of both careism and labelling in practice. Consider the examples of language that have become popular in welfare practice in Figure 1, noting in particular the popularity of the acronym, arguably a distancing, dehumanising label.

Consider also this first description of a young woman and her family by a caseworker, and the second, much softer, normalising description by her own mother.

- This client is a fifteen-year-old ID female. She lives in a resi unit. She is ADHD and has absconded twice. She has holiday access with her natural mother, and goes on monthly access with her natural father and his defacto. She has two younger siblings.

- My fifteen-year-old daughter is intellectually disabled. She lives in a residential care facility. She has some behavioural problems; she has run away twice. She has holidays with me, and visits her father and his partner regularly each month. She has a sister and a brother who are younger than her.

Discrimination via differential language use is one of the more subtle but powerful forms of discrimination. We can see from these examples how the concept of deviance becomes entrenched and unquestioned; the young person and her family are described in a negative, devaluing way which justifies punitive and/or social-control oriented 'therapeutic' responses such as powerful medication over long periods, or locked doors. This will be elaborated upon below in a discussion of Attention Deficit Hyperactivity Disorder (ADHD) and the abuse of medication.

DISCONTINUITY OF CARE

The failure of the child welfare system to provide continuity of care in placements is a longstanding practice concern (Department of Human Services, 2001a). On the basis of experience, the writer suggests that welfare professionals become inured to the impact of placement change upon children and young people, as indeed do the children and young people themselves. This latter effect then feeds the former: the lack of apparent distress evinced by children after numerous moves is cited as evidence that it is

Figure 1

CARE LANGUAGE	COMMUNITY LANGUAGE
Male; female	Young man, boy; young woman, girl
Client	Boy, girl, young person, parent
He is ADHD and ODD	He is over-active, has difficult behaviour
She is ODD	She is rebellious, defiant
She is a damaged child	She is a disturbed child
Abscond	Run away
Go on access	Visit or spend time with his father (mother, etc)
Natural mother, natural father	Mother, father
Defacto	Partner
She is ID	She is intellectually disabled
High Risk Adolescent (HRA)	Street kid, young person in trouble, etc

doing no harm, or even indeed that their 'lack of attachment' in some way apparently justifies the moves, rather than progressively contributing towards it. Professionals can readily justify each move on the basis of 'nearer to home', 'unsuitable mix of residents', 'behaviour problems requiring a different caregiver/model of care', etc, without due consideration to the harm to the child's development of the moves themselves.

This is an example of careism and adultcentrism working together in practice. A useful comparison for professionals is the lengths to which most families will go to avoid discontinuities in the care of their own children.

Placement changes do contribute to the difficulty that children experience in 'attaching' to caregivers. They are reluctant to trust and confide, and tend to build shallower and less effective relationships. Often overlooked is the impact upon their capacity to develop friendships, a critical factor for successful transition through adolescence to adulthood. Both their educational progress and their peer relationships are significantly damaged by each transition to a new school; this is addressed further below.

There will always be some placements that cannot be sustained for various reasons, despite improved supports to young people and their caregivers than in the past. Nevertheless, the travesty is that it would appear that little progress has been made in arresting the rate and frequency of placement changes, and that more energy is going into justifying placement changes, rather than preventing them.

DISRUPTIONS TO SCHOOLING

As mentioned, this is often a concomitant of a placement change, and is often rationalised as giving a child or young person who is not doing very well at school, or having behavioural problems, a 'fresh start'. While the school change may appear to be a 'quick fix', it frequently fails to make a significant difference, rather, often perpetuating both social and educational problems.

Across the English-speaking world, research and policy work has directed

attention to why children and young people in care tend to have such poor educational outcomes. In Victoria, a recent audit of residential care (Department of Human Services, 2001a) found that over 70% of those in care who had left school had Year 8 or lower as their highest level of school completed. None had Year 12. Over half of those age 13 or older did not attend school at all.

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While attention has been focussed on remedial education programs, the phenomenon of school changes goes largely unattended. Again, this contrasts sharply with community standards, where families go to considerable lengths to minimise the number of school changes experienced by their offspring, including driving considerable distances and moving within given areas to allow for continuity of schooling. Children in care, on the other hand, change school even when placed a few kilometres from the school for the convenience of adults; respite care may necessitate further temporary school changes. As with placement changes, where children in care have few friends at school, this is used to justify school changes, rather than such school changes being seen as exacerbating difficulties in establishing peer relations. Again, careism and adultcentrism are at work.

David Berridge (1994) noted this phenomenon in research on the education of young people in care, concluding that it may be better to leave a young person who is quite an ordinary student in their present school, rather than moving them in the hope that a different school will assist them further. Supporting a continuous school placement has the obvious advantages, readily recognised for other children, of

promoting feelings of security, the development of relationships with teachers and the working through of problems, and the possibility of developing and sustaining friendships with peers over time.

Further disruptions to schooling occur in the (careist) practice of expecting older secondary students who are out-of-home to live semi-independently at an age when families are increasing their parental support and influence in a final effort to secure the best possible Year 12 outcome for their young. If young people in care are to be given the best chance of completing their secondary education, they should also be provided with the full care of substitute parent-figures for as long as they are studying and want this level of care. They should not be expected to move to the range of semi-independent living options where they need to finance their own day to day living and education, and care for themselves fully, at the very least until they have left school.

SIBLING SEPARATION

Individuals have longer lasting relationships with their brothers and sisters than they have with their parents or their own children. In infancy, siblings may spend more time together than they do with their father, and at times even with their mother. Very young children have strong attachments to each other, and to older siblings. Their relationships may include much conflict especially in the early years, yet they will frequently defend each other vigorously against others, and miss each other greatly if separated for periods of time. Conflict between siblings usually abates in mid-adolescence, giving rise to more separated, but more positive interaction.

Children can support their siblings in times of insecurity, stress and family disharmony; they give to and receive from each other; and when young, may confide in one another more commonly than in friends (Mullender, 1999, p.12). In later life, siblings often offer each other much companionship and care, and it is not uncommon that they will again live together following the loss of life partners. The death of a sibling during childhood is a terrible loss to a child, and is also a powerful source of grief when it takes place in adulthood.

Not all siblings get along well together, but many who do not still regard their relationships as important and seek to maintain ongoing contact.

The damage inflicted by sibling separation ... can involve the loss of a lifetime's close and loving relationship; support in adversity; a sometimes parental degree of personal care; a shared history; a sense of kinship; of 'flesh and blood'; ... of continuity and rootedness; a source of knowledge about the family; and a resource for the individual's own development of identity (ibid, pp.330-1).

Much effort is made by parents to promote sibling relationships. Most Australian families seek to have more than one child, often citing a primary reason as the benefits for the children themselves. Conflict between children is seen as a problem to be handled, and a learning experience about inter-personal relationships. Where parents separate, priority is given to children remaining together for their sake, even if this means that one parent misses them greatly.

Compare these normative experiences with the experience of the child in care.

Around 80% of children who are placed in care are separated from their siblings over time (Mullender, 1999, p 8). Separation often takes place on admission when children are divided up to fit existing placements, or because they are admitted to care at different times into whatever placements are available at the time. Little effort is given to the subsequent reunification of siblings. Of those placed together, many are later separated when one or more siblings become difficult to manage. Once separated, the norm is for little contact, which over time usually falls away to none. Separation in care normally leads to loss of contact for life. Adults who have grown up in care testify to the pain of the loss of their siblings; many go to great lengths to try to find them and to create some relationship with them. This additional loss – inflicted by the child welfare system which seeks to respond to the pain and suffering caused by the separation from parents – is rarely acknowledged.

There is also the question of other missing siblings – those not in care, or

possibly already adults. Case files of children in care frequently fail to document all siblings (or half-siblings). Even where the names of all are known, key information such as dates of birth, addresses and telephone numbers are often missing. Rarely does much energy go into attempts to find this information, record it and keep it up-to-date. The lack of such basic information bears witness to the lack of importance attached to the maintenance of these relationships. Those siblings not well identified in case files are well on the way to permanent loss for the child.

If young people in care are to be given the best chance of completing their secondary education, they should also be provided with the full care of substitute parent-figures for as long as they are studying and want this level of care.

How to explain this lack of sensitivity to a further profound family dislocation for children who have already suffered separation from mother and father? Much of it can perhaps be accounted for by adultcentrism. In placement decisions, the views of caregivers, social workers and occasionally parents are paramount; little attention is paid to the views of the children themselves. Careism may apply to the assessment of conflict between children in care. While most families regard sibling rivalry as a source of some stress at times, it is rare that separation of children for any length of time is considered as a solution, even when conflict is acute. With children in care, however, sibling rivalry is frequently cited as evidence of a so-called 'lack of attachment' between the children. Conversely, an overly 'maternal' or nurturing sibling relationship is often cited as a reason for separation, rather than for assistance

to the older child to relinquish an inappropriate burden of caring.

Arguably, there will remain a very small minority of children for whom there may be clear advantages to separation from siblings that might outweigh this significant loss. These might be siblings where seriously violent conflict or sexual activity is ongoing and apparently impervious to intervention – bearing in mind that considerable physical fighting, and occasional sexual experimentation, both occur in many normal sibling relationships. However, overall, the benefits of what siblings can offer each other in the way of support, connectedness and identity, needs far more recognition in day to day practice. Research has pointed to the fact that sibling placements are more stable than placements of separated siblings (Berridge & Cleaver, 1987). The needs of children in care for the support of their siblings is if anything greater than children living with their parents, given the stresses and traumas of their lives. The likelihood of sibling relationships improving as children grow up also needs recognition, as does the awareness that separation in childhood usually means separation for life.

Children and young people in care, more than any others, need those important family relationships that can provide long-term ongoing support to them in the vulnerable years as they leave care and establish themselves as adults. They also need this support and affection through their adult lives, the more so as their parents are often unable to provide this. Some specialist programs have begun which address the support caregivers need to take on larger sibling groups (Fischer, 2002), and these are a big step in the right direction. Equal attention needs to be given to those sibling pairs who are separated not because of resources, but because of a lack of understanding or sensitivity to the crucial importance of these relationships.

In the recent Victorian audit of residential child care, the Minister of Community Services called attention to the practice of separating siblings in care (Department of Human Services, 2001a), and the response to this audit (Department of Human Services,

2001b) directs that urgent measures be taken to reverse this practice.

LACK OF PRIVACY AND CONFIDENTIALITY

This is one of the most frequent complaints by young people in care. They say that their most personal business is discussed routinely among large numbers of professionals, sometimes in formal meetings, and often in informal places. Information about personal thoughts and feelings disclosed to trusted persons, hygiene practices, sexual behaviour, etc, are frequently aired publicly. Such information not uncommonly appears in case review reports and case notes. Such discussions about the most personal aspects of a young person's life would be regarded as grossly humiliating and inappropriate for any young person living at home. Yet the fact of being in care appears to make it acceptable for such information to be freely shared among numbers of workers. Again, this is an example of careism and adultcentrism working together, at its most graphic.

In reviewing her experience of child welfare workplaces, the writer reflects that only one of these, a service to young women at high risk, practiced a good level of confidentiality. Conversations in the staff kitchen or hallways never included case-specific material. Case discussions were held in private, whether between two workers for peer review, or in formal supervision. Reports and case files were carefully written to include only that material which was pertinent to the young person's case plan, avoiding gratuitous references to personal information. These records stressed positives as well as negatives in the total picture. Staff meetings only included reference to specific young people when a formal case conference was being held; otherwise young people were discussed in the general rather than the particular. Case material was kept in a locked filing cabinet. This contrasted with other workplaces where it proved difficult to establish and maintain such standards. Comments frequently heard included that 'confidentiality' meant confidentiality within the team, which included everybody in the office and/or a large

meeting (up to thirty people). This is not what the young person has in mind when they are told that information about them will be treated confidentially, any more than it is what other people have in mind when they become clients of a doctor or a counsellor.

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THE MYTH OF ADHD AND THE ABUSE OF MEDICATION

Labelling has one of its most serious consequences in the over-medication of children and young people in care. The most salient current example is in the diagnosis and treatment of 'ADHD'.

The diagnosis of ADD or Attention Deficit Disorder first became popular in the 1980s, when it was said to be associated with food allergies, and in particular red food colouring. It returned in the 1990s as ADD/ADHD (Attention Deficit Hyperactivity Disorder) presumably to stress that the characteristic of 'hyperactivity', long regarded as the definitive requirement for this diagnosis, was now optional. With its return came an overwhelming orientation towards medication rather than diet as the treatment, justified as improving the capacity of the child or young person to attend to their studies.

Associated with this labelling process and the propensity for over-diagnosis of children in care comes the inflated use of medication. Within the general community, it is estimated that the

incidence of children on Ritalin or Dexamphetamine medication for the apparent illness of ADD/ADHD, has risen a shocking 24-fold between 1990 and 1998 (*Age*, 12 March 2001, p.1). Ritalin is an amphetamine related to the illicit drug 'speed'. It is a powerful and expensive drug, and is often prescribed for periods of years at a time. The child frequently continues to be regarded as difficult, and the assumption that they would undoubtedly be more so without the medication is often untested. Paradoxically, their continued difficult behaviour is often cited as a reason why the medication should continue rather than why it should perhaps cease, at the very least for a trial period to assess whether it is making a difference. American Peter Breggin, of the International Centre for the Study of Psychiatry (cited in *The Age*, 12 March 2001), has described this 'drugging of children [as] a national catastrophe', suggesting that 'ADHD is just a list of behaviours kids have when in conflict with adults. There is no biological basis for it' (ibid). This attitude has been reiterated by a number of other experts in the field, such as Melbourne child psychiatrist Dr George Halasz (cited in *The Age*, 12 March 2001), Rick Pring, Head of the Child Behaviour Clinic at the Melbourne Royal Children's Hospital (cited in *The Age*, 8 June 2001), and Peter Mertin, Senior Clinical Psychologist, Child and Adolescent Mental Health Service, South Australia (Mertin, 1998).

The writer was shocked to observe in 1990 in the USA that a high proportion of children in residential care were on medications for behavioural or emotional problems. In 2001, the picture is now the same in Australia. Anecdotal evidence suggests that the prescription rate for children in care is even higher than that in the general community, and that at least one in two children/young people in care have been prescribed Ritalin. Mertin (ibid, p.32) comments on the fact that the diagnosis of ADD/ADHD is more of a behavioural syndrome which allows for some subjectivity of diagnosis, and suggests that it is probably over-diagnosed in children in care, due to the experiences which many have had of abuse in their families, leading to difficult behaviour. He suggests that there should first be an attempt made to

explain the child's behaviour in terms of his/her history and current life circumstances, and that the 'diagnosis of ADHD should only then be made after the exclusion of more compelling explanations' (ibid, p.32).

Ritalin is not the only drug over-prescribed to children in care. Consider the real-life case of Anna¹, a nine-year-old girl in care at the present time.

- Anna is taking Ritalin, and a nasal spray which has been prescribed to address her bedwetting. She sleeps poorly; this is considered to be possibly a side-effect of the Ritalin, and so she thus takes sleeping tablets. The sleeping tablets tend to inhibit her alertness to the need to go to the toilet during the night. The result of these three medications, two of which are apparently actually contributing to her problems, is that she continues to be regarded as having difficult behaviour, and continues to wet the bed. Overall, there are no identifiable beneficial outcomes. The psychiatrist continues to insist that the medications are necessary, implying that perhaps the problems would be 'even worse' if the child were unmedicated. A trial without medication has been refused.

FOCUS ON NEGATIVE BEHAVIOUR AND THE PUNISHING USE OF 'CONSEQUENCES'

Labelling and careism again work together in the persistent assumption that children and young people in care are, by virtue of being in care, 'troubled', 'emotionally disturbed', 'difficult', 'antisocial' or 'high risk'. One young man ex-care spoke of his frustration growing up in care that people he met always assumed he was in care because he was bad, rather than because his parents had been unable to look after him.

Despite the separation of the protective and the corrective uses of care following the declaration of the 1989 *Children and Young Persons Act* in Victoria, both welfare professionals and the community continue to regard children in care as if they are in care because they are antisocial or badly behaved. It follows on that care is commonly regarded as needing to be

'therapeutic' with a strong overtone of corrective treatment. So-called therapeutic regimes all too often revolve around the much-misused concept of 'consequences', or thinly-disguised punishments.

The concept of 'natural and logical consequences' was developed by Rudolph Dreikurs (1970). Dreikurs was an influential writer on child development and parenting who challenged the value of punishment in social learning, suggesting instead that, where possible, children be encouraged to learn from the natural consequences of their behaviour. So, for example, rather than engaging in a power struggle with a child over wearing warm clothes, the child would be allowed to dress as they see fit, on the presumption that they will learn to put on more clothes from feeling cold. Logical consequences were suggested as a way to deal with situations which do not have a natural consequence for the child. So, for example, the jacket which has been borrowed and lost, should be replaced at the young person's expense.

The concept of 'consequences' has moved into child welfare jargon in an almost universal way, although few practitioners are able to describe these original concepts, or to explain in what way a 'consequence' is intended to be different from a punishment. In fact, the word 'consequence' has been substituted for the word 'punishment', somehow giving the idea new authority and imperative: consequences must be imposed for all unacceptable behaviour by children and young people in care.

When a child or young person apparently misbehaves, eg, runs away, speaks abusively to staff, or refuses to do tasks requested, staff jump to the need to impose these 'consequences'. The commonly used ones look remarkably like the old-fashioned punishments, such as pocket money being withheld, 'time-out' (enforced time in their bedroom), no television viewing, or being 'grounded', ie, not allowed to go out. Staff are adamant that they are not imposing punishments, but are at a loss to explain the difference. Little attention is directed towards understanding why the behaviour occurred, and whether the so-called 'consequence' is likely to be

corrective, or to engender resentment, which is likely to provoke similar misbehaviour again. In the insistence on 'consequences', staff may overlook to talk through the problem with the young person when calmer to ascertain whether any further action is actually needed. Again, the concept of careism is relevant. Parents are well aware that adolescents often feel manipulated and resentful in the face of punishment, and are much more likely to attempt to communicate their concerns and expectations to their young in the first instance rather than impose such 'consequences' as an automatic corollary of unacceptable behaviour.

As in behaviour management, periodic case review reports and case notes regarding children and young people in care similarly focus on the negative, as if what is important is to identify their weaknesses and try to correct them. Strengths and progress come a very poor second.

- Helen was considered to be one of the region's most 'high risk' young women, and for many months was cared for in a special purpose unit staffed for herself only. With the aid of a skilled youth worker who gave her much time and support and actively focussed on her interests and strengths, Helen was able to move to a home based care placement where she was no longer deemed to be at imminent risk of assaulting caregivers, suicide and self-harm. She continued to have a number of more intractable problems, including lack of school, work or training, and a marijuana habit. In her next review the workers in attendance focussed on these continuing problems, expressing their great concern for her and exhorting her to do better. In frustration, with the assistance of her worker (as her literacy was low), she wrote a letter of protest to the chairperson of her annual review of guardianship outlining two pages of genuine gains she had made and asking for these to be noted in the minutes of the meeting and in her Departmental file in addition to her remaining problems.

Helen was lucky to have a strength-focussed advocate in her youth worker to assist her to put her case forward, or she might have given up her efforts to overcome the effects of a horrific history of abuse.

¹ All case examples have names and identifying details changed to protect confidentiality.

Youth in care groups around the world are consistent in their appeals for caregivers to provide more understanding and less judgement, to treat them as worthwhile people who are having difficulties in their lives, rather than bad kids who need to be punished or corrected – in all, to treat them more as they would their own children, whether behaving or misbehaving.

(Caregiver) selection decisions are still often being made without careful evaluation of the suitability of the person for the challenges of caring for abused children.

LACK OF EFFECTIVE CONSTRAINTS TO HIGH RISK BEHAVIOUR

Standing perhaps in contrast with the above plea for more normalisation and less punishment, is the situation of the child or young person who is at extreme risk. An unexpected consequence of the rights orientation of the Victorian *Children and Young Persons Act* has been that the small group of young people who are, for a period of their lives, at serious and extreme risk, are being left in large part unprotected. Take, for example, the case of Amanda.

- Amanda is a pregnant, heroin-addicted 15-year-old who was sleeping rough in city streets during the Melbourne winter. She told her worker that she shot up in front of a police officer, who did nothing. Weeks of efforts by her support worker led to no intervention by child protection. When eventually she was apprehended, she was taken to the Secure Welfare Unit, where the pressure to have her released commenced within twenty-four hours of her admission.

Even the maximum detention of three weeks, rarely utilised, might provide little protection for a young person in such a situation.

Young people in this high risk group may die as a direct result of their own

inability to keep themselves safe (Victorian Child Death Review Committee, 1999) – or cause the injury or death of others. The Victorian Child Death Review Committee of 1999 was so concerned about the repeating pattern of adolescent deaths and associated child protection system problems observed in the years preceding, that it commissioned a special analysis of adolescent child protection client deaths over the period 1994-1998 (ibid, p.62).

Young people who have not reached the age of majority have the right to protection from others and also from themselves, and society has the responsibility to provide a reasonable level of protection against high risk. Longer term, fully secure options are needed for this small group of young people. These options cannot continue to be a house with locked doors; young people need to be able to move around in open space, and engage in a range of indoor and outdoor activities, all within safe custody. They need time to detoxify, to settle down, to be taught relevant life skills and to build relationships with caregivers who are trained to care for these highly challenging young people, carers whose specialised role is valued by themselves and others. Young people also need gradual reintroduction to the community, ensuring that they leave secure care with established, supportive networks such as school, work, mentors and rediscovered family.

While much was wrong with the institutions of yesteryear, the better programs at times provided some of these supports. There is no reason why those positive, therapeutic aspects of congregate care could not be reproduced in today's smaller, secure units, combined with a contemporary awareness of the rights and developmental needs of young people, and a much-overdue upgrading of the status, training and remuneration of those who care for them.

NEGLECT OF THE CARE OF OLDER ADOLESCENTS

Perhaps nowhere is the anomaly between community standards and those for young people in care clearer than when young people approach the older adolescent years. Thirty-one per

cent of Australian young people in their twenties are now still living in the family home (Australian Bureau of Statistics, 2001). By contrast, young people in care are expected to leave at around the age of 16, and certainly by 18. On usually minimal income, young people still in care at age 16 are moved to minimally supported accommodation without caregivers, and expected to manage their fragile finances, feed themselves, keep house, and find work. If studying, they are expected to maintain their motivation and study output more or less independently of others. Many Australian parents of young people at the same age living at home are paying for all their children's costs, driving them all over town, excusing them from assisting with household tasks so that they can devote more time to their studies, supplying tutors, etc. The contrast could not be starker.

Conversely, another way young people in care are let down relates to anomalies of the social security system that provides too much income for a short period of their lives. Many young people in care who are being fully supported (for example, in residential care or foster care) qualify for the Youth Allowance at 'young homeless' rates. These are rates designed to provide a minimum level of financial support for living costs such as rent, food, etc, for those to whom such support is not provided by parents or guardians. However minimal this level of financial support, when not needed for rent and food, it compares generously with the 'pocket money' of the average young person living at home. Few young people in care pay board contributions; thus those in full care and in receipt of Youth Allowance at 'young homeless' rates have for a couple of short years, considerable money in their hands for recreational use. In some situations, these funds actually feed a developing drug habit. A year or so later, the young person leaves care or moves to supported accommodation, often with the same weekly income from which they now must pay for all their living expenses, and possibly a drug addiction. Would it be possible to equip a young person more poorly than this for adult life without ongoing family support?

Young people in care need to be treated by government as being offered full care, rather than as being homeless. Their financial support should come, like other young people in the community, through their guardian, and through any earnings they make. These young people are particularly in need of financial support directed towards their leaving care. Federal government support could be usefully directed towards providing them with a 'leaving care package' which might provide needed furniture and household utilities, and other start-up costs of living as an adult in the community.

LACK OF ATTENTION TO CARER SELECTION

There is now considerable literature on the need to select caregivers carefully (Support Force for Children's Residential Care, 1994; Kiraly, 1999). However, selection decisions are still often being made without careful evaluation of the suitability of the person for the challenges of caring for abused children. While it is a community expectation that high standards are set for the selection of those who care for children in the absence of their parents (teachers, nannies, child care centre staff, etc), standards often slip when choosing long-term caregivers for abused and disadvantaged children and young people. The difficulty in attracting foster parents and residential staff in general is the most common driver for poor decisions, together with the difficulty managers experience in identifying the skills they most require. More attention is given to whether applicants have First Aid certificates than whether they can show evidence of the behavioural skills and attitudes needed. Interviews are poorly thought out, and conducted by staff who are untrained in interview techniques. In addition to poor interviewing practice, three other areas of selection practice stand out as problematic: reference checking, criminal records checking, and the use of staff from private employment agencies.

Reference checks are frequently cursory, and references given by friends and relatives are often taken as sufficient. Even experienced professionals acting as referees are

often reluctant to give their true impressions of the applicant's strengths and weaknesses. Where there are indications of unsuitability, these are frequently glossed over. Questions asked of referees often only make the process of giving a limited or frankly false reference easier. The following is a case about which the author was consulted by a rural service in northern Australia.

- Paul was a teacher who was approved as a caregiver and about to take on the care of a boy with some sexually inappropriate behaviours. References had been taken from two people he had nominated, one a personal friend who spoke highly of him, and the other the principal of a school where he had recently started teaching. Before the placement was made, an acquaintance of his came forward to express some concerns. Subsequent checking indicated that the school at which he had taught for several years had terminated his appointment because of his tendency to take boys aside for individual activities away from the group, to his own home and on day trips, without consulting other staff. A number of staff had spoken to the principal expressing concerns regarding his behaviour. Feedback to Paul had fallen on deaf ears. When Paul applied for a job at a different school, however, the reference from the first school had not mentioned these concerns. The second school, where he had been for six months, spoke highly of his willingness to undertake additional duties and activities with students - possibly the same impression that Paul had given in the initial six months at the first school.

A situation like this will only be avoided when agencies take a much more proactive approach to reference checks, identifying clearly work histories, and who they think would be the most suitable referees. In this situation the school where the problems occurred would have stood out as a place where Paul had spent significant time and where the Principal should know him well. Of course, Paul might need a right of reply to a poor reference, and further references might be needed if a conflict in stories led to difficulties in assessment.

The appearance of police records checks in the 1990s was a mechanism that was apparently designed to

improve standards of recruitment. Paradoxically, it is frequently leading to a lowering of standards. This is because in many situations a 'clear police check' is being cited as a bottom-line minimum standard for suitability for a caregiving role. The risks attendant in this approach were recognised years ago in the USA by Carter (1986) who argues that criminal records checks have actually *lowered* the standards of staff selection, by providing an implied standard that if the person does not have a criminal record, they meet the minimum requirements to care for children. So the situation not infrequently arises where children are allowed to be cared for short-term by new caregivers who have never been met by the supervising social worker, providing a verbal 'police check' on the person has been undertaken.

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Why does this not offer sufficient protection in the short-term? It is estimated that only 4% of all offences result in a criminal conviction (UK Dept of Health, 1992). So it is entirely possible that with a 'police check' only, approval may be given for a young person to stay with people who are actively substance-affected, have strong patterns of aggressive and/or abusive behaviour, and have loaded guns in the home - or any other combination of unsafe characteristics - providing they have no convictions. A 'police check' should *never* be done in the absence of an interview (which should be in-home if for home-based care) and appropriately selected reference checks; yet this is happening in many welfare agencies in this country.

A third area of staffing that is of great risk to children and young people in care is the emergence in this country of

'for profit' labour agencies which provide residential care staff to community services organisations. The writer was shocked to read of this practice in the UK in the report of the Warner Inquiry (ibid) which commented on the prevalence of agency staffing across the UK, and condemned it as inappropriate to residential care. As with the child medication practices of the USA, Australia appears to have copied yet another of the worst of overseas developments. Agency staff are frequently poorly qualified, inexperienced and poorly supervised; they lack loyalty, commitment and accountability to the organisation to whom they are sent. The writer has known of instances of agency staff who have refused to move from a temporarily empty residential unit to another residential unit when requested; a staff member who refused to be interviewed when an allegation of assault was made against him by a young person; one who refused to release her home phone number to allow a work practice matter to be addressed following the end of a shift; and staff who have left behind them large bills for telephone and utility usage, and poorly maintained properties.

Community services organisations pay out to these agencies amounts which are more than double the regular wages bill for an employed staff member doing the same work. This waste of money on the poorest staffing arrangements possible is being incurred by organisations which were apparently unable to pay their employed residential care staff sufficient to attract greater numbers of applicants. The problem of unacceptable levels of care remains unaddressed, and the use of agency staff is growing.

Community services organisations need to address this threat to quality of care urgently. They should unite in an agreement that agency staff will not be used in residential care for children or young people. Funds thus saved should be redirected to strike over-award payments for employed residential care workers. Government and community service organisations need to work with unions over time to address the huge anomalies in award wages for residential care workers, and to achieve

an equitable award for the future which might go some little way towards attracting suitable staff.

CONCLUSION

Adultcentrism, careism and labelling are contributing to serious areas of malpractice in child and youth welfare at the present time. The welfare system is still providing far too many changes in children's lives, including multiple changes in caregivers and schools, and separation from brothers and sisters. Children and young people are over-medicated to an extreme degree. They are still treated as 'bad' because they are in care and punished more than other children for similar mis-behaviours. Yet, paradoxically, the young people at highest risk are not securely protected. Insufficient care is still given to providing skilled caregivers for children and young people, and they continue to leave care too young and too little supported. Many of these areas of malpractice described require little additional funding to rectify. Rather, what is needed is a radical reappraisal of the discriminatory and uncompassionate way in which the welfare system all too often has come to treat those children and young people in its care. It is within the power of workers themselves to change many of these practices as they become aware that they are not helpful, and of organisations to develop more sensitive cultures through which attitudes which convey greater respect and humanity can flourish. Good practice exists in many places; but the practices described should be of concern to all in child and youth welfare. ♦

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