Journal of Adolescent Health and Welfare

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Special Feature - "Child Protection and the Family"

Incorporating the Newsletter of the International Regional Chapter of the Society for Adolescent Medicine

- Letter from the editor -

Dear Colleagues,

Again we are approaching the end of a very buzy year - it seems just yesterday that I was writing Christmas and new year greetings for the end of 1994 - and here we are again wishing you happy Christmas 1995 and a prosperous 1996.

What also seems nigh on impossible is the fact that during 1996 Youth Support will be ***ten years old****!*

The Charity was 'born' in 1986 and our first ever event was the Jamaican benefit fair in June 86, coinciding with our relief work for young people in the 86 floods.

During 1996 we will be having a number of events - including a Blues Brother's party celebrating the summer - a Fund Raising 'Dog Night' which will raise money for our latest project, a 'walk in off the street' counselling centre in a deprived area of London - and a scientific conference on Adolescent health to be held at the Royal College of Physicians on October 24th.

We will be producing a special anniversary edition of the journal with lots of news and history of Youth Support.

I hope you will all join us for our anniversary celebrations and contribute to the scientific meetings - articles for the journal are welcome as always and we do have a limited amount of space at the October meeting for 'posters' so do get in touch!

Best wishes,

Diana Birch
Director Youth Support

Dedication of "Kelly's Garden"

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Youth Support Forum on Adolescent Health and Welfare
Tenth Annual Meeting
at the Royal Society of Medicine 1, Wimpole Street London WC1
Wednesday 18th October 1995 at 6-9pm

"Working with Youth - Ten Year's progress"

Subject matter includes - The scope of Youth Support's work School age pregnancy - advances and trends. Self Esteem - Can we achieve change? Bonds and Boundaries in Child protection.

I would like to attend the Tenth Annual Meeting of the Youth Support Forum on Adolescent Health and Welfare at the Royal Society of Medicine on Wednesday 18th October............

I will bring .... guests.
I am a Forum member ...... (attendance free + guests free)
I would like to join the forum and enclose £20 annual fee.
I am not a member and enclose fee of £5 per person for attendance - total .....
Name .... Designation ....
Address .... Tel no ....
.... (Admission free to students and
.... young people under 21)

International News

We have just received the SAM evaluations regarding the 1995 IRC (International regional chapter) workshop and International dinner at the Vancouver SAM (Society for Adolescent Medicine Meeting). Both events were rated highly and the international dinner was hailed as a good way to exchange views with colleagues.
The International Chapter workshop entitled "Incest, where are the boundaries?" had the following ratings -
on a scale of 1-5 (5=excellent; 4=Very good; 3=Good; 2=fair; 1=poor)

Scope of material	- rating 4.33
Depth of material	- rating 4.33
Usefullness of information	- rating 4.14
Style of presentation	- rating 4.5
Quality of handout	- rating 4.5
Expectations met	- rating 4.36

Hence we seem to have some happy customers! Let's do the same next year. Next year's dinner in Arlington Virginia will be 'off site' again. The workshop will be held as usual - see the SAM programme booklet for details - let me know if you have interesting cases to present.

- 'Adolescent Medicine, A personal View' -

Dr Martin Fisher - From North Shore University Hospital, Manhasset, New York. Dr Fisher, a member of SAM (Society for Adolescent Medicine) visited Youth Support House on Tuesday 25th July 1995 and gave the following presentation to the staff group.

Adolescent medicine takes on different perspectives depending on the area and the interest and expertise of individuals. I was aware of that when I wrote a recent article in Archives of Disease of Childhood on Adolescent medicine and it was brought home to me coming here and realising that none of the list of subjects which you had suggested your staff might like to hear me talk abut were actually within my own practice! My perspective is more from the direction of adolescent inpatient units and hospitalised teenagers although we do have satellite programmes in the community.

In the United States we now have between 40 and 60 adolescent units where teenagers are hospitalised. They may attend for pulmonary disease, gastrointestinal disorders and are placed in the adolescent unit. Now the trend is for less hospitalisation, reduced numbers of beds and decreased occupancy which has drastic results on the units which can be threatened with closure. The average length of stay is from 2-3 days for infectious mononucleosis to a few months for inflammatory bowel disease. Up to half of our hospital cases are eating disorder patients.

The hospital also has an 'adolescent clinic' which runs one day a week and is for patients without insurance and 'adolescent practice' outpatients which runs the rest of the week and is for private, insured practice.
The adolescent clinic attenders come for general check ups and medical problems, gynaecology and immunisations. They are really medical rather than psychological issues. One third come from group homes and are referred by social services. There are a few dozen group homes in Queens. Each have 12-18 adolescents at one time aged 9-13 or 13-19 where most residents are placed under court orders.

With regard to the hospital patients - one third have medicaid; one third a sliding scale of fees and one third are fully insured or pay full fees. 50% attend for general problems and 50% with eating disorders and that partly reflects the interest and expertise of staff. Most attend on an outpatient basis and we are developing a day care programme for eating disorder. There are thus three levels of care - 1 - Outpatient; 2 - 'Day' case; 3- Admission. The day attenders have at least two meals per day while in attendance at the unit and literally spend the day there going home in the evening. It is hard to get them to comply with feeding regimes if these are only established on an inpatient basis so we are experimenting with this half way approach.

We are responsible for two satellite programmes - one urban in a poor socioeconomic area nd one suburban more prosperous area. These are school based clinics. In the USA we have developed a number of school based clinics - the first were in 1980 in 3 places - Minnessota, Detroit and Dallas; by 1990 there were 200; by 1992 there were 400; 1994 we had 600 and so on - an exponential rise. They are mainly in high schools (ages 10,11,12 middle school; ages 13-18 high school). They deal mainly with psychosocial problems, sexuality and general care. It is an interesting concept in that care can be given without parents present. Obviously parents need to be involved with younger kids. The older ones initially need parental permission to enrol but can then be seen for anything as many times as they wish.

Regarding our urban satellite programme;- Two thirds of attenders are black and 20% hispanic. 60% of problems presented are medical, eg check ups for the sports teams, there is thus an increased percentage of males because of the sports angle and coaches encouraging attendance. Usually in such facilities the higher proportion are female.
20% attend for gynaecological problems, sex, pregnancy and STDs. Contraception cannot be 'provided on site' butthey are given prescriptions and advice. They can be given condoms because of the HIV prevention (ie would not be able to distribute if it were just a birth control issue). The pregnant girls - half have terminations and half proceed to term. A day care centre in school looks after the babies
20% attend for psychological problems - depression, suicide attempts.The clinic had an impact in decreasing substantially the number of suicide attempts per month from 2 or 3 every month.

In contrast, the 'suburban' more middle class area, shows a different pattern of attendance.

Here they are more prosperous, have their own private doctors so there are fewer visits for general medical problems and 80% of all attendance relates to sexuality - because they have nowhere else to go, not wishing to see the family doctor for sexual matters and pregnancy. There are not so many babies produced by this teen population but there are many pregnancies - 95% of which end in abortion and only 5% continue to give birth.

Other problems relate to weight control - here again a contrast because the suburban girls are concerned about weight control but more often present with eating disorder whereas the urban girls tend not to develop eating disorder (there are no boys).

Depression, acne and tiredness cover the remaining attendances.

HIV prevention grant helps with condom use and awareness - there are several centres - the first teen programmes were in Manhattan Bronx and Brooklyn and were staretd because we were seeing young adults of 20-25 with AIDS and therefore they must have contracted HIV in their teens. We now have centres in other areas including Nassau and Queens although we have a zero level of HIV positivity on routine testing there and the only AIDS cases we are treating are teens who contracted HIV as children - through blood transfusions etc. This is in contrast to the inner urban poor areas where street sex and drug use gave cause for concern.

HETEROSEXUAL ABUSE IN ADOLESCENT MALES

This presentation was made at the IRC Workshop 1994 and was mentioned in the last edition of this Journal.

Authors:- Gustavo A Girard M.D. Castro Patricia M.D. Raffa Silvan Social worker Cal Alicia M.D.

Case history 1 *Carlos* is a 14 year old male adolescent who presented alone at Adolescence Program the Hospital de Clinicas, Buenos Aires, Argentina, with dizziness and weakness. He had a history of smoking since 12 alcohol,cannabis and cocaine occasionally.He never knew his father.His unmarried mother of 33 had lived with another man for 10 years and had 6 children.
Carlos lived with his grandmother until she died when he was 12. He later lived with an aunt and then with a cousin;relationship with his mother was very bad.
He looked older than 14 but was healthy and well dressed.
A little before turning 13 he began working in Patricia's cleaners. Patricia is 38, divorcee living at the back of the store with a son of 11. Three months after he began work at 14 he was sexually initiated by Patricia and passed on to live at the cleaner's. They have sexual intercourse described by Carlos as intense three or four times a day. He refers to having sexual intercourse in the most diverse places such as kitchen, stairs etc. He uses a condom and practices coitus interruptus. Two months after the onset of the relationship Patricia became pregnant. She told him about the situation and decided to have an abortion. Carlos says he felt very bad about it and also said she treats him very well when having intimate relations but ignores him otherwise, treating him as she treats her 11 year old son. Carlos says he is tired due

to Patricia's sexual demands and she is jealous whenever he goes out. She hit him and threw an ashtray and chair at his head once when he was late after going to the cinema with friends of his own age.
Patricia was angry when she heard that he was attending hospital. "That is a place for sick people and you are healthy" she said. Patricia became increasingly angry because of his visits to the hospital and made Carlos leave the cleaners and go back home to an aunt's house.
Throughout this process Carlos went to hospital 9 times where he was seen by a doctor specialising in adolescence and a social worker both under the supervision of the Mental Health Department. He rejected psychological treatment and failed follow up.

Case history 2 *Enrique*, a 15 year old boy. He presented with fever, asthenia and weakness. Father died three years ago, but he had divorced mother five years before that. He has four older siblings that do not live in the household and three younger ones from the mothers second marriage. He has received psychological treatment since childhood. He abandoned his studies in the 1st year of high school. He smokes tobacco, marihuana and cocaine since age 13 but reports he has only smoked tobacco and drank alcohol occasionally for the past year.
Looks weak, asthenic, jaundiced and in general gives a bad impression. Inflammation of the liver causes pain, is felt on palpation 2cm under the costal edge. Later laboratory tests confirmed diagnosis of B type hepatitis.His name was tatooed on his shoulder aged 12.
Enrique has been living with Cristina (29) his sister in law's sister for 6 months. He lives in Cristinas house with her parents and 4 siblings. Enrique would like a son but not Cristina. He says he had a child at 13 as a result of sexual intercourse with a professional model of 22 now living in the USA and says he saw the child twice but often has news about him.
He is found to be HIV+ and mother was notified.She said she is "fed up" with Enrique and that she cannot do anything about it, he "knows how to take care..and will not commit suicide".
Cristina received a notification and said she already knew about Enrique's condition. She reported having ended the relationship with him and Enrique is now living with his mother. Cristina proved negative as regards HIV or Hepatitis B.
An interdisciplinary approach was taken by doctor, gynaecologist, specialist in infectious diseases, psychologists and social workers.Legal aspects were dealt with by the Minors Legal Counsellors.

The aim of this paper is to provoke discussion on an issue which is seldom reported in literature on sexual abuse. The health team can be surprised by these cases. There may be and ought to be different answers according to different realities, social classes, societies and cultures. What are similarities and differences in approach?

What was our reaction to the title of this presentation? What was our reaction to these cases? How do we believe this would be considered by those societies in which we must perform as professionals? Would there be a legal impediment on heterosexual abuse in minor adolescents?

The problem is posed......

Youth Support Forum on Adolescent Health and Welfare
Transcript of the Ninth Annual Meeting
at The Royal Society of Medicine
On Wednesday 19th October 1994

"Child Protection and the Family"

Introduction - Dr Diana Birch -

We decided on the title of "Child protection and the family" for this meeting since the pattern of work has changed considerably since the children's act and we are now doing much more family work. It is also an excuse to plug "Bonds and Boundaries", the latest Youth Support Publication which deals with this subject.

Family can be stuck between binding too tight together, having too much control, and giving support while allowing some freedom of boundaries to let individuals run their own lives. Families should support children but not restrict.Professionals need to do the same and this is something we will be discussing tonight - we will look also at court proceedings and how they affect our work.
Our speakers, from a range of disciplines will consider the question 'how do you balance the needs of the individual child against the needs of the family' In a family where child needs protection; does the child need to be removed - to the perfect replacement family which does not of course exist or should the family be kept together.

We often see that adolescents who were adopted or put in care when young have great difficulty coming to terms with the 'guilt' of being 'rescued'and continually wonder what happened in their family of origin. How do we preserve the family and support good parenting?.

This meeting has always been informal we do involve young people - we need to bear in mind when talking that some of our Youth Support House residents are present. We will keep questions on a general level rather than to a specific case.

"Working with Families"

Dr Jonathan Dare, Consultant Child Psychiatrist from Department of Child and Family Psychiatry, King's College Hospital, London.

It is crucial when working with and helping families that this should be within a multi-disciplinary framework. To clarify my position, I am a childhood psychiatrist. Adults with emotional problems can often be understood in terms of family experience. I am member of a multi-disciplinary team with psychiatric social workers and psychotherapists working with people from Kings locality, not from advantaged area but indigenously deprived grouping.

In Child protection it is important to think about antecedents of abuse. We tend to compartmentalise abuse into categories, sexual, emotional, neglect, important to remember certain characterists within child and family. When you have a young person who has been abused at some stage later in life there is often an earlier history of neglect - communality of problematical relationships with parents and in particular violence has a damaging effect. You find common things - repetition, always need working on, so it does not happen in their own adult life. It does not necessarily mean they will abuse, it is just a feature seen often.

Some concerns are noted in working with the whole family. Clarification of who does what is blurred. Lack of clarity about who lives with who, antipathy between members of family, abnormalities in heirarchy. A recent referral was a 4 yr old boy whose GP asked me to see regarding temper tantrums which caused parents such problems they were splitting up. Obviously crazy but responsbility was placed on the boy.

How much sharing of ideas is there - we do an exercise to help parents learn what it is like to talk without adults responding. One exercise involves adults talking 5 minutes without interruption. The partner must show no interest. After 5 minutes going around twist with concern, they understand a little of what is it like for a child not listened to.

Another family where parents although living in UK came from abroad. A boy coming up to 15, was batted between Spain and England with parents difficulty in relationship. Maternal family in spain, then taken back. Settled in England and during that period be began to show number of disturbed behaviour patterns; fire setting aggression etc. due to earlier experience of disharmony and distrust; parental relationship breaking up. Mother had had a deprived childhood and was negative towards child with degree of harsh physical punishment. When the boy was aged 11, I became involved as consultant to boarding school for emotional and behavioural problems residential which boy was referred to. How much do you try to keep a child in the family?

Perhaps he could get better expereience in school which augmented experiences at home. Individeual work from therapist, staff work by myself and social worker seeing mother at home and occasionally father. I lost contact after a couple of years

then when he was nearly 15 I was asked to see him at King's as child psyochotherapist. Asked to do family work with him.

I met the mother who by this stage had a new partner and two younger children. Mother, stepfather, 15 month old and 15 year old. Mother said she was fed up with being involved in child's problems for 15 years, 'I tried to live my life' and insisted John should have individual treatment, she should not be involved in his life. The solution for her was not being involved in process. 'He is like his father, a bastard who always finds excuses - he is bad like his father'.

I said I would see John on his own, he was over conciliatory about his family insisting on mother being totally good person with no blemishes. He wanted to change for the better and I found this very sad; whole said in flat unemotional fashion due to given no credibility throughout his life. Treatment of family had no possibility as clearly degree of hostility but that is example illustrating and raising points about how much better is it to keep this child in his family?

I would like to look at a list of things found to be effective in abused children - these ideas come from research based in Lambeth based on long periods of care of children and research from New Zealand looking at adults who had been abused during childhood working out which things seemed to protect them as adults. Notion that if that person grows up and forms partner relationship with someone who did not have similar experiences that is very helpful - secondly importance of education making enormous difference to self esteem. Positive caring relationship outside immediate family is very important - caring aunt or uncle but someone able to stick to that child is very beneficial. Obviously an adult confidante is another important feature. Not just someone in the professional field. We cannot do much about full time employment but it does emphasise importance of helping someone to get a vocation.

Lastly, I wanted to look at range of involvement in working with children where they remain in family of origin. Some children do get removed because for whatever reason it is felt family of origin does not meet their needs without support. Family therapy is about helping families to make use of their strengths, not about saying you are terrible family but identifying family herarchies, communication problems etc and helping use strengths to overcome problems. Counselling parents to think about the way they parent and alter that to promote support. A wide variety of agencies which give support promoting families. Extra support is needed for child protection. I should emphasise that there are limitations to psychotherapy, which is not a magical property, the reality is you can help overcome conflict of earlier life but cannot give parenting. Sharing with young children guilt feelings arising from abuse to help overcome them.

All these require that there should be a framework of multidisplinary agency involvenment as no single person can effectively meet the needs.

Questions -

DB We work with role reversal - little mums aged 7 or 8 trying to

mother their parents. It can be difficult working with real mother getting her to be more adult and little girl can be resentful on losing role.

JD Young person has put on them inappropriate degree of responsibility - when that carries on burden too much. Taking it away helping parent initially that may cause resentment - after initial period child feels more secure. Asking anyone to give something up will cause resentment.

DB Sometimes families are not damaging to children but act in different mode

JD We are often accused of being family engineers - there is enormous difference in ways families function and I work with notion of how can family he helped in manner which works for them because you cannot know the precise details of family background - find solution when identified problem.

"Working with children and families - a problem solving approach"

Diana Austin Guardian ad Litem

The title of my discussion is working with children and families - a problem solving appraoch. By the time I am involved with families somebody has considered difficulties of one sort or another and the courts are involved. My particular approach is set within the court framework of the children's act guiding everything we do.

The first task applying to social workers as well as others is to define the problem clearly. What are the basic expectations we have about quality and nature of care of children? We have to examine our own assumptions and be clear about families and their assumptions of the situation. Sometimes the difficulties lie within their own experience of parenting and wrong assumptions they perhaps brought with them. We also bring assumptions to that assessment which may be inappropriate.

The 'significant harm' test which is enshrined within the childrens act is quite a useful concept to work with - there is an assumption that if one is to be given an order one must be able to dmeonstrate level of significant harm either in past, present and the assumption is that this will continue in future without the intervention of an order. That needs discreet assessment of family and child requiring psychological physical and emotional assessment of child and family.

It is important we have a clear view of the different perpectives and values of different disciplines which should not detract from each other but provide information and enrichment to the assessment of the situation.

Let us consider culture in the wider sense; each group has different expectations on relationships with parents and what children should be doing. We have to be aware of that when assessing. Most Guardian ad litems tend to be white British, middle class and we could be seen as imposing our values on other

cultures without taking account sufficiently of different views.

There are conflicting needs between parents and children which happen in any family, sometimes where there is a problem those needs are so conflicting that parent cannot nurture child sufficiently for there to be a strong bond or attachment. This frequently is result of life experiences of parents themselves. I think some parenting skills are given to us and if some are missing we can find it later from other sources. This is confirmed by Rutters work on disadvantage and work at Tavistock clinic. Findings can be traced back sometimes four generations when specific incident had repercussions down generations. Sometimes needing order or intervention with social services.
The concept of 'good enough' parenting is useful where childs needs are met sufficiently well by parent to limit intervention. The other aspect of the good enough parenting is question of rights of parents and children. I know we have legal representative - talk about that in legal sense. Not talking about parental rights but responsbilities, change of emphasis within act. I also have difficulty when working with families where sibling v siblings where one sibling's needs conflict with another. An example is a family where there was an adolescent and a three year old child both who needed placement away from family of origin. The adolescent was still closely tied to the natural mother but wanted contact with his younger sibling - on the other hand there were very strong reasons why the natural mother should not know where child was. There was difficulty in the court process as to how that problem could be resolved in such a way that adolescent could have contact with young sibling, the sibling could be placed appropriately and there would not be conflict brought into new placement by mother turning up on doorstep.

We also assess ability or room for change within parent. Sometimes we under estimate that. We need resources in order to assist change and this I think is most difficult because of funding problems everywhere. It is disheartening to see placement not taking place due to budgetting problems when child and parent could be brought on to remain together safely and progress together. This is a short term view, this is not done because of high cost - you will then have next generation when you will have to spend money, short term view when budegetting decisions made.

The concept of partnership is highlighted in the children's act - document called working together illustrating need for multi disciplinary work. This is important, but in cases where there has been an order made such as a care order or superivison order final responsibility lays with social workers. If anything goes wrong they will be ones carrying responsibility for that. Unfortunately we have situation where there is need to blame. I think we see damages to social workers and also children raising level of anxiety. Partnership between social workers and parents has inequitable balance of power; where there are grave concerns about protection then balance tipped strongly towards social worker.

As need for protection of child lessens and as work progresses one would hope to see balance of

power shift to more responsbility to parent for decision making for child. In my view, court orders should be used to facilitate work between parents and children and local authorities. The purpose and function is to protect and assist children and families; it is a mechanism for assessment and a way of managing risk.

Risk has to be carefully assessed to know what degree of intervention is appropriate. There is a potential failure is management of risk - the word 'risk' itself implies there is potential for failure and we have to accept that there are times when families and social workers will get it wrong and we will have tragedy. One must avoid it and manage work so it does not happen but nevertheless intrinsic in working with risk situations we are going to miss something placing child and family at risk and we will not be able tot intervene quickly enough. When these things happen blame flies around and social workers have a tough time.

I am appointed by the court when an application for an order is made, usually by the local authority. My task is to go in, assess, look at why anyone asked for order, why is it necessary, what parents views are, assess child, get some understanding of developmental stage, see whether there is inappropriate behaviour in child or parent, understand how this family functions.

I am always pleased and surprised at the willingness and generosity of families talking to someone who is looking at them for a short while, not contributing but listening who they know is going to write down what they say to show the Court. I have yet to meet a parent who has been anything less than generous and helping me in my task. I have always been pleased by their assistance. I also have responsibility to ensure that wishes and feelings of children are made plain to the court. Sometimes these can be unexpressed. Children say one thing because they know that is what the family wish them to say, but in another way in behaviour or saying something different - it is always difficult getting balance in that part. Children can be put under considerable pressure during court process as result of having to ask older children to express feelings.

Court intervention also is stressful for everybody involved and I sometimes feel I wish there was a better way of doing things but that is system we have to work with. We try to make it less adversarial but not alway spossible. It is going to uncomfortable for families as intrusive however careful we are. Our work is time limited - I come in when court is asked for an order and when that is made I disappear again. Sometimes I am lucky to hear whispers as to how families are faring which is heartening but it is difficult and interesting work.

"Working with families, legal aspects and the Children Act"

Nigel Murray - solicitor, Member of the Law Society, Child Care Panel.

My role is to get involved in cases where there is some court action - situation where child about to come before court and somebody is concerned about the child's welfare, whether the child is at risk and in danger of significant harm. I represent one of the family parties - I have worked for local authorities but the bulk of work is now either for parent or child. there are different roles - in acting for a young child my job is similar to Diana Austin representing best interests and following guardians instructions.
For an older child it means taking instructions from the child and trying to advocate before court, also for parents. This can be an adversarial role - which can be criticised but I subscribe to the view that if client wants children back saying social worker is a liar within bounds (I will advise them of likelihood of success) I will take that role for them, using the law as best I can to their advantage. Unpopular concept of what solicitors are about but I would want it said social workers got it wrong if they did.

I have prepared a handout on the children act which is detailed in sense it is designed for social workers, lawyers and others involved in work - technical side of act. It provides two areas of involvement in sort of cases I see - removal of child by police, interim care or care order; in other words, removing the child from wherever it lives placing it in foster care or residential care. That is one side of court function. The other side is assisting family or child where they live, interim supervision orders, family assistance order, prohibitive step orders etc

The law was changed in many ways when children's act came in. It works well when there is working in partnership and agreement. Like most laws, that is fine if there is need to remove as everybody agrees that is right - no problem. We need a legal framework in which to do that. We don't need an act to state that but do need legal framework. The difficulty comes with conflict in situation when someone says they did not cause injury, did not abuse, the child should be living with me and not in foster care.

My views is that childeren's act in court context is a disaster in the sense that it has removed jurisdiction of court to police and investigate properly making recommendations and orders that it can then continue to police and look after in the future. What they did was to abolish the old wardship procedures which enabled a child to come within protection of the court - who could say what will happen to that child, ordering local authority to fund residential assessments staying for periods of time with local authorities paying that regardless of budgets. That is all gone.

We now have the situation where a court can make certain care orders etc. but in making those orders it cannot make other directions which may be needed. One has to go through legal loopholes - once it decides for example that a care order should be made it has to see if there is

a care plan. The local authority social workers must set out a care plan when working within childrens act - if the court disapproves of care plan so long as it comes within the document there is nothing court can do regarding wish to go to assessment centre or otehr measures. The judge can only make a care order, not say that the family should be for instance admitted to a centre.

When one considers protection of the child, nobody is suggesting social workers do not approach their job with skill wanting to do what is right - if there is agreement about that we don't need consent of court, it is those situations where there is disagreement. Social workers do disagree, taking view that child going into care is going to resolve problem etc. The guardian's role in this is to mediate, but even if guardian takes view that rehabilitation centre is good and assessment of family can benefit child and the court thinks it good idea local authority may not fund it so the court can do nothing.

This removal of wardship jurisdiction is a big disaster for child care in real conflict situation occurring in care act proceedings. For example if parents or children should undergo therapy - cannot order that now. Before one could come back to court every six months for review and look at the plan to monitor progress - cannot do that now. Court cannot control what is happening to that child if local authority take particular view.

All this leads to the situation Diana explained. That is the real reason why we have this childrens act, hailed as great step forward but I take view that it is an act designed by a tory government to minimise and prevent local authorities having to spend money in terms of what was preventative work to stop children coming into care, providing resources and facilities helping to prevent neglect and difficulties at home.

Who hears nowadays of preventative social work? It must occur but there is no budget to provide preventative work to stop children ocming into court system on any level at the moment. The way the government has achieved a situation whereby local authorities have to look at their budgets year by year; by saying we won't let courts interfere by ordering us to spend money in areas like going to residential centres, we won't allow courts to monitor situation, so at the end of the day you run services in the way we say and if you don't under the act and a child dies as a result we will have enquiry and blame you anyway in saying you are incompetent. Government throwing all responsibility back onto social services. Good local authority or bad, they have to manage budget yearly so opt out of situation. That is the perniciousness of the act. Whether that is result of government actions may be arguable, my view is that that was intention and they have achieved that.

I was going to give examples - they may clarify what I have been saying. Case referred to Diana Birch for help - new baby, mother suffering from myotonic dystrophy - found it difficult to have a normal life - clearly major problems looking after her young baby. Father obvious skills but was bit of drinker, marriage shaky, he wanted no part in looking after child. Local

authority wanted to remove child acknowledging long term financial need. Guardian wanted to involve mother and father in therapeutic work but local authority would not agree. Court had final hearing date due to start - for variety of reasons local authority realised they would lose the case, and decided to go for residential assessment. We lost a year during which time valuable work could have been done. Under old system judge would have been convinced that residential assessment would be invaluable yet under new legislation there was nothing that could be done to achieve what everybody thought was right.

I acted for children where mother addicted to crack cocaine - could not look after children - mother was then able to rehabilitate herself. Local authority, because foster placement broke down, not due to children but problems of foster parents decided to return children to care of mother, who had become intentionally homeless. Local authority put her into bed and breakfast, fragile in emotional state with two young children under 7 with enormous pressures. One would want to hope local authority would provide proper accommodation to give best scenario to keep family together. Local housing authority said she made herself homeless intentionally so could not help, social services said this comes under childrens act and you should be providing accommodation. I wrote saying if you do not do somehting I will judicially review you and get court to make comments about this. Before response to my letter House of Lords made decision that if you make yourself intentionally homeless local autholrity should not rehouse you. Classic example of sorting out what everybody saw as difficult situation but because authority did not have finances they were not helping that family. Case is managing to stagger on but is fragile.

That is my critique of childrens act. There are some remedies - you can judicially review but that is really not very useful because court only has to decide whether local authrolity has come to reasoned decision, not reasonable. You can make complaint under Section 26 of act and 2 years later it will be dealt with, meantime the family progresses or does not. You can ask secretary of state to make default order which you can do after local authority completed their complaints procedures so 2 years later they will go to secretary of state who a year later may make a default order - what does that do for the child, nothing? You could sue local authority for breach of statutory duty - you could go to court saying they are not providing services, breaching their duties set out in childrens act but the court of appeal in the case of the London Borough of Lambeth said the act does not incorporate statutory duties, just guidelines. You cannot sue them or force them.

Coincidentally if you built a house and asked surveyor about what you should do, he would advise complying with that regulation and if later the wall falls down you could sue him for default of statutory duties. If inadequate support provided and family breaks up there is no statutory duty there. I would have thought that a roof falling down and splitting up a family cannot be compared but that is the situation. So remedies are not remedies. The adversarial

approach acting for parents going in fighting order saying this not right kicking up fuss, choosing right judge and magistrate - get to know judges and make case you want before judge going along with you.

A Lambeth case involved 6 children placed in care for 9 months with nobody visiting them nobody doing anything about placing children in foster care or going home. I said to judge this is appalling, one child sexually abused in home and riot involving older boy - I want assistant director to explain what is happening. He said I am only here for care order or not. He made it then we went back to say same thing - the assistant director came next week and a week later found foster carers. Kicking up fuss working in that situation but it should not work that way in protecting children and families. Judge who did kick up fuss had no power to order anything, assistant director came and said nothing he could do about it - question of choosing right judge.

Other areas solicitors can try is writing letters and getting guardians to put in his or her report why it is wrong couched in terms of her recommendations. No statutory power behind it but no legislation to act in best interests of children. To protect child in best way. We have been looking from the prospective of childeren who are being got at in wrong way by social services - at the same time there are many cases where social services depts are doing good work in difficult circumstances.

Child Protection and the Family - the Social work and Voluntary sector role

Paul Griffiths - The Children's Society (lately of the ISPCC, The NSPCC and Childline)

Child abuse and child protection is a serious matter - I was reminded about my grandson - I said to my daughter and her busband, you two go out and I'll look after two children, but they decided to play up. It reminded me how difficult it can be parenting young children with limited support; grandad now gets on phone a couple of times per week offering support.

I have worked in local authorities for some time and with voluntary sector; I always held dear listening to childeren and hearing whan they said. When we started to work with children particularly those who were sexually abused it became clear for many years these children had carried the secret and had no way of talking about it. They had seen teachers, police, etc but had no way of using this. Somehow they did not talk - this was the thought behind Childline, now taking around 8,000 calls. Diana setting up Youth Support knows about all the opposition from all kinds of people - they told us this wouldn't work, but now Childline is taking all these calls. Listening needs people like us to determine and understand the needs of the childeren and families, working

out what they need. When I started working in child protection it was in a preventive way with the National Society for Prevention of Cruelty to Children - authorities were working under Section 1 of the Children's Act 1963 and there was great scope to that. Now it is neither one thing or the other - pulls children and families onto roller coaster over which they have no control. This has been illustrated here well in discussions.

Voluntary agencies and others - their work reminds me of an incident working with Mary a few years ago. Mary wrote me an account of an incident of child abuse that I wanted to talk about - we can then best think about what helping agencies there would be around for her now. She was a person isolated in a council flat on the 23rd floor, a partner who came and went living in considerable poverty, with a 9 month old baby and herself 19 years old. This is what she said:-

"I came down about 10am on Saturday morning - Susan the baby had slept downstairs because she was crying until 2am. I picked her up from the cot and sat her in an armchair, and told her she would be alright while I went into the kitchen I came back in the living room and she started to cry when I picked her up".

... Here is a mum beginning to feel rejected by her baby. "I tried to give her some food but she wouldnt take it, and when I turned my head she spat it at me. When I tried another spoonful she just refused. I put the bottle in her mouth and she usually then swallowed the food - this time she pushed the food out the side of mouth. I took the bottle out of her mouth and cleaned her down. She had some milk left in her mouth, and then spat it at me. I tried again but she carried on crying. I tried to undress her to put her on the potty but she kept screaming all the time. ....She just wouldnt shut up. I left her on the potty in a chair but she carried on crying. I put her in a bath but she wouldn't stop crying. When I tried to quieten her she cried more. I tried again with a bottle but she didn't take it. She had had a bad cold so I picked her up, and when I lifted her off my shoulder she had been sick all over me. She started to cough, I stood her up against me and she stopped - I put her on a rug and towel, she started to scream again, her arms and legs going up and down. I picked her up and put her down several times, but she wouldn't stop screaming. I got cleaned up, came back, and she still wouldn't stop. I then grabbed her by the throat and banged her head several times on the floor in anger - when she didn't shut up I bit her several times, and I still don't know why I did it. I picked her up and nursed her until my father came home from work at 4.45".

I wonder how many parents have actually almost been there and can actually experience that - it is probably right to comment that young people with children are probably more isolated than we were without the obvious links for support. What is going on and how preventive would the services be if they were there?

I take the view having worked in child protection for 30 years when there were only books available on child protection, I am not sure in those initial stages if we created an environment where young parents could without any sense of shame and without a sense of being labelled be able to knock on a social workers door and ask for

help. I know there were voluntary agencies then, but even local authorities now are often tied up with service agreements or contracts with authorities which do particular jobs - I knock on the door of the National Childrens Homes and say "please help me I am in trouble with my parents", "You cant come here, we only do sexual abuse work etc....." Dr Barnados homes "Sorry you cant come here" ..... where do parents in this kind of distress go? I am not going to answer that, other than to say there are places not obvious to the parents at the end of their tether.

There is the health visitor, but we know the health visitor is through the GP. I came back to work for a local authority in West London and wanted to see what it would be like working in frontline child protection again on a consultancy basis; I asked to work and manage their child protection team. I found that 90% of their work was investigation, reactive work, fire engines charging about the place - around 300 miles per week. The tendency to go down the legal path because nearly every time the police had to come with us (I am not sure why because that criminalises the whole thing). In this particular authority there had been six child protection enquiries into deaths of children so it was safer for the social workers for police to go with them - what it didnt do, and I wrote a report as a consultant, was give parents and children space to talk about it, take their time talking to me as they had done even five years before. On average in this particular team five enquiries a day were received with two of us to do it.

I am pleased to see young people listening here, because there is so much there for you to complain about and you now know how. Yes, there are child protection registers. I recall research done in the DOH - I think it was dynamite as it demonstrated that social workers wanted to work with families listening to the difficulties etc and were prepared to take risks, befriending and if time would visit frequently, send in aid etc. The further you enter this organisation and got to the senior social worker he or she would think some statutory proceedings were appropriate and once area director was reached you are really going down that way; when the director of social services (place of safety then called) he saw the child protection procedures as insurance policy against enquiries which might happen, you know what happens when a director is involved in child death enquiry in his area, he tends to get early retirement packages.

So what can voluntary agencies do? I think and I dont have directors permission to say this that we have to get out of this service thing - I think we have to back and work with voluntary agencies like Youth Support, the Childrens society etc. working in communities where our roots are. be available for people to talk to us, this is what people who support and raise money for us think we do. People ask how many childrens homes we have, we dont - but what we do have within the Childrens society we are rejecting notion of working with service level agreements doing what local authorities want, we are talking to other professionals and setting up services young people want.

As an example of that in a school down the road from my office in Peckham - because the young people told their teacher they wanted a centre within the school to talk to us about anything at all, a walk in childline. I think that school has been brave to want it, there are 32 first languages spoken in that school and it is amazing the children work through and overcome this. We are saying we are good at helping young people too, so we are going to help train young people to have their ears open and where they want specific help or guidance we will work through them and advocate through the system. The Childrens society is rejecting traditional approaches and opens up the door for young people to approach them unconditionally on whatever issue they wish. Another example is a project in North London for children with disabilities but I had better stop now.

DB - Thank you; Getting back to working with families, a lot of the work we do is treatment of abuse whereas most of the statutory agencies diagnose only. With regard to the law, sometimes this works against us when we are trying to do healing. When I was teaching a group of young doctors in America during a workshop we were talking about counselling of abused teenagers, specifically runaways - and I was immediately struck by the fact that you can get no further than this because in the States they have to immediately report it to the Law and all therapy stops while legal process carries on. We are getting to a danger point over here whereby law is overtaking and we are not going to be able to work with families properly.

Youth Support House

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(24 HOUR-FAX)

"Bonds and Boundaries"

- Child Protection and The Family -

Diana M. L. Birch

* * * * * * *

To work in the field of child protection and particularly when it involves assessment of a family and possible rehabilitation is an area fraught with difficulties.

All families have problems of one degree or another. All children make their parents angry at times, most toddlers have tantrums, 'normal' married couples have blazing rows, children will compete with each other for attention and little girls do have crushes on their fathers and get jealous of their mothers. Where do we draw the line, the boundary between what is acceptable and what is harmful, abusive and requires professional intervention?

And if we do intervene - how can we be sure that our intervention is helpful and does not in itself cause more harm than good?

The needs of the individual are not necessarily compatible with the needs of the group - in this case the family - and weighing up these needs and placing them in some order of priority can be nigh on impossible. It requires empathy and sensitivity - but most of all a high degree of professionalism.

Subject matter includes: Rehabilitation and The Family - Working with Families - Bonding, Separation and the Rehabilitation process - Results of Rehabilitation including outcomes of our experience at Youth Support - Disordered Family Structures.

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Published by **"Youth Support"** Charity No: 296080

- The Children Act 1989 - Important Features in Child Protection - Prepared by Nigel Murray

A . DUTY TO INVESTIGATE - S.47

1. General principles

Where a local authority:

a) are informed that a child who lives, or is found, in their area -

i) is the subject of an Emergency Portection Order, or

ii) is in police protection; or

b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm,

the Authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child;s welfare.

2. Denial of access

Only remedies available if carer refuses access to child are:-

a) Emergency Protection Order

b) Child Assessment Order

c) Supervision order

d) Care Order

Application for one of these orders must be made if child's welfare cannot be satisfactorily safeguarded.

3 Inter-departmental co-operation

Unless unreasonable, Local Authority, Local Education Authority, Housing Authority and Health Authority and specified bodies must assist enquiries of the Local Authority

B. CHILD ASSESSMENT ORDER - S.43

An overlap with the Emergency Protection order?

1. Grounds

Court can order assessment where:-

a) Reasonable cause to suspect child is suffering or likely to suffer significant harm

b) An assessment is required to see if child is suffering or is likely to suffer significant harm and

c) It is unlikely an assessment will be made or be satisfactory without Court order

2. Options available to Court

The Court can:-

1. Make Emergency Protection Order instead
2. Order maximum 7 day child assessment order
3. Keep child away from home
4. Direct purpose of assessment
5. Order contact between child and "other person"

3. Procedure

1. Must give notice to parent, holder of parental responsibility, guardian, child, subject of contact order
2. Such parties can apply to vary or discharge order
3. Guadian Ad Litem to be appointed under Section 41 if necessary
4. If application fails, no further application for 6 months without leave of Court

C. POLICE PROTECTION - S.46

S.46 Replaces S.28(2) Children and Young Persons Act 1969(Police Place of Safety)

1. Grounds

a). Constable can take child into police protection if he/she believes same conditions are met as for an Emergency Protection Order (S.45/48)
b). duration is for 72 hour sonly

2. Procedure

a). Inform local authority and child.paents.carers
b). Discover, if possible, wishes and feelings of the child
c). Move child as soon as possible to Local Authority accommodation or child refuge
d). Apply for Emergency Proection Order if necessary with or without Local Authority consent or knowledge

S.21 b) Local Authority msut have accommodation available for children on remand or in Police accommodation.

D EMERGENCY PROTECTION ORDER - S.44

1. General

a). Replaces Place of Safety Section 28 Children and Young Persons Act 1969
b). In short term order to enable child to be kept safe

2. Grounds

a). Anyone can apply for an Emergency Protection Order which will be granted if the Court believes there is reasonable cause to show that the child is likely to suffer singificant harm if:-

i) he/she is not moved to other accommodation or

ii) he/she is not kept where she/he is

N.B. No need to show harm has already occurred and therefore wider than Place of Safety

b). The Local Authority can in addition apply if it can show it is:

i). Carrying out an investigation under Section 47 where there is reasonable cause to suspect a child is suffering or likely to suffer significant harm and

ii). Those enquiries are being frustrated by access to the child being denied unreasonably and

iii). There is reasonable cause to believe that access to the child is urgent

3. Guidelines for the court.

a). S.1. Wlefare of child paramount importance
b). Child should only be removed in order to safeguard his/her welfare
c). Welfare check list does not apply

4. Types of emergency protection orders available.

Court can make an order:-

1. For 8 days maximum extendable once for a further 7 days
2. That child must be produced by carer
3. That whereabouts of child should be disclosed

4. That premises can be searched for child and other (preferably named or identified child)
5. That police should assist and be able to use reasonable force (replaces Section 40 of the Children and Young Persons Act 1933)
6. Requiring or preventing medical or psychiatric examination. Mature child can, in any event, object
7. Requiring or preventing contact between child and carers

5. Effects of an emergency protection order.

1). Parental responsblity passes to successful applicant but on limited terms
2). Contact shall be maintained between child and carer subject to Court direction
3). Child should be returned if safe to do so

6. Procedure.

1). Application to be made according to regulations
2). Application can be with or without notice to child / carer
3). Guardian Ad Litem can be appointed to attend
4). Written statements / reports can be shown to Court and hearsay rule can be ignored
5). No appeal by applicant possible if Emergency Protection Order refused
6). Application by carer or child to discharge Emergency Protection Order can be made 72 hours after Emergency Protection Order made unless:
- a). The person is present at original hearing
- b). Emergency Protection Order being renewed (objections could have been heard at renewal hearing in this case)

E. CARE AND SUPERVISION ORDERS - S.31

1. General Grounds

This is now the only civil legislation available under which care or supervision orders can be made
Two stages:-

1) Stautory Threshold Criteria (S.31)

A Court may only make a care order or supervsion order if it is satisfied on a purely factual level:-
- a). that the child concerned is suffering, or is likely to suffer significant harm, and
- b). that the harm, or likelihood of harm, is attributable to:-
  - i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect the parent to give to him; or
  - ii) the child's being beyond parental control

2). Consider (once 1 above is met) whether order should be made and if so what type of order (S.1 (4))
- a). No order should be made unless the Court is satisfied it will be better for the child to do so
- b). Children Act does not require Local Authority to wait until a child has suffered actual harm
- c). Moral danger, non school attendance and commission of an offence are no longer grounds in themselves for making an order. N.B.Local Education Authority can aply for education supervision order
- d). Police cannot make an application for full care order
- e). Guidelines for Court
  - i) Section 1 welfare of child is paramount -
  - ii) Welfare check list applies but only when considering if and what type of order is necessary
  - iii) Civil standard of proof applies (S.96) i.e. Case must be proved on the balance of probabilities, hearsay evidence admissible and self incrimination privilege is abolished

2. Definitions:- S.31 (9)

a) Harm

Ill treatment or impairment of health or development. In considering of this harm is significant, then Court should compare childs health and development to that of similar child

b) Development

Physical, intellectual, emotional, social or behavioural development

c) Health

Physical and mental health

d) Ill Treatment

Includes sexual abuse as well as non physical ill treatment

Court must consider arrangements for access and seek comment from parties
Court must set timetable for hearing

3. Orders available to Court

1). Supervision order (S.35)

- a). Supervisor advises, assists and befriends and must take steps to effect order and when / if appropriate consider discharge
- b). Order last one year unless extended. Maximum 3 years. Expires aged 18
- c). Directions as to attendance and participation in activities can be made
- d). Psychiatrict and medical examination can be required by Court. child, if able, must consent. Responsible person can be required to take all steps to produce a child for examination
- e). Psychiatric and medical treatment can be required. Child if able must consent
- f). Application for discharge can be made by child, parent or supervisor every 6 months
- g). Care order cannot be substituted. Fresh proceedings must be started

2). Education Supervision Order - S.36 (3)

- a). Available where Court concludes child is not being properly educated
- b). Parent who persistently fails to comply with directions given commits an offence

3). Care Order

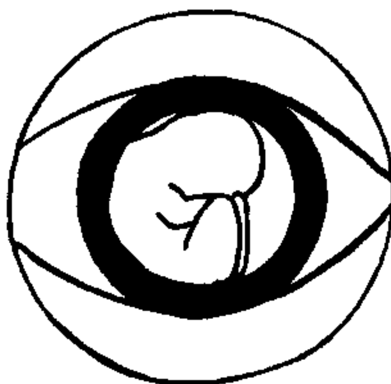
- a). Local Authority cannot change childs religion, give consent to adoption, move child out of the U.K. or change childs name
- b). Local Authority has parental responsibility and power to determine extent to which child can meet parent or previous carer
- c). Local Authority must allow reasonable contact between child and his/her parent / carer unless notice of termination served and Court adjudicates child, parent or other person (with leave) can seek contact order from the Court which can be refused - S.34

4). Interim Care and Supervision Orders - S.38

- a). Available pending full hearing
- b). First interim may last for 8 weeks, but there may be subsequent orders which should not last longer than 4 weeks
- c). Medical and psychiatric examination can be ordered or prohibited Child if able must consent
- d). Interim Residence Order can be made when adjourning care proceedings or giving directions - S.8
- e). General i. Guardians Ad Litem to be appointed unless Court considers not necessary to do so in order to safeguard child. Guardians Ad Litem appoint solicitors
  ii. Official Solicitor can still be appointed

INNER WORLDS AND OUTER CHALLENGES

Diana M.L. Birch



Part One - Inner Worlds - Confronts the question of how we develop personalities and discusses varying personality types.
Part Two - Outer Challenges - How our personalities are affected by disability, violence, abuse sexuality and assaults on self esteem.

NEWS NEWS NEWS NEWS NEWS NEWS NEWS

Conference on Adolescent Health - 24th October 1996 , Royal College of Physicians St Andrews Place, Regents Park London - enquiries FAX 0181 659 3309
New York International Conference on Eating Disorders - April 26-28 1996 Details from Preston Zucker Montefiore Medical Centre 111 East 210th Street Bronx NY 10467 tel 718 920 2176 FAX 718 920 5289.
Youth Support Tenth Annual Forum Meeting at the Royal Society of Medicine Wednesday 18th October 1995 6-9pm.
Advance Warning - 1996 is Youth Support's tenth anniversary year - Whole day meeting on Adolescent Health at the Royal College of Physicians - October 24th 1996 - keep the day free.
Third European Forum on Adolescent Health - Lisbon July 1-2 1996 - Contact Helena Fonseca FAX 351 1 7930315

Are You My Sister Mummy?

How does it feel to grow up with a mother only twelve or thirteen years older than yourself? "Are you my sister, Mummy?" is the definitive text on **Schoolgirl Pregnancy** - Dr Diana Birch reports the findings of over twenty years work with more than 150 very young girls, their boyfriends, families and children. The second edition with up-dated statistics, a new preface and conclusion is now available (Price £10 inc P&P) from:-

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Youth * 1986 / 1996 * Support

Don't Forget - The 1995 Forum meeting is the tenth meeting and we hope it will prove to be a special event ..... but 1996 our Youth Support Tenth Anniversary year will be marked by a Scientific Conference on Adolescence - social events and fund raising exercises - please let us know if you are interested in helping or participating - Watch this space for developments - or contact Youth Support House for information ... Coming up .. a 'Blues Brothers' event we hope! For information ring Lisa or Sonia 0181 650 6296

The Tenth Anniversary of Youth Support will be marked by a

Conference on Adolescent Health

to be held at the

Royal College of Physicians
St Andrews Place, Regent's Park, London

on

Thursday 24th October 1996

Conference 9.30am - 5pm
Followed by Keynote Lecture
Followed by Tenth Anniversary Dinner

The conference will highlight advances in Adolescent care over the last ten years and will deal with a number of important areas of young people's health. Sections include Teenage pregnancy and sexuality; self harming behaviours and substance abuse; eating disorders; emotional problems; youth and violence.
Our speakers are renowned experts from the field and we hope to include some of our international colleagues.

Please write in now to :-

Youth Support Conference Administration
Youth Support House,
13 Crescent Road London BR3 2NF   or FAX 0181 659 3309

if you wish to receive further details or to make advance bookings

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