BLOCK 3  PRIVATE TROUBLES AND PUBLIC ISSUES

UNIT 15  RECEIVED INTO CARE
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UNIT 16  CHILD ABUSE
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Unit 15 RECEIVED INTO CARE

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STUDY GUIDE AND OBJECTIVES

This unit and its associated television programme (TV programme 8, ‘Why care?’) have been designed to offer you the opportunity to explore three rather different aspects of residential care provision for children and young people.

Firstly, both offer basic information — about such things as the history of residential child care, the kinds of services offered, the procedures involved and the constraints (e.g. the law) within which decisions are made.

Secondly, both the unit and television programme convey some of the emotions involved when children and young people are received into care, and something of their feelings about being in care. To make sense of a topic like this needs to include opportunities to gain empathy with the experiences involved.

Finally, and most importantly, the unit and the television programme are intended to challenge your taken-for-granted views and perceptions. Residential care for children and young people raises complex questions about the way we construe the needs and rights of children and young people, the obligations and rights of families, and to what extent the state has a right — or a duty — to set child-rearing standards and intervene when these are not met. In principle, residential care is a service provided to serve the welfare of children and young people. But who defines ‘welfare’? Why is it that residential care is provided (rather than, say, live-in help for the family, or extra state benefits)? And why do some families ‘need’ state provision, when other families manage without it?

Thus the unit is woven around these three themes, and in most sections you will be expected to tackle in parallel new information, explorations of emotions and feelings, and lots of questions and re-evaluations. There is no supplementary reading for the unit, and just two fairly brief activities, and so you can tackle it in one (fairly long) go, or break it up into sections.

Television programme 8 concentrates on the decision-making processes involved when a child or young person is received into care. It contrasts the bases for such a decision in the mid-eighteenth century, when the state first began to undertake a general responsibility to care for foundlings, with the way such a decision would be taken today. The programme includes a simulated ‘case conference’ in which professionals who make such decisions discuss a simplified case study, and their responses are commented upon by representatives of young people in care and family rights groups.

Probably the best way of approaching these two components of the course is first to read through the unit fairly rapidly, allowing yourself time to pick up the main issues, without trying to do the activities or tackle any of the major ‘thinking through’ of the ideas raised. Then check through the notes associated with TV8 so that you are familiar with the case study details used in the programme (this will allow you to follow the discussion much more easily). Next watch TV8, and carry out the linked activities. Finally, go back to the unit and work through it in more detail, taking each section in turn and linking them to the points raised in the television programme.

The unit and television programme can only offer you the briefest introduction to what is a crucial area of social policy and service provision. If you want to know more, then some additional reading is suggested at the back of the unit. Other sources of information are the associations of young people in care — NAYPIC in England and Wales, Who Cares? in Scotland, and the Family Rights Group. The Department of Health and Social Welfare within the Open University also produces learning materials in this area.
**Objectives**

When you have completed work on this unit and the associated television programme (TV8) you should be

1. more aware of the assumptions and expectations which socially construct the process of receiving children and young people into care,

2. able to trace historical changes in our ideas about the relationship between children, the family and the state – and how these have affected residential care provision,

3. able to list at least three reasons why a child or young person may be received into care today,

4. able to describe at least two reasons why the children and young people in care reflect social and economic divisions in society,

5. more informed about the functions residential care is intended to fulfil,

6. able to describe at least three different kinds of residential care provision,

7. able to list some of the advantages and disadvantages of foster care compared with institutional care,

8. able to suggest some reasons for the tensions that have grown up between residential care staff and field social workers, and some of the steps being taken to reduce them,

9. able to review changes in social policy that could reduce the number of children and young people received into care,

10. able to describe some reasons why residential care will need to be provided for children and young people,

11. able to make recommendations about the basic minimum standards of care to which all children and young people ‘in care’ are entitled
1 INTRODUCTION

Jamie
It is three o'clock in the morning. Two-year-old Jamie is standing in his cot, screaming loudly. The neighbour in the flat next door has called the police. The night duty team of the local Social Services Department has sent two social workers who arrive, accompanied by a police officer, and ring on the doorbell. When, after several minutes, there is no answer, just the piercing screams, they open the door (which is unlocked) and, finding nobody else there, go into the bedroom and pick up Jamie. His nappy is soaking wet and filthy, his buttocks red and raw. His cries stop, and he gazes at the social worker with a look of fearful, frozen watchfulness, just whimpering slightly. The room is cold, bare, with just the cot and rubber mattress smelling of urine which has leaked out in puddles on to the torn linoleum floor. There is no blanket on the bed. Jamie is dressed in just a tiny, dirty vest and the stinking nappy. Putting on a fresh nappy and wrapping him up in a clean cotton blanket they have brought with them, the social workers carry him away to their car. Jamie is being received into care.

Julie
It is ten o'clock in the morning. Joan hears the telephone ring in her office in Saltleigh Social Services Department, where she works as a field social worker. It is Rose, asking her to go to her sister Sally’s house. Sally has been ‘picked up’ by the police again for soliciting. Rose has gone in to look after the children, but wants to talk to Joan about a ‘problem’. When Joan arrives, Rose says the problem is Julie, Sally’s 12-year-old daughter.

I can cope with the little ones, but I can’t take her. She won’t do anything I tell her. She won’t go to school. Sally’ll get a stretch this time. I know she will, she was threatened last time. I can take the little ones in, but I won’t take Julie. You’ll have to take her. I won’t be held responsible, she’ll go the same way as her Mum, unless somebody does something. You’ve got to take her.

Rose is adamant, and Joan goes back to her office to begin a process that will ultimately result in Julie being received into care.

Jim
In Glasgow, it is ten o’clock at night. The police are called to a pub by the landlord. When they arrive the landlord and several of the ‘regulars’ are holding Jim, who is sitting angrily and swearing loudly.

He lost his cool when I wouldn’t serve him. He was with a load of mates, but they ran off. They’re all under age, and they come in here with muck all down their front – they’ve obviously been on the glue, you can smell it on them. Well, of course I wouldn’t serve them, so then they get abusive, and this one started falling around and pulling the furniture, and shouting my customers, so we got him and called you.

The two officers radio in, and take Jim back with them to the station. When they get there, they send for his parents. This is not the first time he has been taken to the station. He is 15 now, and has already been before the Children’s Panel after joy-riding in cars, with his parents saying he is becoming more than they can cope with. The sergeant mutters that this time Jim will end up ‘inside’.

Jacob
Jacob is a newborn baby with severe brain damage that has left him mentally and physically handicapped. His mother, a single parent, is unwilling to care for him. She already has two small children, and seems overwhelmed by his handicaps, quite unable to consider looking after him herself. The hospital call the Social Services Department, asking them to receive Jacob ‘into care’, and they begin to seek foster parents to look after him.
Four young people, in very different circumstances, being ‘received into care’. This unit is intended to help you explore what we mean when we say a child or young person has been ‘received into care’ the processes entailed, the statutory procedures used, the social policy issues that are raised, and the different kinds of residential care that are currently provided for children and young people. Our examination of ‘care’ offers an opportunity to examine the processes and policies within which ‘reception into care’ and ‘care’ itself occur, and, equally importantly, a chance to think through the taken-for-granted ideas behind these processes and policies, and the way in which this form of social intervention has bound up within it all manner of expectations, moral judgements, tensions of ideology and processes of social control.

I have written the word ‘care’ in inverted commas in the above paragraph because I am using it in this unit to convey a specific meaning. Children and young people ‘in care’ are those for whom the state has undertaken some degree of control over their upbringing. It is important to recognize, however, that many still still live at home with their parents. In this unit I am using the term ‘in care’ predominantly to refer to children and young people who live and are brought up away from their biological parents, either in residential institutions or with foster families. I will also be concentrating on the use of residential care for children and young people who are neglected or abused rather than on its use for young offenders. From now I will drop the commas, but it is important to remember these specific meanings in this context.

The main issue we have to face is this: given that there are many thousands of James, Julies, Jims and Jacobs in Britain today, what should be done? What provision should be made for such children and young people? To begin to answer this question, we will need to recall some of the ideas raised in earlier units about the social construction of childhood and adolescence and the needs and rights of children and young people, and link them with a consideration of what we mean by ‘abuse’, ‘neglect’, ‘moral danger’, ‘beyond parental control’, ‘a threat to society’, ‘delinquency’ and ‘special needs’. In this way we will begin to find out how our interpretations affect policy and practice.

Whereas most children and young people in Britain live with and are brought up by their parents or parent, some quarter of a million sit down each morning to an institutional breakfast and spend most of their time living away from their homes. Over half of these do so in (predominantly private) boarding schools. But the rest live in various forms of residential establishments run by local authorities. There are, proportionally, more black children and young people living ‘in residential care’ than white, more from areas of urban decay and disadvantage than cosier middle-class suburbs, more whose parents are unemployed than are in professional, well-paid jobs, more whose parents are socially as well as economically impoverished. One of the major tasks of this unit will be to explore why it is that being received into care is both a function of disadvantage and a system which tends to promote it.

To undertake this task we will need to consider three potentially competing areas of ‘rights’, ‘needs’ and ‘obligations’ the rights and needs of children and young people themselves, the rights, needs and obligations of parents and families, and the rights, needs and obligations of society. It is within this context that we must examine the functions that care is intended to fulfil. Inevitably, this will take us further into the debate already well established within the course about the relationship between the state and the family, in particular into questions about their roles in the socialization of children. It also raises, as we shall see, some important issues concerning the professional roles of caring for children, and questions about the tensions that exist between different professional groups.
2 THE HISTORY OF RESIDENTIAL CARE PROVISION
FOR CHILDREN AND YOUNG PEOPLE

There are two main reasons for starting to examine care by looking at its history. First, many aspects of contemporary child care have grown up out of what happened in the past – from the Poor Relief Acts and laws about juvenile crime, which set the scene for current legislation, to the way in which the asylums, orphanages and reformatories of the past provided the institutional bases of today’s care provision. Second, a historical perspective enables us to consider the links between the *provision* that was made at different times for different circumstances, and the *motivations* for them. By taking the opportunity to stand back and examine the behaviour of people in times different from our own, it is easier to see how what is provided reflects the values of those times, and of the people in power. In this way we are helped to think about how the values, assumptions and prejudices of our own time show through in what we do (and do not do), and our ideas about what are the ‘needs’ and ‘rights’ of children and young people and our obligations to them.

2.1 The beginnings of institutional care in Europe

From before the Middle Ages, extended family care was supplemented by the Church. From the time of Constantine the Church saw itself as having an important part to play in providing for orphans and foundlings, both as a source of income and an act of charity. For example, in the Middle Ages in Britain two London hospitals, St Mary Without Bishopsgate and St Bartholomew, cared for the children of mothers who died in childbirth until they reached the age of seven. The Conservatorio Della Ruota in Rome – which took its name from the turning box at the door through which babies were admitted – was set up by Pope Innocent III, who was shocked, according to tradition, at the number of drowned newborn babies that fishermen were catching in their nets in the Tiber.

Nevertheless, care provided by the Church was inevitably uneven. There were isolated attempts to regulate provision (i.e. make it a duty rather than just an elective and arbitrary act of charity), such as a statute in Cambridge in 1388, whereby local parishes were given a responsibility to support their own poor. However, it was the Poor Law legislation that, by way of the ‘poor tax’, offered the first attempt at state provision for children.

However, the provision was based on a philosophy which assumed a parental obligation to care for children, with the state only needing to take over from the family and individual under circumstances of ‘last resort’. The legislation made no special provision for children, they were simply treated like any other member of the community in need of poor relief. Any notion that children might need or deserve special provision was overshadowed by the function of discouraging irresponsible parental behaviour, and the desire to keep the ‘poor tax’ as low as possible. In consequence, right through until the eighteenth century, the vast majority (often well over 90 per cent) of the children living in workhouses died of starvation, neglect or disease. Outside the workhouse, those children who had no families to care for them lived as vagrants and beggars. In London, for example, they were called the ‘Black Guard’, who stole and begged on the streets by day, and slept where they could find shelter by night.

2.2 The ‘general reception’

In the eighteenth century, the large numbers of destitute children became an increasing concern. Not only were such ‘vagabonds’ seen as a social problem in themselves, but it was feared they would grow to be feckless and criminal adults. The very high child mortality rate worried the ruling classes because there was a growing need for servants, labourers, sailors and soldiers. It was probably these factors that enabled the philanthropist, Thomas Coram, to set up a ‘general reception’ to care for children. The first Foundling Hospital was opened in London in 1741, and soon afterwards Parliament granted £10 000 (a great deal of money in those days) to pay for the wet-nursing in infancy and institutional care in childhood.
of every baby presented to the authorities 'in need of care'. Only young babies were accepted, but for a few years a system of comprehensive state care operated, with 3300 babies received in the first year. However, this soon broke down because many babies died on the journey to London (often sent drugged by pack horse), unscrupulous inspectors pocketed the wet-nurse payments, wet-nurses became infected with syphilis, and parish officers objected to the influx of bastards. Increasingly the 'general reception' came to be seen as socially divisive, freeing whores and whoremongers from any need to pay for their sin. Just nineteen years later, Parliament decreed that no more state money should be provided (McClure, 1981, provides a fascinating detailed account of this early experiment in child care).

2.3 Specific provision for children

Although the 1834 Poor Law amendment was punitive in the way it limited state care to the 'deserving poor', it did at least recognize for the first time that children had particular needs and were entitled to a basic minimum of care. In practice, however, children were seldom offered anything better than 'undeserving' adults, and many continued to pen in workhouses. Slowly, though, specific provision for children was increased through the Charter and Bluecoat schools and such institutions as the Infant Orphan Asylum, which opened in Wanstead in 1814 for the fatherless sons and daughters of 'respectable' families (whose widowed mothers did not have the means to care for them). To gain a place the children were selected by votes, which were sold to the wealthy as a form of fund-raising (see Grist, 1974).

2.4 The impact of industrialization

The practice of apprenticing pauper children took on new aspects with the coming of industrialization in the nineteenth century. The factories and mines opened up opportunities for children to be used as cheap and expendable labour. Indeed, very small children could, within an industrialized society, take on jobs that adults could not, their size enabling them to perform tasks like cleaning under machinery, reaching into narrow mine tunnels, and climbing chimneys. Thus the beginning of industrialization heralded a time of terrible exploitation for poor children, as documented, for example, by Charles Dickens's *Oliver Twist* (1838), Charles Kingsley's *Water Babies* (1863) and George Crabbe's *Peter Grimes* (1810).
However, reactions against such dreadful conditions did, fairly soon, begin to be
mobilized – by the working class themselves, by enlightened employers who
recognized that sickly workers were not productive, and by moral reformers such as
Robert Peel and Lord Shaftesbury. By the late eighteenth century magistrates began
to restrict apprenticeships, and by 1842 a number of parliamentary Acts had been
passed to regulate the employment of children and young persons in mills, factories
and mines. From then on a series of laws were passed which gradually improved
conditions and eventually put a stop to the employment of young boys as chimney
sweeps (see Heywood, 1978, chapter 2, for a full account).

2.5 Victorian philanthropy

The Victorian era, although not the start of philanthropic care for children, was the
time when real inroads were at last made into the widespread poverty and
depprivation of children. It began with the ‘Ragged Schools’ (originated by John
Pounds), which were set up to teach street children reading, writing, arithmetic and
the rudiments of a trade, a movement which spread rapidly, schools being set up
both by the wealthy and by the working class.

Mary Carpenter, one of the most notable Victorian philanthropists, went from an
initial interest in ‘Ragged Schools’ to a particular interest in young delinquents,
influenced by experiments in Germany and France offering an alternative to prison
A New Pupil for John Founds, engraved from a painting by E. H. Wehnert, ragged Schools, such as this, inaugurated a period when philanthropic efforts began to have a real effect on children’s deprivation.

for young offenders. Such experiments heralded a new perception that young people who commit crimes are in need of care and ‘treatment’ rather than mere punishment, and that children and young people have emotional as well as physical needs. Mary Carpenter wrote in a letter to the Reverend John Clay (1850)

Since the prison system, even as best conducted, is proven ineffectual as a preventive and reformatory measure for children and such institutions as Mottitai have exceeded their expectations, they should be tried. It is not the spirit of fear, but of power and love, and of a sound mind, which can be powerful enough to subdue these hard hearts, and without touching the inner spirit no external measure will be of much avail (quoted in Heywood, 1978)

It was by running a Ragged School that John Barnardo first became involved in the care of destitute children. One night after class, one of the boys from the school begged to stay and shelter in the schoolroom. When Barnardo learned from him that the alternative was sleeping on the streets, Jim led him to see for himself. Barnardo saw a group of hungry, cold boys aged from about nine to eleven, huddled on a roof.

Just then a cloud passed from the face of the moon, and as the pale light fell upon the upturned faces of those sleeping boys, I realized the terrible fact that they were absolutely homeless and destitute, and were almost certainly but samples of many others (quoted in Heywood, 1978)

With funding from a well-known member of Parliament, Samuel Smith, Barnardo opened his first Home for Destitute Boys. At first he adopted a policy of taking in only those for whom there was room. But after a boy he had refused was found dead, over the door of his Home he fixed a signboard ‘NO DESTITUTE CHILD EVER REFUSED ADMISSION’
2.6 The origins of ‘child saving’

Barnardo’s work was based on the idea that it was upbringing, not inherent characteristics, that determined an individual’s behaviour and personality. He reflected a new (though by no means universal) world-view that was beginning to take shape in the Victorian age: instead of assuming that fecklessness is inbred, or that children are born to a ‘station’ in life which inevitably determines their position in society, anyone can ‘make good’ and improve her- or himself by effort.

Thus Mary Carpenter and John Barnardo were both working at a time when fundamental changes were beginning to occur in the way childhood was conceptualized. Carpenter’s idea was that young offenders were not so much ‘wrongdoers’ as people to whom wrong had been done – they were deprived of a proper upbringing, and this is why they acted in lawless ways. Barnardo’s view was that what deprived children needed was ‘saving’ from the poor care provided by their parents.
What implications do these ideas offer in terms of the care which should be provided for children and young people? Write two or three lines about the implications you see for the following:

- the perceived needs of children,
- the perceived rights of parents,
- the perceived rights of others to intervene

This world-view insisted that children and young people needed more than just physical care — they needed an upbringing which would mould their characters, and opportunities to better themselves. If the children of the poor were to move out of the disadvantaged situation of their parents, then they had to be given the chance in their childhood to learn a better way of life.

The previously assumed parental right to regard children as their ‘property’ became subservient to the needs of the child. In consequence, people like Barnardo saw themselves as entitled to intervene ‘in the child’s interests’, removing children from their families — sometimes without parental consent — to offer them a better start in life. Barnardo found himself in serious trouble on several occasions when he did this, and has been criticized for assuming he knew better than parents what was right for children and young people.

There are two sides to this. On the one hand, there were no laws at the time to protect neglected and abused children living within their families, and so Barnardo broke the law to ‘save them’. In this he was only doing illegally what social workers and others do today as a legal duty. On the other hand, it does raise what we will see are crucial questions with regard to state intervention in the care of children and young people: how can we balance the rights of a family to privacy from interference, and the rights of parents to bring up their children as they see fit, against the needs of children and young people? Who decides, and how do they decide, what is ‘in the best interest of the child’?

Think back to the examples at the beginning of the unit. Jamie, Julie and Jim. The parents of these children and young people probably have no wish for them to be received ‘into care’. I suspect Jim and Julie do not want it to happen either. Yet these are the situations in which children and young people in Britain today do enter care. How far is this necessary? How far is it justified?

2.7 The preconceptions behind institutionalization

Institutions like the Foundling Hospital and the Infant Orphan Asylum were primarily intended to give homes to children, ‘because their mothers could not care for them’. Barnardo took in destitute children but also actively sought to remove children from ‘bad’ parents ‘because they did not care for them properly’.

Put like this, we may wonder why the people of those times chose those solutions? In part it was because of taken-for-granted assumptions about mothers-as-carers and fathers-as-wage-earners, about causes of unemployment and low wages, and about family (not state) responsibility for children. Historically, child care was a product of socially constructed notions about the allocation of resources within society and between men and women, and about the allocation of responsibility for children.

These assumptions did not disappear in Victorian times, but were overlaid by new ones which created tensions between conflicting perceptions of rights, needs and obligations. On the one hand, for social order to be maintained, there had to be a group of people who were willing to do the menial jobs, and there needed to be a state of deprivation which ordinary people would strive to avoid. On the other hand,
even the poorest people should have the chance to better themselves. Similarly, the Victorians faced a tension between their moral judgement of sex outside of marriage as sinful (and, therefore, a need to deny respectability to unmarried mothers), and their belief that even a bastard could, given the right upbringing, become a respectable citizen.

The provision of institutional care was therefore undertaken with little consideration of the potentially damaging effects of depriving children of their parents and the stigmatization of being in care. Taking children from their parents met the child’s needs for a ‘proper upbringing’ without being seen to encourage immorality, or undermine the class and economic divisions seen as necessary for the smooth running of society.

2.8 Substitute family care

Although people like Barnardo and Carpenter argued for the removal of children from their parents, they also questioned the desirability of rearing them in large institutions, believing that families, or small residential homes that were like families, were a better, more normal setting in which to bring up children. They set up villages of cottage homes and farm schools with much smaller numbers of children (between ten and twenty), ranging in age (though often still segregated by gender) and cared for by ‘housemothers’ and ‘housefathers’, a practice which spread rapidly.

However, the construction of self-contained ‘villages’ was by no means universal. In Sheffield, for example, it was decided to opt for a system of ‘boarding out’ (what we would now call fostering) for those children with no family ties (e.g. orphans and deserted children). In Scotland ‘boarding out’ had always been more usual than institutional care for a number of complex reasons, including the Calvinistic stress on family responsibility, much earlier and better state schooling, and the fact that the Scottish Poor Law did not impose any compulsory ‘poor tax’ as it did in England (Parker, 1982). In Scotland ‘boarding out’ was very much a process of shifting poor children from the cities to the country, where the ‘boarding out’ fees and extra ‘hands’ enabled crofters to continue to live on the land.
Summary
An historical overview enables us to see that social policies are generally multiply determined, and always reflect the prevailing ‘world-view’ of the culture and time. Residential child-care provision was based in earlier times on philanthropy and religious duty. But it was also used to meet demands for social order and to fulfill the needs of dominant groups in society. Thus policies and provision reflected a number of tensions – for example, between the desire to raise impoverished children as healthy, law-abiding productive citizens, and the necessity to prevent feckless parents failing in their obligations. The Victorian era introduced additional tensions, which arose particularly from the expectation that every person can ‘make good’, and these were seen to justify the removal of children from ‘inadequate’ parents. In parallel, changing views about children’s needs and particularly an increasing valuation of ‘the family’ led to changes away from earlier, large-scale institutional care in the seventeenth and eighteenth centuries to more ‘family substitute’ care in the nineteenth century.

3 THE ESTABLISHMENT OF THE PRESENT RESIDENTIAL CARE SYSTEM FOR CHILDREN AND YOUNG PEOPLE

3.1 The rights and obligations of state and family
Probably the most important shift in the world-view that underpins our contemporary attitudes to residential child care is in our perceptions of who has obligations to and responsibility for children, and who has the right to decide what is ‘best’ for them.

The major tension pervading our current social policies and service provision for children and young people is between the rights and obligations of parents to bring up their children as they choose, and the rights and obligations of society to intervene and impose particular standards of child care for all children, in order (in theory at least) to protect and promote the rights of children to a ‘good’ upbringing.

The major change which heralded our contemporary system took place when the setting up of the welfare state involved undertaking comprehensive responsibility for all children. Once the welfare state accepted this responsibility, it thereby assumed major rights and controls – for instance, the right to insist that children should be educated to a particular standard, whether or not their parents want this. Compulsory education offers a means by which the state can disseminate services to children (e.g., medical checks), engage directly in the socialization of children (health and sex education), and monitor parental care. Other welfare services such as health visiting provide access to younger children (as you saw in Unit 11) and the resulting ability to disseminate services and monitor parental care and socialization.

The welfare state, in taking over from parents some of their responsibilities and some of their rights, assumed (a) an obligation to offer a voluntary residential care service for children whose parent(s) could not care for them, and (b) an entitlement to set up a compulsory system of state intervention that removed children from those parents deemed to be incapable of rearing them adequately or properly. As we shall see later, the distinction between these two aspects is not as clear-cut as it looks.
3.2 Professional tensions

In response to growing public disquiet, mobilized by the scandal of the death of Dennis O’Neill in 1945 as a result of ill-treatment in foster care, the Curtis Committee (1946) was given the task to inquire into existing methods of providing for children who from loss of parents or from any cause whatsoever are deprived of a normal home life with their own parents or relatives, and to consider what further measures should be taken to ensure that these children are brought up under conditions best calculated to compensate them for lack of parental care.

The situation immediately prior to 1946 was chaotic, with numerous departments in central and local government and a plethora of charitable and voluntary organizations all responsible in some way for children ‘deprived of a normal life’. The Curtis Report argued for, and subsequent legislation (the 1948 Children’s Act) implemented, the setting up of a specialized, centralized and comprehensive Child Care Service.

The change was not just organizational, but to do with the welfarist principle that services provided to disadvantaged and deprived persons should be seen as their entitlement, as citizens within a welfare state, to share in its resources – not as charity or gifts from the more fortunate. The aim of the 1948 Act was not just to prevent the blatant abuses of cruel foster parents and residential care staff, but to remove children in care from the ‘chilly stigma of charity’ (Allen, 1944).

There were now three (often competing) sets of ‘rights’, ‘needs’ and ‘obligations’:

- parental rights to family privacy and to rear children as they saw fit,
- children’s rights to a safe, nurturing childhood,
- and state obligations to ensure that all children received a good standard of care.

The new children’s officers, appointed by the Secretary of State, were predominantly young and academically qualified. Residential workers, appointed by local authorities, were generally older and unqualified. Many of today’s tensions between field social workers (evolved from child care officers) residential care staff and employing authorities reflect these origins, and the competing motives and constraints – policing families, promoting children’s interests, and managing scarce resources.

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Death of 13 Year Old Boy
Farmer And Wife In Court
Manslaughter Charge
Allegations of Neglect and Violence

Reginald Gough, a 31-year-old farmer, together with his wife, Esther Gough, aged 29, both of Bank Farm, Hope Valley, Minsterley, Salop, appeared before Pontefract Magistrates’ Court on Monday charged with the manslaughter of Dennis O’Neill, a 13-year-old boy, who was sent to the Newport (Mon.) Education Committee to live with them on June 25th, 1944, and died on their farm on January 9th, 1945.

The Goughs were defended by Mr Gough’s solicitors, and the Chairman of the Magistrates was Sir Ollivier Wakeham. The proceedings were watched by Mr J M Whiteley (Salop County Council) and Mr Mervyn Jones (Deputy Town Clerk of Newport). Mr H H Maddocks, prosecuting, said that the allegation was that the accused had killed the boy by neglect and violence. On May 30, 1940, Newport Juvenile Court committed the boy and his two brothers, Terence, aged nine, and a younger boy, Frederick, to the care of Newport Council on the ground that they were in need of care and attention, their parents having been previously convicted of offences against them. It was intended that they should be placed in the care of a Mrs Pickering, who lived near Minsterley but a bust arose, and she could take only two of them. Mrs Pickering suggested that Dennis might be taken to the home of the accused, and this was done. Gough signing an undertaking that he would care for him.
These conflicts and tensions, and the meteoric growth of residential child care (the numbers taken into care were far higher than Curtis assumed would be ‘in need’) help to explain why the intentions of the 1948 Act were not achieved. What it wanted to do was to give every child and young person in care as good an upbringing as children in ordinary families. And it failed. Children who grew up in care continued to see themselves and be seen by others as ‘different’, they were stigmatized as having an impoverished, sub-standard childhood. They continued (and still continue) to do, on average, much worse at school than their peers, be in trouble with the police, and more likely, when they become parents themselves, to have their children taken into care. If you want to measure for yourself whether the stigmatization still operates today, how would you respond to the information that one of the members of this course team grew up in a children’s home? Or if I told you that my daughter lives in one? Are you surprised that somebody successful enough to become a lecturer at a university had such an upbringing, or that somebody like me has a child in care? Do you react by thinking that, considering the lecturer’s background, he has done well? And why do I feel compelled to explain that my daughter in care is not my natural child, but a foster child? Aren’t we both making judgements that undermine what Curtis intended?

3.3 Inequalities of needs and resources

The idea that only ‘problem’ families need a state service for residential child care is still very much with us, and was bound to prevent the 1948 Act achieving its aims. However good the standard of care provided, children received into care could never overcome this basic prejudice.

When we think of residential care for children and young people, the image that springs to mind is usually of a children’s home, not an expensive boarding school. While a boarding school clearly is a form of residential care, it is viewed by most people predominantly in terms of its educational function and as a privileged form of upbringing that only some parents are fortunate enough to be able to afford.

As in other parts of the course, we see here another example of social policy affected by the public/private dimension. Parents who have ‘problems’ with child-rearing, but who can afford to pay for alternative care, are perceived by our society as having no problems at all. They are merely employing a nanny, or sending their children to boarding school. Indeed, the majority of the Conservative Cabinet at the time of writing (summer 1987) spent from the age of seven until eighteen in residential care, albeit very expensive residential care. Those who have access to the social resources of a network of friends and extended family to share responsibility for child care are merely having Gran, or ‘my sister’s family’ or a friend ‘help them out’. Most children and young people spend periods living with people other than their parents.

The state residential care service rationalized by the 1948 Act was not really intended, as it was purported to be, for ‘children in general’, but only for those children whose parents did not have the resources to provide alternative care. Being received into care is not just a matter of meeting a ‘need’, but a reflection of the way resources are distributed inequitably within our society, so that only some people have such a ‘need’. In consequence, children and young people from just one sector of society are much more susceptible to having their upbringing determined by the state.

However, both boarding schools and children’s homes are run in ways that inculcate moral and social values. And, as we saw in Unit 2, such socialization is not just a matter of ‘upbringing’ but a political activity. Institutional care has always been explicitly recognized as a way of socializing children, as well as simply caring for their physical needs. Residential care for children and young people has acted as a system of social control. Even though our present care system claims to have moved on from meeting the needs of society to meeting the needs of children, those ‘needs’ are defined by the people who run them, and reflect their constructions of the right.
and proper role for children and young people in society. Social control runs through all forms of residential care, state and private, imposing upon children and young people the values of others. The point is that the state system is specifically designed to supplant the values of the children’s parents by the values of the state.

3.4 A shift to foster care

You have already encountered in Unit 14 the theories of Bowlby (1953, 1969) about ‘maternal deprivation’, which have introduced into our perceptions the concept of a child’s ‘needs’ for the love and care that only natural parents (or parental substitutes) can provide. Bowlby’s work was conducted within our contemporary world-view, which has become permeated with psychodynamic notions (which began with Freud) wherein we assume as one of our taken-for-granted that childhood experience, particularly emotional trauma in childhood, can have far-reaching effects upon adult well-being. In consequence, within the 1948 Act, foster care (and, where appropriate, adoption) were considered better for children than institutional care.

This embodied the assumption of the day that accorded the family a taken-for-granted superiority, even though the richest and most powerful classes in society elected to place their sons (and less commonly their daughters) into institutions for much of their childhood. It also led to the devaluing of the work of residential care staff, which was seen as less professional (and therefore lower paid) than that of boarding-out and children’s officers. The perception of the family as the ‘natural’ way to bring up children implied that the job of the residential care-worker required little more than the ordinary skills any parent had anyway.

This has had far-reaching implications for the residential care service of today. In 1987, while the vast majority of field social workers have specific social work qualifications, a significant majority of residential staff have had no specific training. What this has meant is that those young people who do grow up in children’s homes are those most likely to have been deeply disturbed by the experiences that
have led to them being taken into care. It is these troubled individuals who may face a Home life in which there is a continual turnover of staff, low morale and a level of care which offers few opportunities to overcome their feelings of rejection, failure and stigmatization, or the effects of sometimes very terrible experiences (such as severe violence, and/or devastating forms of sexual abuse).

List three reasons why fostering was the solution favoured by the 1948 Act, and two of its undesirable consequences. (My answers are given below.) Can you think of another solution that might be better than fostering?

Fostering was favoured because
1. It avoided some of the stigmatization of living in an institution
2. It was assumed that a family upbringing was the best way of rearing children
3. It was cheaper

Some of its undesirable consequences were
1. It made contact with the natural family more difficult
2. It devalued the professional task of caring for children in residential establishments

3.5 'An even better and cheaper way'

The newly created Children's Departments initially put most of their efforts into carefully selecting and supervising suitable foster families, but soon they began to consider the alternative of keeping children with their families. A report produced in response to Curtis by the Women's Group on Public Welfare called *The Neglected Child and his Family* (1948) concluded that 'the removal of the child provides an easy answer to the problems of an unsatisfactory home, but not a psychologically sound one'. Thus even as the Child Care Service was being set up, there was a strong 'preventive' lobby, and in 1952 local authorities were made responsible for preventing child abuse and neglect. Children's Departments began to work with families who appeared to be having difficulties, in a specific attempt to keep children with their parents rather than take them into care. In part this was a response to the shifting world-view, but it was also pragmatic at a time when the numbers of children being taken into care had begun to rise rapidly. In 1949, 55,000 children were in care in England and Wales, by 1952 this had increased to 64,000.

One major reason for children coming into care (up to 20 per cent at its peak) was homelessness, caused by the family being evicted for rent arrears, for example. Preventive work therefore included liaison with Housing Departments and the National Assistance Board to seek to avoid eviction. Much work was very practical, providing food, furniture and bedding begged and borrowed from local traders and agencies like the Women's Voluntary Service (WVS). Such hand-to-mouth sources of aid were seen as unsatisfactory and frustrating, however, and the child-care officers began to root for funds of their own.

They did, nonetheless, manage to reduce the number of children in care. From the peak of 1953, they were lowered to 62,347 in 1956 and to 61,560 in 1959. Other government departments (e.g., the Ministry of Health) and voluntary agencies were increasingly involved in prevention. Barnardo's, for instance, gave grants to unwed mothers to enable them to keep their children. In fact, the proliferation caused its own problems, with one woman offering to leave a door key at the Town Hall, to save the many do-gooding visitors the bother of knocking on the door.
Pressure built up for a clear demarcation of responsibility, resources and legal powers to provide a preventive service, and in 1963 a new law was introduced. It was a compromise, bowing to the pressure of rivalry between the different departments of local and central government, making it clear they would all have a continuing role in prevention and leaving the precise arrangements to be made locally.

However, the 1963 law did give Children’s Departments the funds they needed to engage directly in prevention (for example, paying rent arrears and fuel bills). Costs rose rapidly from £88,000 in 1966 to £202,000 in 1969, even though at that time such payments were discretionary, and children continued to come into care for no other reason than that their parents were homeless. This expenditure in 1987 is estimated to be more than £5 million a year. And yet as Heywood and Allen (1971) have noted, while the new legislation made it possible to avert short-term crises, it did not begin to tackle enough of the long-term problems to make a substantial dent in the figures of children ‘in care’.

3.6 Changes in organization and policy: foster care reassessed

The effects of the Seabohm Report (HMSO, 1968) and the subsequent incorporation of Children’s Departments into Social Services Departments (which you have already examined in Unit 14) occurred at a time of reassessment of foster care. A number of research studies (e.g. Parker, 1966; George, 1970) showed that up to 60 per cent of foster placements broke down. Children and young people in care far too often faced the double trauma of first being removed from or rejected by their own family, and then subsequently being removed from or rejected by their foster parents, in many cases several times over.

There are at least three different reasons why foster care broke down so often. First, the 1963 legislation covering England and Wales and the more radical 1964 Scottish legislation, designed to reduce the number of young law-breakers receiving custodial sentences, brought into the residential care system large numbers of ‘difficult teenagers’. The law regarded them as troubled youngsters in need of help rather than criminals (in theory at least). But foster parents, with little training and back-up, often found them very disruptive and hard to look after.

Second, the 1963 legislation emphasized the desirability of returning children and young people to their families, and local authorities developed policies which stressed ‘rehabilitation’. Foster parents consequently faced the need to achieve conflicting goals: to provide substitute family care and to help prepare children for going back to their original home. There were often marked differences between the child-rearing values and practices of the foster and biological parents which made this task very difficult.

Finally, there were changes in the motivations for fostering. In the 1950s and 1960s adoption was relatively easy, so that childless couples usually specified (and were allocated) exactly what kind of child they wanted (usually white, able-bodied, newborn babies). However, by the 1970s other social changes (easier access to contraception and abortion, and more liberal attitudes to single parents) considerably reduced the numbers of babies available for adoption. People who would previously have adopted were often persuaded to become foster parents instead. These frustrated adopters found it all the more difficult to accept social work supervision, and particularly hard to offer short-term care and then help to return children to homes they considered less suitable than their own.

As the pressures to find foster parents grew, these competing motives became muddled, with consequent problems for foster children, and ‘tug-of-love’ cases occurring. Social workers began to reconsider the desirability of foster care, particularly for those children for whom attempts were being made to rehabilitate them back home.
In residential homes staff were expected to see themselves as ‘alternative carers’ rather than substitute parents, and could be supervised more explicitly, thus they could provide more stability, since residential workers could not so easily demand that the child be removed at short notice. Homes could be pressured to take demanding and ‘difficult’ children that foster parents refused. Parental access and home visiting could be more easily insisted upon by fieldworkers, and more stringently supervised. Whereas a fieldworker visiting a foster parent had to respect the domestic privacy of their home, visits to a residential establishment were visits to a workplace, and residential care staff, because they were accorded lower status, were much more controllable. However, while fieldworkers regarded this control as a valuable feature in their task of directing a child’s future, not surprisingly it exacerbated the existing tensions between them and residential staff.

Thus the 1970s was a time in which the proportion and overall numbers of children and young people in children’s homes increased, and fostering decreased. By the time of the 1969 Children and Young Persons Act, fostering was no longer specified as the preferred method of care. By 1972, the proportion of fostered children had fallen to 42 per cent. It was difficult to obtain the funds needed to increase the number of residential establishments, and there was consequent overcrowding which often led to a reduction in the quality of life for young people living in children’s homes. The quality of personal caring for children as individuals suffered, as establishments took in more children than they could cope with. All of this was made worse (for the children at least) by attempts to improve the working conditions of residential staff, reducing their hours, and making changes in regulations about being resident.

3.7 The current situation

At the time of writing this unit, child-care policy is in a state of major upheaval. The Barcley Report (1962) specified that residential care should fulfil three different functions, providing a refuge, controlling and providing therapy for law-breakers, and improving the life chances of disadvantaged children and young people. But nonetheless, policies and practices vary widely from one local authority to another. Some are currently seeking to close residential establishments altogether and place all children in foster care or with adoptive parents. Others are arguing to increase the professionalism of residential work, stressing its therapeutic function, and seeing it as a ‘best option’ for children and young people ‘with special needs’. The growing public and professional concern about sexual abuse seems once more to be increasing the number of young people taken into institutional care, in some areas at least.

On a more promising side, the need for a flexible system of residential care provision is at last being recognized, and in some areas residential care is being expanded to provide a variety of services such as day-fostering, and twenty-four-hour ‘on call’ support. Attempts are being made to increase the training and relative status of residential staff (Brown and Stewart, 1986) and to improve care provision, for instance by adequately preparing young people for the transition they face when leaving care at eighteen. The perception of fostering is changing to that of residential care rather than substitute parenting. Certainly the aim (if not always the actuality) is for children and young people in care to receive a better home life and better life opportunities than they would have done if nobody had intervened.

Summary

The introduction of the welfare state marked a shift towards a residential care policy intended to meet children’s needs. However, such a principle has had to be developed against a backdrop of (a) other needs and rights (including those of parents to be free from state interference and the ‘taxpayer’ not to be unduly burdened), (b) different understandings of what children’s ‘needs’ are and how they should best be met, and (c) the rivalries and competing motives of the different professional groups involved.
4 COMING INTO CARE

4.1 Legal routes into care

At the time of writing (August 1987), the government is actively considering drastic changes in the law relating to children and young people. It is likely therefore that during the life of this course, regulations will change. For this reason I will not be specifying in great detail. Act by Act, the law as it now stands, but rather looking at the main principles and the issues raised by them. There should be opportunities in your tutorial sessions to gain up-to-date information about the current position. In talking about the law I will follow the convention of using the word 'child' in its legal sense. Note that this includes young people up to the age of eighteen.

'Voluntary' care

In legal terms a distinction is made between 'care' that occurs voluntarily and 'care' which is imposed by compulsion, though the terms are somewhat misleading.

Voluntary care is what happens when parents request that their child be taken into care or, more usually, they agree to a proposal by the local authority that they should do so. However, children can be taken into so-called voluntary care without parental agreement because they are considered to be lost or abandoned.

The local authority can only refuse to take a child into care if it is able to argue that intervention is not necessary to protect the child's welfare, and can demonstrate that the child is not at risk of injury or abuse.

Following a voluntary care order the child's parents retain most of their 'parental rights' over the child, and a duty to maintain them if they are able, by making a contribution to their upkeep. However, the local authority has the power, in some situations, to pass a resolution to acquire some parental rights, excluding the right to agree to adoption and the right to determine the child's religious creed. The parent(s) may request the return of the child at any time during the first six months of voluntary care. If the local authority wishes to refuse, it must apply to a court and have the issue arbitrated there. After six months the parents must give twenty-eight days' written notice of their intention to apply to take the child back.

On assuming voluntary care of an 'abandoned' child the local authority has a legal duty to take all reasonable steps to discover the parents' whereabouts, and to return the child to their care if it is considered in the child's interests, or try to pass the care to a relative or friend.

'Compulsory' care

Compulsory care is care by a court (e.g. juvenile, magistrates' and divorce courts, Family Division of the High Court) in England, Wales and Northern Ireland, and a Children's Panel Hearing in Scotland. Local authorities have a legal duty to make enquiries into any case in which they have received information suggesting that there are grounds for bringing care proceedings, unless they are satisfied that such enquiries are unnecessary. Other people have a right to do so, including the police or authorized persons (e.g. NSPCC officers). In Scotland anyone may refer a child to the Reporter, who decides whether they should be referred to a Children's Panel Hearing. In both settings the grounds for referral are broadly similar:

1. If the child's proper development is being avoided or neglected, health avoided or impaired, or s/he is being ill-treated.
2. If it is probable that the above is true (e.g. if there are other children in the family where the above applies, or a person moves into the household who has been convicted of an offence against a child).
3. If s/he is exposed to moral danger,
4. If s/he is beyond the control of their parent or guardian,
5. If the child is of compulsory school age, not receiving efficient full-time education,
6. If s/he has committed an offence (excluding murder) and is considered in need of care and control which s/he is unlikely to receive unless an order is made.
As well as establishing one of these conditions, a 'care and control' test has to be applied. It must be demonstrated that the child will not receive proper care, or is at risk, unless the court makes an order.

4.2 The problems of legislation for 'taking children into care'

The complex legislation reflects the tensions that are inevitable when there is pressure from one side (e.g. public outcry following the death of a child like Maria Colwell or Jasmine Beckford) and then from another (public concern about the number of children taken into care in Cleveland in 1987). Currently the law is very muddled (and likely to be changed radically within the life of this course). In part the muddle arises because Britain today comprises not 'one nation' but many cultures and social groups, each one offering an alternative value system, which do not merely coexist in a cosy sort of way, but compete with and contradict each other. Such contradictions are not new (recall the differing motives between Coram's setting up of the Foundling Hospital and the views that ended its state funding), but I suggest they are becoming more diverse.

The law is assumed to be value-free and neutral, but of course it cannot be. It embodies the values of just some people, both in the processes by which laws are made and in the systems by which they are implemented and interpreted. The law about taking children into care is not simply under attack because it is 'bad law' (though there is a lot wrong with it), but because it deals with subjects about which most people feel very strongly, care deeply, and take seriously; incest, parents who neglect, beat up and murder their children, the privacy of the family, whether drug addicts make bad parents, whether handicapped babies should be left to die. Not only do people have strong opinions, but they disagree about balances between one and another, and about what social policy should do.

This has to do with the nature of law. We tend to assume it is just a set of rules, but it is much more than this. It is one way in which society tries to embody its values. When laws are very specific it is difficult for them to be applied in ways that respond appropriately to individual situations. But when they have discretion built in so that all the different particulars of each situation can be taken into account, they give a lot of power to the persons (whether judges, magistrates, Children's Panel members or social workers) whose discretion decides what should happen. (Bottomley, 1984, argues this case strongly) Discretion enables some people to impose their values. We saw in Section 3.3 that state residential care for children and young people is not a service provided for everybody equally, but one used predominantly by those in society who have least access to other resources. Thus the law about taking children into care, which is highly discretionary, acts as a means by which one sector of society (i.e. the group from which law-makers, judges, magistrates, panel members and social workers are drawn) can impose their values on another sector (the poorest and most disadvantaged).

Both, of course, impose their values on children and young people. Being received into care is always compulsory for the child. Attempts have been made recently to try to ameliorate this situation by providing for children to have a guardian ad litem involved in the legal arguments about their care - somebody whose job it is to safeguard their interests. But guess what kind of person this will be? In most cases it is a social worker (though it cannot be a social worker employed by the local authority involved in the case). However, pressure groups such as the National Association for Young People in Care (NAYPIC) are seeking for children themselves to gain more legal controls of their own lives, and direct involvement in legal processes like care proceedings.

4.3 Residential care as a system that promotes inequality

The consequence of these competing value systems is that being received into care is a process which tends to promote, not counteract, inequality. About equal numbers of children and young people come into care via voluntary and compulsory
orders. At present about half of those in voluntary care return to their families within eight weeks. But half remain, sometimes for the rest of their childhood. The term ‘voluntary’ suggests that parents have made a positive decision to seek out care, but many have argued that it is often not a free request, but something that is forced on parents, either because they are persuaded that their agreement would avoid the ‘naughtiness’ of a court hearing, or because they do not understand their right to refuse, or because they have a real need for substitute care for their children without the resources to get it in any other way.

Holman (1973) demonstrates that poverty has always been a major factor. Far more children are taken into care from areas of the country that are depressed than from areas of high living standards. Although the Homeless Persons Act (1977) entitles families with children to accommodation to prevent children being taken into care, implementation has been uneven across the country, and children still do enter care because their parents are homeless, or because their accommodation is inadequate.

While current legislation places a duty on local authorities to keep children out of care if at all possible by providing social work support and resources such as special needs payments, entitlement to these is being drastically reduced. While the law in Britain is clear about the duty of local authorities to keep children out of care if at all possible, they are simply not given the resources to fulfil this obligation. The majority of receptions into care are in fact, if not in law, compulsory. If we were to make fundamental social policy changes to remove the large numbers of children and young people from the poverty in which they are raised we would dramatically reduce the numbers of children and young people in care.

4.4 Children's needs and rights

The large number of children cared for by the state could be interpreted as the result of a caring society taking seriously its responsibilities to ensure that all of its children and young people have access to a better alternative to inadequate parental care.

We accept that in order to be able to study, 18 year-old university students are entitled to residential care (in a hall of residence). If education is a good enough reason to supply people with residential care, why should access to a safe, secure home life and a stable, caring upbringing be less of a reason? Put this way, residential care is a means by which children's rights can be protected, offering them a sanctuary from abuse, neglect, mistreatment and exploitation. All children should know that there is somewhere they can live and grow up where they are safe.

However, a focus on children's rights can also form the basis for arguing that there should be fewer children and young people taken into care. Proponents of children’s rights (e.g. Farson, 1978, Holt, 1975 and Hoyles, 1979) argue that children and young people should be afforded the same rights, privileges and duties as adults (see Unit 2). Consequently, intervention into their lives should only occur in conditions where society would intervene into adults’ lives. The threat of being received into care should not be used as a means to impose different standards of behaviour on children and young people than we would impose upon adults. Think of Jim’s behaviour described at the beginning of the unit. Behaving badly in a pub may be undesirable, but we do not put adult drunks into residential care – indeed, they can kill and maim as drunken drivers and still avoid custodial treatment.

What this argument says is two things. First, we need to rethink the way we construe children and young people, and our preconceptions about their ‘best interests’. It is not an argument about treating children and young people exactly the same as adults, but a reminder that our assumptions about them are socially constructed, and change with time and fashion. The ‘problems of youth’ are socially constructed by us, and their law-breaking activities are often ‘status offences’ (see Unit 3). Radical and contentious steps like allowing children to work for a wage, judging them by the same legal principles as adults, or reducing the age of compulsory education, would reduce the number of young people in care.
Secondly, we have to ask whether taking children into care is always the most appropriate way of meeting their needs and protecting their rights. For example, a youth wage, a benefit of right for all young people over the age of sixteen, would enable those young people who want, say, to continue their education beyond the age of 16 to be able to do so, irrespective of their parents' wishes. It would enable young people who are being abused to live independently. Such a benefit would thus reduce the numbers in care, not by replacing parental control by state control, but by empowering young people.

4.5 Imposing standards on family diversity

Theorists from both the left (e.g. Morris et al., 1980, Taylor et al., 1980) and from the right (Mount, 1982, Goldstein, Freud and Solnit, 1980) have argued that state intervention undermined children's rights. However, this argument is predominantly about parents' rights to rear their children as they see fit, without undue interference from the state. It extends beyond the 'care' issue into many areas such as education (e.g. should parents have the right to choose whether their children receive sex education or be subject to army recruitment in schools?) and health care (e.g. should parents have the right to refuse their children access to contraception below the age of sixteen?)

This argument is increasingly salient in a pluralistic society in which a wide diversity of alternative cultures coexist. For many of those cultures, particularly those that have their origins outside Britain (e.g. from Southern Europe, the Far East and Asia) or are based upon religious conviction (e.g. Muslims and Jews), 'the family' is a crucial and central part of cultural life and organization (recall, for example, Television programme 3).

Packman (1975) notes, for example, that parents of African extraction may seek private foster care for their young children, often some way away from where they live, in order to free them to study for qualifications (e.g. nursing, degrees and postgraduate diplomas). They then take back their children when they are older, and
because of their improved standard of living, are able to offer them better living standards and a better education than they themselves had as teenagers. This form of ‘family life’ transgresses our currently held assumptions about the needs of babies and toddlers to build close relationships with their parents. But for a culture in which high educational qualifications are the only route to ‘a better life’, it is a style of family organization which makes sense. These parents balance what they see as less important (closeness to their children when they are young) against what they see as crucial (being able to pay for older children to receive further education), and have set up their family lifestyle according to these values.

Some of these children have ended up in state-controlled residential care, and a proportion are not returned to their parents, because they are seen as ‘uncaring’. In this way we see state intervention policing styles of family organization, setting criteria of what are, and what are not, acceptable family values. We have then to ask whether such policing is a denial of the right for people of different cultures to run their families according to their cultural values, or a just and desirable protection of the rights of children to ‘a proper family life’? (See Holman, 1973, for a fuller account.)

Similarly, state intervention can be used to particularise the ‘normal’ family, and of who is considered to be a ‘fit’ parent. Lesbian women and gay men are rarely considered suitable to be foster or adoptive parents, and many women have lost custody of their own children, simply for being lesbians. Such households are assumed not to offer children a ‘normal childhood’ in which they can acquire a ‘normal’ sexuality. Yet most lesbians and gay men themselves grew up in ‘normal’ heterosexual households, and research shows that there are no psychological differences between children brought up by lesbian mothers or by single heterosexual mothers and those in nuclear families.

Thus within the notion of ‘family rights’, many children and young people are in care because the state seeks to impose the prevailing values of the dominant groups in society. Children and young people should not be taken into care because their family’s values are different. In a truly multi-racial, multi-cultural, multi-religious and multi-ideological society, being taken into care should not be a means of imposing homogeneity.

### 4.6 State responsibility and its use of power

As well as economic, social, class and gender inequalties bringing more children and young people into care than need be there, many come into care because of the way dominant hegemonies in our society use their power.

Professional groups create social ‘problems’ that only they can tackle. Illich (1973) claims that social workers have a vested interest in seeking out and defining ‘social problems’ because to do so keeps them in well-paid jobs, gives them control over others, and enables them to feed their own self-esteem by seeing themselves as caring professionals helping those less fortunate than themselves. They use the power invested in them by the state to further their own interests, including the power to remove children from their parents (and its threat). Taussig (1986) argues that totalitarian states portray the diversity and complexity that exist in society as ‘disorder’ to which only their policies can bring ‘order’. He cites the preoccupation of the far right with ‘law and order’, the way fascistic regimes stress their capabilities to control social disorder, and the denial of civil liberties by totalitarian regimes of the left as the means by which dominant elites gain power.

All use the custodial separation of dissidents, or undesirables, to achieve and maintain their power base. Within this argument, taking children into care (and its threat) can be seen as a way of marginalizing and ‘depowering’ certain sectors of society: parents (if they threaten the status quo), and children (when they behave in anti-social ways).

Taussig would not claim that Britain is a totalitarian state using child care to imprison dissidents. But his argument suggests that we need to consider, for
example, why so many young people end up in residential care because of their 'criminal' activity, and why certain forms of residential care (e.g. the 'short, sharp, shock' treatment) have been introduced. The government's own research suggests that they are ineffective deterrents, and the government is committed by existing legislation to treating young people as 'deprived' not 'depraved'. We need to ask whether some young people are taken into care not for their own interests, their parents' interests or even the interests of society at large, but to demonstrate that strong measures against 'disorder' are being taken, and to convey an image of society as 'in crisis' which only those committed to strong law-and-order measures can govern strongly?

This is not an argument just against the right, for Taussig stresses that similar measures are used in communist countries. It is an argument against states misusing power. Taken with Ilich's reminder that we need to look carefully at the motivations of those who have the capacity to misuse professional power, it helps to make us aware of the fact that a particular social policy is deeply embedded not just within personally constructed world-views, but within political and ideological systems.

4.7 Standards, policies and practices

All societies define particular standards of 'normality' and 'acceptability' against which they judge 'deviance'. They define policies to respond to deviance, and set up institutions and practices to implement them. It is these standards, and the ensuing policies, institutions, and practices that determine social phenomena (such as having many thousands of children and young people in care). The particular standards we set for child-rearing and child behaviour define what we consider as deviant child care, and it is these that determine our social policies about receiving children into care, the institutions we provide to manage this process, and the practices by which they are implemented.

We cannot, therefore, simply paint social workers as villains who snatch children from their families. Nor can we simply castigate them for not providing an adequate service to prevent, for example, the exploitation and misuse of children by their parents. We can (and I think we should) worry about the extent to which the inequalities within adult society and the misuse of power by adults make children and young people vulnerable. And we can, and should, look at the way our own prejudices contribute to the stigmatisation of being taken into care. If we are to transform residential care into a service which is genuinely good for children, then we must begin by rethinking (and if necessary reconstructing) what lies at the base of our policies, institutions, and practices.

Summary

This section contains information about the legal procedures that are used to take children and young people into care, and about the differences between voluntary and compulsory care. Laws about such policies are not value-free sets of rules, but socially constructed processes that enable some people to use discretionary powers to impose particular standards and values on others. Consideration of children's rights may suggest that the numbers in care are appropriate and necessary, offering children and young people a sanctuary for poor parental care, but it can be argued that taking so many children into care is a means of imposing particular standards of behaviour upon them. 'Taking children into care may also be viewed as an attempt to impose a particular form of 'family' care upon a culture in which a wide diversity of alternative systems of child-rearing exist.' Child-care policies also reflect political and ideological features of society, including the potential for certain professions or political groups to use them for their own ends. Children are biologically and socially dependent, and within a society which seeks to share responsibility for its more vulnerable members, we do need to provide social policies to protect and support them. How we do so reflects our social values.
In this final section I want to try to give you some sense of what growing up in care is like. This will necessarily have to be very brief, and if you want to know more I suggest you read some of the books listed at the end of the unit, or obtain material from one of the associations set up by and for young people in care. Who Cares? in Scotland, and NAYPIC in England and Wales. We will use this section to explore the different kinds of residential care provided for children and young people, though I have limited this to provision for ‘ordinary’ youngsters, as room does not permit me to tackle the complex and changing world of custodial care.

5.1 A childhood in care

As I noted in Section 3.7, children in care often face a very unsettled childhood. While the desirable strategy is for a child or young person to be given stability and continuity, very often, for a number of reasons, this does not happen. To give you some insight into just how unsettled a childhood in care can be, I will introduce you to another young person, Helen, and describe what her care history has been. It is based upon an interview I conducted with her as part of my research for another course. It is a distressing story, indicating some of the problems and mistakes that can occur. But it is by no means an exceptional example of what may happen when children and young people are taken into care.

I have chosen to begin with this complex biography because I believe we can only make sense of some of the provisions made for residential care, and the decision-making processes involved, by recognizing that experiences of growing up in care are typically very complicated, and reflect many of the competing motives and changes in policy that this unit has described.

Helen

Helen’s mother, Kathy, was 17 when Helen was born, unmarried and living in a large city in the north of England in the late 1960s. Helen, a premature and sickly baby with a large birthmark, was confined to an incubator for her first month of life. As Kathy was uncertain about whether to have Helen adopted, Helen was then placed in a residential nursery for two weeks until Kathy and Steve (Helen’s father) found a flat and took Helen to live with them. Almost immediately their relationship was stormy and Kathy had great difficulty caring for Helen, particularly feeding her. Within six weeks the social worker became increasingly concerned, and persuaded Kathy to let Helen be taken back into the nursery until she was stronger and Kathy and Steve had settled down. Kathy visited Helen about twice a week, but had several arguments with the care staff, and after about a month began visiting less and less. Helen remained in care for about another six months.

Kathy and Steve split up, and ‘on the rebound’ (as she described it) Kathy married Pete, a young man of nineteen she had ‘gone steady with’ when she was fifteen, when he was home on leave from the army. They moved to a country town in the south of England, where he was posted, and lived in service accommodation, taking Helen with them. A year later, Brian, their first son was born.

Soon after Brian’s birth, the local health visitor became increasingly concerned about Helen. While she had no evidence that Pete was physically abusing her, he treated her very differently from his own son, on whom he doted, and who was a contented baby. Helen had become a silent, tearful little girl who ran away as soon as anybody approached her, and she did have a lot more bruises than would be usual for a toddler, though none showed obvious signs of being deliberately inflicted. Kathy was constantly tearful, and, soon pregnant again, seemed unable to cope, particularly with Pete’s frequent angry outbursts towards Helen, which he made no attempt to hide. After some months Helen was taken back into care, and placed again in a residential nursery in the south of England. By now she was three. The Social Services lost touch with Kathy, who appeared to them to be making no attempt to find out how Helen was doing. The files indicate that they had no knowledge that during this time Kathy had her first nervous breakdown.
Helen began to cheer up, and seemed happy in the nursery where there was a lot of rough and tumble and cuddling, particularly with the elderly woman who ran the home. One of the care workers, Mrs Lacey, a woman in her forties with grown-up children of her own, began inviting Helen home for weekends. Helen's social worker was trying to find a foster home for Helen, and when Mrs Lacey offered to take Helen, she readily agreed, and for reasons that are not clear, none of the usual vetting procedures (other than the mandatory check with police records) were carried out. At four, Helen moved to live with the Lacey's.

Helen lived at the Lacey's for two years. At first all seemed to be well, but her new social worker, on her three-monthly visit, soon began to be worried. Helen became more and more subdued. On visits she sat in the corner on a small stool and seemed only to whisper 'please' and 'thank you'. When this was commented upon, Mrs Lacey became very angry, and said how could she be expected to give Helen a proper upbringing with social workers interfering all the time. One day Helen's teacher telephoned the Social Services Department. A week ago Helen had been sent to school in her underwear as a punishment for 'getting dirty' and now Helen had arrived again in just her vest and pants. Her behaviour, too, was becoming even more subdued.

The social worker visited Mrs Lacey, who refused to allow her into the house. She telephoned, and told Mrs Lacey that Helen was to be removed. She asked Mrs Lacey to take Helen, the next day, to visit new potential foster parents, and asked for Mrs Lacey's co-operation in making the transition as gentle and easy for Helen as possible. Mrs Lacey was very angry. Next day Helen arrived at the Scotts. Mrs Lacey handed her over, with just 'Be a good girl, Helen' and stalked to the car. She immediately telephoned the social worker and told her to keep Helen at the Scotts, and come and collect her clothes. 'If you think I'm not good enough, then take her. I never want to see her again.' The social worker arrived at the Scotts, and tried to explain to a bemused six-year-old Helen that she would be staying there.

The Scotts were very distressed, but agreed to keep Helen and see how things went. Because Helen and the Scotts' daughter of the same age became very antagonistic, within ten days Helen was removed, and placed with temporary foster parents until a more permanent foster home could be found. In a month Helen was moved to the Clays.

The Clays were experienced foster parents, having previously taken in five different children on short-term foster placements. They were now looking for a child who would stay long-term, and hoped that Helen would be the one. At first there was a 'honeymoon' period, when Helen was quiet but charming, still saying 'please' and 'thank you' at every opportunity, and little else. There was then a period when Helen was a very troubled little girl. The Clays needed a great deal of support from the social workers (staff changes meant there were three different workers in succession during this period) to cope with her temper tantrums and periods of self-destructive behaviour. Helen wet the bed frequently, and tore her clothes. She often became very angry and abusive. But slowly, after two years of careful and patient care, she settled down.

Helen, aged eight, was allocated a new social worker who decided to contact Kathy and Pete who had moved back into their home city and now had five children. Kathy asked to visit Helen, and this was arranged and paid for by the Social Services Department. She came to the Clays to see her, and soon Helen was sitting on her mother's knee. 'Oh, Helen, you are lovely, I love you so much, I've missed you so much. I would love to take you home to meet your brother and sisters.' Two weeks later Kathy visited again, this time with Pete. A couple of weeks after that Mrs Clay took Helen to stay with her family. On her return, Helen said she loved Mr and Mrs Clay, but she wanted to go home to 'my real mum.' The Clays were devastated, but always knew this might happen. Six weeks later, after several more short visits, Helen moved home.
Kathy and Pete managed to get a new, larger council house, to accommodate the six children. But things did not go well. Kathy had another ‘breakdown’ and this time went into a mental hospital for three months. Pete had to give up his job to care for the children, and rows soon broke out between him and Helen. Helen asked her social worker to be taken back into care, and Kathy, in hospital, agreed.

Helen was now 12. She was placed in an assessment centre for eight weeks before being transferred to a ‘family group home’, a large family house that had been converted to take ten children of different ages. Helen was not very happy there and did not get on with the head of the home, who upset Helen by speaking very badly of her ‘dreadful parents’. Helen felt ‘left out’ as the other, much younger children in the home had been there for some time, and she felt an outsider. After six months she began visiting her parents. Helen had another social worker, who was determined to rehabilitate Helen back into her family, feeling that this had not been done properly before. Within another six months, during which time the social worker did a lot of intensive casework with Helen and her family, she was returned home. Helen seemed much better now, and she and Helen became very close.

Helen, now 13, stayed with her parents for a year. She got on well with her mother, but her relationship with Pete went from bad to worse. After one particularly bad row, Helen ran away. The police were called, and she was found in the city’s red light district, trying to ‘pick up’ a customer (so the police claimed, but Helen denied it). Helen was taken back into care. Once more she spent six weeks in the assessment centre, and then she was moved to another family group home.

After another eighteen months when Helen was 15, she began to see her parents once more, first just her mother, and then staying with the family. Kathy was ill again, and Helen went to help her with the younger children. Once again, with another new social worker on her case, Helen was introduced back into her family home. After some weeks, she asked to return, and it was decided at her review to ‘try just one more time’. The staff at the family group home were adamantly against this, and there were strong arguments with the social worker, who, they claimed, had not read Helen’s file properly and did not understand the situation.

Helen returned home. Six months later, after another row with Pete, she went to the Youth Club and pushed her arm through a window and cut her wrists. She was rushed to hospital. They managed to save her life. She was transferred to a mental hospital psychiatric unit for young people, where she stayed for three weeks. She wanted to go back to her last home, but they refused to take her. Their reasons, they said, were that they had lost faith in her social worker, and anyway, with just the three staff (who were usually on duty singly) felt they could not cope with a young woman who was a potential suicide. Helen was placed in an adolescent hostel.

When I met Helen, she was 17 and had been living in the adolescent hostel for two years. As this harrowing story unfolded, I found it difficult to believe that anybody could survive and seem so self-confident and stable as Helen did. She was at college, training for a career in catering. ‘I see my mum sometimes now, but I know I could never go home again, though they still ask me. My mum still says she wants me home, and that they will keep me while I go to college. But I know they won’t. She’s poorly again now, and I think she’ll have to go back into hospital. My step-dad only wants me home to look after the other children.’

When I met Helen again, some weeks later, and got to know her better, she seemed less self-confident. ‘I do wonder sometimes if I’m mental, like my mum. I wish there was somebody to talk to about my feelings. I feel so mixed up. I liked talking to the psychiatrist at the mental hospital. She was good. But if I went on seeing her everybody would think I was mental. I’d rather try to cope on my own.’
5.2 Alternative forms of residential care provision

Helen lived in the following kinds of local authority residential care
1. Residential nurseries
2. Foster homes
3. Assessment centres
4. Family group homes
5. Adolescent hostel

Berndge (1985) notes that another form, one of the few Helen had not experienced, is the multi-purpose unit. Let us look at each of these.

Residential nurseries

These were provided for babies and toddlers in the 1950s, 1960s and 1970s, but have been closed down now, except in a few rare cases. Today, following Bowlby’s work, virtually all babies and small children taken into care are fostered.

These nurseries varied considerably, some stressed physical rather than emotional care, though it would seem that the second nursery in which Helen stayed was not like this. Helen can remember that it was small and run by a ‘motherly’ resident housemother, so it appears that the children who lived there managed to avoid some of the detrimental effects of having nobody with whom to form the strong bonds which Bowlby argued were so important. Helen spoke of her housemother with great affection: ‘She was the first person who ever made me feel good about myself.’

Today small children of this age are placed with foster parents, who usually receive support (and sometimes training) to help them perform the difficult task of balancing the child’s needs to become close, and any intentions to rehabilitate the child home.
Foster care

Helen's story mentions two different forms of fostering: short-term and long-term. The first provides emergency care, where foster parents take in children at short notice, often in emergency situations, until a more permanent placement is found or the child can be returned home. Both Jamie and Jacob (recall them from the introduction to this unit) would be likely to be placed in such a foster home initially. Slowly the job such workers perform is being recognized as a lot more than just being a substitute parent, and their status, training, support and payment are being improved. Short-term foster parents now often specialize, for example, in receiving abused children like Jamie or handicapped children like Jacob.

Similarly, long-term fostering is acquiring more recognition, with more care being taken to establish what task is being undertaken. Some foster parents receive substantial 'wage' payments to look after 'difficult teenagers' as a more desirable option to the institutionalized custodial care of young offenders. Others receive special payments and support to look after children with handicaps. Some take in 'ordinary' children, but are more likely these days to be given information about their role to provide a long-term stable family life for a child unlikely ever to return to his or her parent(s), or to work over an extended period with social workers to return the child home.

It would be nice to be able to say that mistakes and bad practice like those that led to Helen being placed with unsuitable foster parents like the Laces never happen today. The strains within residential care that occurred in the 1970s were apparent in Helen's story, though one may still wonder how the Social Services Department was so stretched that Mrs Lacey was accepted with so little attempt to discover whether she would be a co-operative foster parent who would look after Helen's interests.

With any system based on human judgement, mistakes still occur sometimes. But certainly Social Services are seeking to improve the quality of foster care they offer - some, for example, appointing training officers specifically to improve fostering skills. It is to be hoped that moves to improve the status of residential care staff (which is how many departments now regard foster parents) will help in this improvement.
**Assessment centres**

These are intended as places of transition for children and young people entering care, coming back into care, or whose previous placement has broken down, thereby enabling appropriate decisions to be made about where they should go next. They are supposed only to provide care for a matter of weeks, though sometimes by default they can become more permanent homes.

They are generally disliked by children and young people. Because they take a very wide diversity of youngsters — some of whom are there as a consequence of court orders for law-breaking, others because of serious abuse, and others because they have been rejected — they tend to be places of high emotion and very troubled people. With such a mix it is very difficult to meet the many different needs of those who are facing a traumatic and distressing transition. For example, to ensure security for the small proportion who may be a danger to themselves and the community (but not very violent or abusive) they usually impose very strict rules upon all residents. Furthermore, the transitory nature means that staff have few opportunities to build close relationships with them. They can be very cold, impersonal places, with bars and locks on windows, rows of identical chairs and tables, and none of the clutter that makes somewhere feel like home. Many local authorities are finding alternatives such as experienced foster parents for this function.

**Family group homes**

These were set up after the decision had been made to close the large institutional orphanages and replace them with much smaller establishments. They usually contain between about six and twelve children and young people of varying ages (though these days seldom younger than ten), and are specifically designed to provide substitute family care, with a lifestyle as close as possible to ‘an ordinary family’. Berndt describes them as matriarchal in organization, usually with a woman head of home supervising other care staff, all of whom are often poorly paid and untrained. In consequence they vary a great deal, depending a lot on the characteristics of the head of home. Some heads, as in Helen’s first home of this kind, are very set in their ways and, like her, see parents as ‘dreadful’ — people to be scorned and kept at arm’s length. Still today they can be run by inadequate people who enjoy the sense of power their job gives them, and exploit staff and terrorize children. Some homes are, however, very good indeed, real homes-from-home, run by committed staff who act as a team and who genuinely try to meet each child’s individual needs. However, as we saw from Helen’s second family group home, because of their small size, they are limited in what they can offer. For example staffing quotas often only allow one member of staff to be on duty at a time, which leaves them unable to cope with young people who are ‘difficult’, or potential crises like an attempted suicide.

**Adolescent hostels**

These are a more recent development, created in response to the particular needs of the growing proportion of teenagers in care. They too vary a lot in their organization, but are mainly for people of between 14 and 18 with good quality living accommodation, and care by staff specifically trained to look after these older individuals, in particular to help them adjust to leaving care. Many include forms of intermediate living accommodation such as self-contained flatlets, where young people can develop the skills of home management, budgeting and so on that they will need once they live independently. They also contain larger numbers (about twenty to thirty) of mostly single bedrooms, with communal facilities such as lounges, games rooms, dining rooms and kitchens. Some are specialized, for example providing secure accommodation for young people regarded as in need of a high degree of control. Others may offer facilities for young women with babies. A recent development, following the Barclay Report which argued for greater integration between residential care and the community, is for such hostels to be used as a resource by a wider group of young people, for example by running youth clubs or drop-in centres for young unemployed people.
**Multi-purpose units**

These are large establishments, sometimes known as resource centres, usually staffed by trained specialists offering a variety of care services within a single unit. For example, some combine the functions of an assessment centre with secure provision, others have sections designed for short-term transit care, or to prepare children for fostering, a few innovative units have begun to take in whole families, or provide an on-call, home-based service, as an alternative to taking children away from their families when they are taken into care. Like adolescent hostels, these are more institutional, though they too have resources such as games rooms and facilities for sports and crafts. They are typically managed by a man and based very much upon a ‘professional’ approach to the task of caring, and usually operate by teamwork, with division of labour but also, for example, regular meetings to plan ‘care programmes’ collectively.

There are, of course, many variations between all of these and other kinds of establishments (e.g. community homes with education on the premises, and therapeutic communities). The majority are run by local authorities (about 1600 in England and Wales) but others are run by voluntary bodies, such as the National Children’s Homes. There are about three hundred of these. Finally there are a smaller number (about seventy in England and Wales) of private establishments, run for profit, where local authorities pay to have children cared for.

### 5.3 Living in care

Who knows, perhaps one day your children or your children’s children could be in the same position as me — in a children’s home. It’s not too bad. We are not locked up and we don’t have bread and water to eat and drink every day, though some people think it’s like that. Well I hope you believe me because it isn’t like that at all. I wanted to be in care because I could not get on with my step-father, and he kept hitting me, so I kept running away from it all. I just couldn’t do anything at home. When I went into care it was like my life starting all over again, it was like a holiday. I started going out and meeting people, and eventually started work when I left school. People in this children’s home are looked after well, better than living with parents who don’t care for you at all. Sometimes I wish I knew my real Dad and I miss him so much. I often wish my Mum and Dad were together like other families, then I could go home (A young woman in care, cited in Berndge, 1986, p 1)

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A shared bedroom in a self-contained unit designed to cater for children aged between 6 and 18

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*Copyright material removed*
Living in care today is not at all like the images some of us still have of rows of regimented uniformed children sitting along tables eating institutional food. Some children’s homes I have visited would be very difficult to tell from an ordinary family home. Except for the staff accommodation, with its rotas and notices from ‘head office’ pinned on the wall. Others have far more of the look of student hostels. Secure accommodation is, inevitably, more institutional, but attempts are usually made to avoid the look of a prison, as far as possible.

The experience of growing up in care varies a great deal, according to the resources provided by different local authorities and by the particular staff that work in the establishment. But what distinguishes living in residential care from living with a family has very little to do with accommodation.

Children in care all have a field social worker allocated to their overall care, though as we saw from Helen, there is usually a series of different fieldworkers as staff move on, get promotion, and so on. Many also have one particular residential worker allocated to them, called a ‘keyworker’, in an attempt to provide some sense of continuity, and enable them to build up a closer relationship. All children in care have a ‘file’ kept about them, which records the reasons why they came into care and is used to keep track of their care career, including any assessments that have been carried out, and reports on particular incidents (e.g. major rows, or if they have run away). Children in care have a ‘review’ every six months, at which their social worker, keyworker, or another member of staff from their establishment, sometimes their parents and other interested people (e.g. psychologists, teachers) meet together to evaluate what has happened in the last six months, and make decisions about the future.

There is a growing debate about young people’s rights to see their own files and attend their own reviews, and these are subjects which were very important to all the young people in care to whom I have spoken. Some local authorities have adopted a policy of completely open access, allowing all young people over thirteen or fourteen to see their own files whenever they want and to attend all reviews in full. Others offer more limited access, with the right to see sections of the file (keeping from the young people parts considered to be disturbing) and to attend parts of the review, while a few still exclude all young people from both files and reviews.

NAYPIC and Who Cares? are seeking to have all local authorities make explicit, within for example individual ‘care contracts’, the rights and obligations of each young person in their care for instance, to attend reviews, see files, receive mail without it being seen by anybody else, have somewhere private where they can lock personal items and correspondence. They would like local authorities to specify the rules that each individual is expected to follow (e.g. about bed-times, smoking, opportunities to go out at night, parental visits and visits to friends) and resources (e.g. pocket money and money for clothes).

These kinds of rules are another characteristic of growing up in care. Anybody who is or has been a parent of a teenager will know just how difficult the task is of negotiating boundaries and ‘house rules’ within a family. This task is much more difficult when a teenager is cared for by a number of people, within a context of other young people living in the same place, and where there is a degree of monitoring from line management, and indeed by the Directorate of Social Services.

The experience of growing up in care is bounded by explicit rules that arise from the nature of local authorities themselves, such as having to conform to fire regulations, and having to answer for the use of taxpayers’ money.

All children and young people in care have had a great deal of contact with social workers, are cared for by people who are increasingly jealous of their professional status, and see the task of child-rearing as a job. This means that the talk of youngsters in care is peppered with terms like ‘preparing for independent living’, ‘needs for self-esteem’, ‘my file’, ‘my last review’, and ‘my care contract’. The shift
towards making residential care a more thoughtful, goal-directed task for staff brings the process of growing up into a much more explicit discourse for those who are in care. Many are very articulate about their rights, and see themselves as having more opportunities to negotiate the arrangements for their daily living than a young person growing up in a family, who may be more likely to accept that they must work within the framework that the parents set.

But young people in care are often also very aware that they have been given a raw deal by society or by their parents (or both). Many have experienced events (like a parent dying, acrimonous divorce, violence, neglect, emotional and sexual abuse) and home lives (with parents who are violent to each other, mentally ill, drug and alcohol users, or who have served prison sentences) which they have found deeply distressing, and which they have difficulty coming to terms with. Many experience ambivalent feelings about their parents, loving and missing them terribly, but feeling rejected and failed by them too. And many have had very unsettled lives, with a succession of failed attempts to return home, foster homes and previous placements. In parallel with their articulate expositions of their needs, rights and future plans are usually troubled feelings of one kind or another. They tend to see ‘being in care’ within this context. Like the young woman whose statement began this section, they are often warmly grateful for what some of their care staff have done for them, and what being taken into care has offered them, and yet resentful that they have been denied the family lives of other children, which some, at least, see through rather rosy spectacles.

5.4 So what should we do?

Given that a large number of children and young people could be removed from care by tackling problems of poverty, there still remains the question of what we should do about those who are mistreated or neglected by their parents. We can summarize the kind of intervention into the family that a society may adopt in terms of three alternative strategies. The first, like other social policies you have met in this course, is *laissez faire*. We should intervene as seldom as possible, accept that parents have a right to rear their children in a very wide diversity of different ways, and leave them to do so except in cases of dire emergency and gross abuse. The second strategy is probably best summed up by the term ‘*good enough parenting*’. Society has a duty to set baseline standards of child care and to monitor parents to ensure they meet those standards. When they fail to achieve them, society has a right to remove the children from the family and undertake their care. The third strategy is a *pluralistic* approach, which suggests more stringent criteria than *laissez faire* but accepts that, within a pluralist society, not only must intervention be sensitive to the different values of different cultural and social groups, but it must also engender flexibility of values in the alternative care provided.

You may feel that I have glossed over the fact that even when you strip all the socially constructed aspects away from childhood and adolescence, there remains a level of biological and social dependency. Children have a right to be dependent, and, in their dependency, to call upon the nurturing of adults.

It is not the dependency of children and young people that is at issue, but the _kind_ of dependency that our social institutions and organizations generate. To argue that such dependency should be provided by the family alone is to deny our mutual dependency as a society, and to deny our collective obligation to children and young people to make sure they are cared for in a dignified and nurturing way that respects their autonomy even though they are dependent. It is _how_ we do this that is the question. We need social policies that _enable_ parents to care for their children properly and which do not trap them into levels of poverty that make good quality child-rearing impossible. And we need social provisions that can _enable_ those children and young people who are abused and neglected by their parents to be nurtured in ways that give them at least the same opportunities and freedoms in life as other people.
History

Both McClure’s book, *Coram’s Children*, and Gnest’s *A Victorian Chanty* (full details are given in the references) are compelling and easy to read and offer insights into the very different ways child care was perceived in the past. Although they are both about specific institutions, they also offer much broader analyses of their times.

Heywood (1978) and Packman (1975), while now both rather old and out of date, do a good job of describing the historical origins of our current system. Jean Packman’s book remains a well-respected classic and I recommend it as the one book you really should read if you are at all interested in this area. It is a thorough analysis of the development of child care since the setting up of the welfare state (though it explores the period prior to this too) Heywood is more general in its scope, covers a much longer historical time-span, and gives a particularly good analysis of Victorian times, and the impact of Barnardo and Mary Carpenter.

Children in care

Barbara Kahan’s book, *Growing up in Care*, is good for getting a better ‘feel’ for what it is like to spend your childhood in care. David Berridge’s more recent *Children’s Homes* does this too, and also gives more detail about the different kinds of residential institutions themselves. Both, however, tend to paint a glowing picture at times, and tend neither to challenge the *status quo* in any fundamental way, nor to explore the rights issues in any depth. Bob Franklin’s *The Rights of Children* (Blackwell, 1986) fills this gap well, particularly the chapters on children’s rights in care, juvenile justice, black children’s rights, and the Scottish perspective.

Another ‘oldie but goodie’ is Juliet Berry’s *Daily Experiences in Residential Life* (Routledge and Kegan Paul, 1975). It focuses particularly on the residential worker, and gives good insight into the problems faced and the difficulty of the tasks concerned. Other good books in this field are Roger Clough’s *Residential Work* (Macmillan, 1982) and Ann Davis’s *The Residential Solution* (Tavistock, 1981). Clough is particularly good in the way he raises issues about, say, the need for autonomy, and then discusses the practical implications. Davis’s strength lies in her elegant analysis of the roles of residential care vs a vs family care. All three of these books are written well, and though challenging reading, are well worth the effort.

Two courses produced by the Health and Social Welfare Department of the Open University are pertinent to this area. At the time of writing only P653 *Caring for Children and Young People* is available. It is a short course consisting of an individual study pack and a group-work pack. P254 *Children and Adolescents*, a half-credit course, is due for first presentation in 1989. For details about either of these two courses, please write to The Maintenance Office, Department of Health and Social Welfare, The Open University.

The state, families and children

If you want to follow up on the issues raised in this unit, a good place to start is Freeman’s *State, Law and the Family* (Tavistock, 1984), of which about a third is devoted to issues about children and young people, including a good chapter by Dingwall and Eekelaar on child protection, another is by Colvin on issues surrounding care, and a critical analysis of the dangers of welfarism (e.g. in terms of family cultures) by Bottomley. These three chapters, while more ‘academic’ in tone and style than the books mentioned so far, offer a good grounding in the debates about the rights/responsibilities of parents and the state, and such questions as whether there are too many children and young people in care. Each chapter offers a single viewpoint not a balanced review, but they do all give good references to a range of different arguments made by other people. Freeman’s earlier book, *The Rights and Wrongs of Children* (Pinter, 1983) is another excellent starting point, particularly his final chapter on ‘Who knows best? Child-rearing decisions, parents and the state’.

Finally, if you would like to know more about the O’Neill case, Tom O’Neill wrote about it, and about how he and his brothers came to be in care, in his autobiography, *A Place Called Hope* (Basil Blackwell, 1981).
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This unit explores the issues of child abuse and why and how it is of such significance for social workers. It will be argued that many of the debates about the efficacy, role and responsibilities of social workers in the last twenty years have been carried out primarily via the issue of child abuse. Similarly, the impact on social work policy and practice has been much wider than just with children at risk of potential or actual violence at the hands of their parents.

The first four sections are concerned with trying to analyse when child abuse was first defined as a social problem, why it became such a priority for social workers, and what were the main recommendations outlined for policy and practice. Section 5 then indicates the impact the issue has had on social work practice with children and families more generally. Section 6 reflects on the dominant explanations and assumptions that have informed these developments – making a series of critical comments. Section 7 then outlines what research has demonstrated about the nature, incidence and social distribution of the problem. It is only in very recent years that major concern has been expressed about sexual abuse, and while reference will be made to developments in this area, the primary focus will be physical abuse and neglect.

Objectives

When you have finished this unit you should have some understanding of

1. How social problems are identified and defined and the way this has direct implications for everyday social work policy and practice

2. The tensions and contradictions inherent in social work practice – for while social workers may have only limited resources, knowledge and skills, they are expected to tackle problems which are deeply rooted in social processes, structures and attitudes

3. How the solution to social problems is itself rarely clear cut and straightforward

4. How certain assumptions and explanations of the problem are taken for granted and how these invariably fulfil important ideological functions for the wider society

5. How certain ‘events’, particularly the cases of Maria Colwell and Jasmine Beckford, became symbolically important moments in the development of social work, particularly with children and families
Child abuse, perhaps more than any other problem with which social workers are involved, raises high emotions. I often get confused and bewildered as to how we can do such things to children in a supposedly advanced society. Such feelings are probably heightened when you have children of your own.

Before you proceed any further, reflect for a few moments as to your own thoughts and feelings on the subject and write down some words which you feel best express them.

John Grady (1983) has put into words some of the powerful feelings the subject raises for me – and, I suspect, many others.

We all know that child abuse exists and is terrible. We’ve all heard at least one story we’ll never forget. Let me tell you mine. A brief note in the newspaper reported a little boy scalded to death by his father, who sat him in the bath-tub and poured boiling water over him. The little boy, it was reported, kept saying, until he died, ‘Daddy, I love you.’ I remember weeping when I read it. Most people would, if you’re a father, as I am, the emotional depth of the response would be mediated by your relationship with your own children. You’d remember your explosions of anger, the look of bewilderment and fear in your child, your realization (often not as quick as it should have been) that you’d gone too far. Your relief that, thank God, you hadn’t gone that far. Finally, your sickening sense that you were part of a world that could generate terrible, unspeakable things, and that it was not all that unfamiliar (Grady, 1983, p 111).

Certainly in recent years the problem has received considerable public, political and professional attention. The media in particular have given it increasing coverage. In the process, however, certain themes predominate. These are clearly illustrated in the story reproduced from the Sun.

Now read the newspaper cutting overleaf and note down what you see as the main themes.

The major themes are that
1. Child abuse is a major social problem
2. It is predictable and preventable
3. It is social workers who are responsible for doing something about it. Therefore it is social workers who should primarily take the blame when things go wrong
4. Because of these failures the role and focus of social workers should be seriously questioned

Social workers are very aware that if a child on their case-load is seriously injured or dies they are likely to be subject to severe criticism. The issue is surrounded by considerable professional anxiety and fear.
In this unit I intend to look at the way the issue of child abuse illustrates a whole series of tensions in the relationship between social work and social problems. In particular, social workers are attempting to protect children and hence intervene in families in a society which essentially upholds the value of the private family and where parents are seen as having primary responsibility for bringing up children. Hence there is little social, moral or legal legitimacy for state interventions into family life. The state should become involved only when things are seen to go wrong. Child abuse is a focal point for many of the issues which you have already encountered in this course. It raises questions about the relations between state intervention and the family, about the role of social work, and about whose interests and rights are served by social intervention. It is also a highly problematic area for social work itself. As we shall see, there are far more potential cases than there are resources to cope, and nor do social workers necessarily have the knowledge and expertise to carry out the tasks expected of them.
The growth in coverage of child-abuse stories in the media and the way they are presented, particularly in the popular press, suggests that child abuse is a new and growing problem. Certainly social and political concern about it has grown immensely in recent years. Yet, as you might expect, those that have looked at the history of violence to children (May, 1978; Thane, 1981) have demonstrated that there is considerable evidence to show that children have suffered at the hands of adults throughout history. However, apart from the last quarter of the nineteenth century (Behlmer, 1982), rarely has the issue been seen as a major social problem requiring state intervention.

The issue has achieved prominence in the last twenty years for a variety of complex but interrelated reasons. In order to understand the current situation in terms of knowledge, policy and practice it is important to analyse how this prominence came about.

What becomes evident is the way in which child abuse has been defined almost exclusively as an ‘individual disease’ during the period. Children suffer abuse because their parents are ‘evil’, ‘brutes’ or perhaps ‘mentally sick’ and the parents are seen as very different from normal parents. Similarly, individual practitioners are castigated because they fail to protect the children as they should.

Many of the early articles written about the problem in this country in the late 1960s registered their debt to previous American work. To understand how the problem was first discovered, and by whom, we must turn to the United States of America. Recognition in the USA began in the mid 1940s with the work of Dr John Caffey (1946), a distinguished paediatric radiologist, who demonstrated a relationship between the two conditions of multiple fractures to the long bones and chronic subdural haematoma (inflammation around the skull). While he thought that both conditions were likely to be caused by some sort of injury, he neither attempted to define the cause of the injury nor provide a firm label. However, Woolley and Evans (1955) suggested that the injuries were ‘due to undesirable veters of force’ and made reference to ‘parental indifference, alcoholism, irresponsibility and immaturity manifested by uncontrollable aggressions’ as the cause. The major breakthrough in locating it as a major social problem came with the intervention of Dr Henry Kempe and his colleagues from Denver, Colorado, in 1962, who provided the label of ‘the battered child syndrome’.

This label was to prove crucial in helping to gain the attention of the wider medical profession to the problem, helping to publicize it and encourage the state to take action. While the label was designed to be emotive it played down the legal and socially deviant aspects and defined it as an illness (a syndrome). The label proved a powerful factor in mobilizing wider concern, and in the process conceptualized it centrally as a medical problem (Pfohl, 1977).

Kempe and his team claimed that the syndrome characterized a clinical condition in young children, usually under three, who had received serious physical abuse, usually from a parent, and that it was a significant cause of childhood disability and death. They argued that it was often mis-diagnosed and that it should always be considered in cases of childhood injury or neglect and where the injuries did not appear consistent with the stories presented by the parents. The role of the doctor was to make the correct diagnosis and to prevent such incidents in the future, in part by reporting all such cases to child care or law enforcement agencies.

Significantly they considered that the problem was to be found in all sections of society and that it was not simply one dimension of the problems associated with poverty, social deprivation and inequality. Rather it was a particular kind of parent who perpetrated such behaviour ‘immature, impulsive, self-centred, hypersensitive and quick to react with poorly controlled aggression’ (Kempe et al., 1962, p 19).

Recognition of the problem in Britain developed much more slowly and was first discovered by two orthopaedic surgeons, Griffiths and Moynihan (1963) in the form of ‘the battered baby syndrome’. They made explicit their debt to the work of Henry Kempe in the USA and stated their primary aim as ‘to give publicity to a syndrome
which we think more common than is usually believed and which would appear often to be mis-diagnosed with possible tragic results. However, the two main branches of the medical profession that were most active during this early period in Britain were paediatricians and forensic pathologists. We can therefore locate the discovery and consequently the early definitions, explanations and policy recommendations about the problem in the medical profession. It was usually stressed that a purely punitive attitude to the person inflicting the injury was ill-advised and that the 'management' of the problem was primarily the responsibility of the medical and social work (children's department) agencies.

In the latter 1960s the emphasis on the need for a more obviously benign social work response is made more explicit via the influence of the National Society for the Prevention of Cruelty to Children's (NSPCC) Battered Child Research Unit. The unit was set up in 1968 with the function of publicizing the problem, developing research and intervention strategies and bringing it to the attention of the various professions concerned.

The unit approached the problem in terms of a theory of human behaviour that was consistent with the professional social work model of family casework evident at the time and which has been discussed at some length in Unit 14. Thus the emphasis was on working with the family by helping the parents grow emotionally and socially. Child battering was seen as a symptom of family breakdown. One thing that all battering parents were thought to have in common was that their own childhood was grossly deprived and unhappy, so that there is a breakdown in the 'ability to mother' and therefore care and bring up their own children successfully. It was argued that while the problem was a clinical condition there was a crucial need for a social work psycho-social assessment and a fully co-ordinated multi-disciplinary team approach. The social workers should carry out the central diagnostic and therapeutic work (for a summary of the work of the unit see Baher et al., 1976).

The approach to the problem was essentially 'non-punitive.' The crucial factor for the social worker was not to establish whether the law had been broken and whether the parents were guilty of an offence, but to form a consistent, trusting and professional relationship. Indeed the legal system and the courts were seen as significant only when they were part of a more general treatment plan.

Such an approach contained within it the seeds of many of the confusions and arguments that were to surface about child abuse in later years. It expresses very clearly some of the problems already identified within this block, and in Unit 2 on children's rights. Who is the client, the parent or the child? Is this model of family casework an appropriate response to the problem? What is the appropriate social work role and to whom are social workers accountable? Does such an approach provide sufficient protection for the child? What is the significance of the law? All these questions are related to more fundamental issues concerned with what is the nature of child abuse and what is the best way of overcoming it.

Q Who were the main participants in the discovery? How was the problem defined, conceptualized and explained in the 1960s? Why should it have been social workers who were seen as the main means of responding to the problem?

In this section I have suggested that while the initial discovery of the problem can be located with paediatric radiologists working in the USA in the late 1940s and 1950s, the introduction of the label 'battered child syndrome' by Henry Kempe was crucial. These developments prompted a similar discovery in this country from 1963 onwards, particularly by paediatricians and forensic pathologists. From the mid 1960s onwards the NSPCC Battered Child Research Unit played an important role in publicizing the problem and bringing it to the attention of various professional groups. The definition of the problem as the 'battered child syndrome' was important in gaining the attention of the wider medical profession. While a fairly emotive label, it defined it clearly as a disease or syndrome.
In spite of the publicity surrounding the problem of child abuse between 1968 and 1973, it was not seen as a major social priority and was given a low profile by welfare professionals, the media and central and local government. It was the case of Maria Colwell which proved crucial in establishing the issue as a major social problem and in introducing fundamental changes in policy and practice. Not only was her death constructed as a national scandal in its own right, but the reaction to it reflected a more pervasive social anxiety about disreputable families and the accountability and activities of social workers. The case ensured that from then on child abuse would no longer be experienced by social workers as marginal to their everyday practice. It would take on the highest priority and would create deep personal and professional fear about a child on their case-load or in their area dying in similar circumstances.

Maria Colwell died on 7 January 1973 at the age of seven. She had spent over five years in care (including being fostered by her aunt), but was returned to her mother and step-father at the age of 6 years and 8 months, being placed on a supervision order from then on. The family was visited by a variety of social workers, and concern about Maria was expressed by her school teacher and neighbours. However, when she died she was found to weigh only about three-quarters of what would have been expected for her age and height, and she showed signs of previous abuse. Mr Kepple, her step-father, was convicted of manslaughter and sentenced to eight years' imprisonment.

The decision to hold a public inquiry into the case was crucial in drawing the attention of the public and the media to the problem. It was not the death of Maria but the inquiry that was the significant dramatic event. This can be illustrated by the amount of press coverage given. For example, between 1968 and early 1973 the only two mentions of child abuse in the *The Times* followed the publication of the two major reports published by the NSPCC Battered Child Research Unit in 1969 and 1972 (Skinner and Castle, 1969, Castle and Kerr, 1972). However, between 10 October and 7 December 1973 it carried three hundred and twenty paragraphs on the problem. Nearly all of this focused directly on the inquiry into the death of Maria Colwell. The only reference to the case in *The Times* prior to this was an entry of eleven lines when Sir Keith Joseph announced he was setting up an inquiry. This is not to say that the case and the trial of Mr Kepple had not received some earlier coverage - particularly in the local area of Brighton and East Sussex - but that the decision to establish an official inquiry was crucial in establishing the case as a scandal and the issue as a major social problem.

The then Minister for Social Services, Sir Keith Joseph, made explicit his explanation of social deprivation and suggested solutions accordingly. He put great emphasis on the 'cycle of deprivation' which argued that deprived parents pass on to their children the very habits and behaviour which caused their condition, so that each generation reproduces the failings of the former. The prime cause of social problems and deprivation, therefore, is a small minority of families who require certain specialist interventions so that the 'cycle' can be broken. This thesis seems to have had an increasingly pervasive influence on the Department of Health and Social Security, both in the way problems were conceptualized and policies were prioritized.

Most of the research and publicity on child abuse, both from the USA and the NSPCC Research Unit, stressed that the common factor in abusing families was that the parents had themselves been abused as children. The general explanation as to why parents abused their children was thus that they had been subjected to similar treatment themselves as children, which set in motion a 'cycle of violence'. Cases of child abuse could thus be seen to epitomize the notion of social deprivation as defined by Sir Keith Joseph.

It is also likely that civil servants at the DHSS would have played an active role in bringing the issue and the work of the NSPCC to the Minister's attention. This was particularly the case after Joan Court, the first Director of the NSPCC Research Unit, was appointed as a civil servant at the Social Work Service at the DHSS in 1971.
However, the intervention of the Tunbridge Wells Study Group (TWSG) on Child Abuse proved crucial in reaffirming Sir Keith’s interest and crystallizing DHSS policy. The TWSG was a self-appointed ad hoc group which aimed ‘to share and discuss with the various welfare professions and groups the views which stem from Dr Kempe in Denver and the NSPCC in Britain. The group consisted of leading paediatricians, psychiatrists, social workers, health visitors and the police. Formed in 1972, a conference was held at Tunbridge Wells (after which the group was named) on 15–18 May 1973, which Sir Keith Joseph and civil servants from the DHSS attended, and to which the DHSS gave some organizational and financial assistance. The announcement of the inquiry into the death of Mana Colwell was made just a few days after the conference on 24 May. It is apparent that the TWSG played an important role in influencing events in 1973. Not only did it legitimate concern about the problem, but it also helped inform the decision to set up the public inquiry. Similarly, the report and resolutions of the TWSG conference were circulated to local authorities and Health Service Executive Councils in October 1973, at the same time as the opening of the inquiry. As I shall demonstrate later, this is an important document as it provided the groundwork for much of the policy formulation that developed subsequently.

It would be wrong, however, to see the increased public attention arising from the inquiry as simply reflecting specific concerns about violence to children. It connected with much broader social anxiety about the decline of the family, the growth of violence and permissiveness, and concerns about the relationship between disreputable families and state welfare officials, particularly social workers. Concerns about child abuse have been inextricably interrelated with debates about the nature and direction of social work and the accountability of social workers. These surfaced explicitly at the time of the Mana Colwell inquiry.

During the 1960s and early 1970s we can identify in this country the emergence of an increased sense of social anxiety among sections of the population who placed particular priority on certain values. The traditional values of hard work, individual initiative, respectability, responsibility, delayed gratification and social discipline were all seen to be under threat from the rising tide of permissiveness, commercialism and social disorder. The source of the social anxiety arose from both concerns about Britain’s economic and political decline in the world and the social, cultural and moral changes that seemed to have taken place in the post-war period. Apart from a number of legislative innovations which were regarded as shifting legal definitions of morality in a permissive direction (particularly in the areas of abortion, homosexuality and divorce), there was a steady increase in the rates of delinquency, violent crime and marriage breakdown. The institutions and values which were thought to be so central to the smooth running and organization of society were seen as under attack, particularly from misguided liberals who were leading the country astray.

The central social institution felt to be most at risk in such circumstances was the family. It is this central concern for the family which helps us understand the growth of a number of moral campaigns in the late 1960s and early 1970s. It is in the family where the social and moral compulsions are generated and primary socialization is carried out. Thus fears about a breakdown in the social order increasingly focused on the family, and those who have a responsibility for ensuring its ‘proper’ functioning. If the family is under assault, then it is children who suffer most as they are especially vulnerable to permissiveness and violence and are seen as the innocent victims of social indifference. A number of commentators have shown that by the early 1970s this sense of social anxiety was reaching crisis proportions (Hall et al. 1978, Chishall, 1977) and that increasingly it was being centred on fears about the growth of ‘violence’. It is perhaps not surprising, then, that the social reaction to Mana Colwell was so forceful, as it coalesced a range of fears related to both violence and the decline of the family.

Many of the child-abuse cases which have received publicity, of which Mana Colwell was the first, concerned families where a step-parent was involved, thus providing
an apparently stark reminder of the consequences of divorce and more liberal attitudes to the family. You have already seen these arguments about the breakdown of the family in Unit 7, and some of the efforts to ‘revitalize’ traditional family values in Unit 10. What is significant here is the way in which the decline of the family and danger to children were linked to the failings of ‘misguided liberals’ in the social work profession.

The case provided an opportunity to express parallel concerns about the newly-created profession of social work. While the practice of social work has a long history, it was the reorganization of social services departments that established it as a central part of the state. As was seen in Unit 14, it took place within the parameters of Keynesian social democracy and the modernization of the welfare state that was occurring during the 1960s. The role outlined for this was one of coordinating other welfare services in the community and trying to improve the social functioning of certain inadequate families. It would provide the personalized dimension to the welfare state, the primary tool being the social worker’s use of relationships. Thus the new service, and the profession which would be its hallmark, were to be flexible and benign in philosophy and approach. The establishment of social work and social services departments could thus be seen as the most recent and obvious manifestation of the social democratic welfare state, just at the time when such developments were being subjected to growing scrutiny and criticisms which focused on the political use of the New Right.

At one level, these criticisms argued that the growth of the unproductive welfare state was acting as a burden on the productive, primarily private, sectors of the economy. Economic growth and the accumulation of wealth were thus being fundamentally undermined. At another level, perhaps more significant for our analysis, it was argued that the growth of welfare encouraged soft attitudes to deviance and the undeserving. It undermined individual responsibility and morality. The activities of social workers were seen as particularly dangerous in this respect, because they undermined parental responsibility and authority.

More specifically there were other related issues which, while more internal to social work itself, fed into the concerns. Firstly, there was a real disquiet expressed by those in health and welfare about the organization and efficiency of the recently reorganized social services departments. It was suggested that the quality of the service had deteriorated as a consequence of reorganization, and that child care was receiving far too low a priority. Secondly, there had been recent debates about the rights of foster parents, changing attitudes to the blood-tie and the law relating to adoption. In the late 1960s a number of cases had received publicity as ‘tug-of-love’ cases. As Unit 15 showed, one major argument was that too much emphasis in child care had been placed on rehabilitation and preserving the natural family, so that parental rights had been guarded too fiercely at the cost of substitute parents and of the children themselves.

What were the major factors contributing to making the Maria Colwell case such a scandal? Make some notes for yourself and compare them with my comments.

I showed that Sir Keith Joseph, when Social Services Minister, and senior civil servants played active roles in bringing the issue to public attention and establishing the Colwell Inquiry. It was the inquiry, rather than the original tragic death of Mana, that received so much national publicity. Similarly, a number of professional pressure groups – particularly the NSPCC, sections of the medical profession and the TWSG – played important roles in the early 1970s. I have also demonstrated that concerns about child abuse and the activities of social workers at this time can be related to a more general social anxiety about the decline of the family, the growth of violence,
permssiveness and concern that inadequate families and innocent victims were being seriously let down by welfare professionals

The Mana Colwell Inquiry (DHSS, 1974a) provided an excellent opportunity to bring the arguments into public and political debate. More generally, the ‘mistakes’ and ‘errors’ of the welfare professionals involved, particularly the social workers, provided the catalyst for the ‘traditionalist’ assault on the ‘soft liberalism’ of the welfare agencies.

The role of the media was central in not simply reflecting but fuelling the concerns. It was not just that the media gave the issue more coverage, as we have seen, but that it took on a far more active, crusading and independent role. It did not simply reflect the views of the NSPCC Research Unit, TWSG and expert witnesses to the Colwell Inquiry, but actively reconstructed the issues and interpreted the events. It played the populist role of expressing the views of the ‘man in the street’ and claimed to speak on behalf of ‘society’s’ anxiety and concerns about both the family and social work intervention.

The Colwell Inquiry provided the platform whereby the issues, explanations and approaches which had been available for some time received massive exposure. However, the nature of the case and the way it was presented in the media provided a more severe reaction which demanded a more authoritative role from social workers than was previously suggested by the NSPCC Research Unit. The media tended to over-simplify, sensationalize and personalize the problem. It was presented in terms of culpability, right and wrong, black and white. There was no room for shades of grey.

For example, even in the *The Times* it was the dramatic which appeared in the headlines, e.g. ‘Girl was like a skeleton, neighbour tells Inquiry’ (11 October 1973), ‘Girl’s bones sticking out’ (12 October). The headlines become increasingly personalized around the role and activities of the social worker, so that the media articulated an inquiry into social work where the social worker is found severely wanting, e.g. ‘Social worker made error of judgement’ (3 November), ‘Social workers wrong, QC tells Inquiry into the death of Mana Colwell’ (6 November). A number of themes are interrelated in the stories themselves: that the problem of battered babies is an identifiable syndrome, that social workers and social services departments are the central responsible agency, and that there needs to be a less sentimental attitude towards natural parents and the ‘blood-tie’.

There is no doubt that the case sensitized the media to both child abuse and social work. Both became newsworthy, where disasters were evident. Certainly the themes provided in coverage of the Colwell Inquiry and the cast of characters for this ‘drama’ have continued to reappear at regular intervals since, via other child-abuse inquiries. For example, cruel parents, innocent victims, and incompetent social workers were well illustrated in the headlines that accompanied the publication of the Inquiry into the death of Lucie Gates on 13 November 1982, ‘Clear signs of ill treatment ignored, says report’, ‘Failures that let Lucie Gates die’ (*Daily Telegraph*), ‘Lucie: the tiny victim of a sorry saga of blunders’ (*Daily Express*), ‘Doomed girl “failed” by welfare worker’ (*Daily Express*), ‘Council slammed over Lucie’ (*Sun*), ‘Why “Little Angel” Lucie need not have died’ (*Daily Mirror*)
While the Colwell Inquiry was the crucial event which spurred recognition of child abuse, a series of subsequent inquiries by the DHSS, Local Authorities and Area Health Authorities during the 1970s served to underline and consolidate the issues (DHSS, 1982). The inquiries acted as the political touchstones to stimulate administrative and managerial procedures for coping with the problem.

The inquiries have usually been concerned with:

1. setting out the central ‘facts’ of the case,
2. assessing critically the role and work of the significant professionals and agencies involved, and
3. producing a set of recommendations for the future.

Little discussion usually takes place about the causes or nature of the problem. This is partly because this is assumed to be self-evident and not of significance. It also reflects the limitations of developing an understanding of a problem from studying a one-off individual case.

Stop for a moment. What do you think might be the limitations of studying a problem through individual cases? Make a note of what you think, and compare it with what is said below.

I think there are three main difficulties associated with this case-by-case approach to the study of child abuse:

1. All of these inquiries into child-abuse cases proceed with the benefit of hindsight. They invariably argue that sufficient ‘signs’ of worrying factors were in evidence prior to the major abuse, and that social workers should have seen those signs and acted accordingly. But these inquiries have the advantage of knowing the final outcome, and can assume that it was the predictable outcome of earlier stages. Social workers, then, are expected to interpret the signs correctly and be able to predict the likely outcome. We shall be returning to this problem of prediction in a later section.

2. Focusing on individual cases may make it harder to analyse the general causes of child abuse. Focusing on the characteristics of the particular case (by definition atypical, since it has been severe enough to require an inquiry) is not necessarily informative about the wider patterns of child abuse. Indeed, it is possible that patterns identified in the particular case may be seized upon and treated as if they are typical.

3. Because of their focus on a particular case, the recommendations which such inquiries put forward for improvements in dealing with child abuse tend to be concentrated upon finding better ways of dealing with individual cases.

The system of child-abuse management was effectively inaugurated with the publication of a DHSS circular in April 1974 (DHSS, 1974b). The problem was officially labelled ‘Non-accidental injury to children’. Following the title of the TWISG report, it underlined the value of multi-disciplinary team work and was concerned with both the management of individual cases and the local organization of services and expertise in order to improve understanding and training. The circular strongly recommended the introduction of area review committees, case conferences and the establishment of non-accidental injury (NAI) registers in each area. This quickly followed.

However, the primary agency concerned with controlling the problem and co-ordinating procedures, services and information was seen as the social services...
department, with the social worker as the critical professional. For the circular argued that case decisions should be made only on the basis of 'social, maternal and psychiatric assessments' of the family and of whether they can/will respond to the support offered to them.

The circular also attempted to encourage a sharper and more authoritative edge to decision making, particularly among social workers. It stressed that children should always be admitted to hospital if NAI is suspected, and that if a child had to be removed from home for a period this should be on a statutory care order, rather than voluntarily under Section 1 of the 1948 Children Act (now Section 2 of the 1980 Child Care Act), once in care the child should be returned home only on the advice of a case conference. Clearly, voluntary work with parents was seen as inappropriate in such cases and the use of statutory intervention is encouraged. This is something of a shift from the position originally taken up by the NSPCC Research Unit. While the general conceptualization and approach of the unit is still very evident, there is a greater emphasis on intervention that is more decisive on behalf of the child and which is not afraid to use the powers vested by statute in the social worker.

Thus, since the mid 1970s the nature, administration and management of child abuse has attempted to tighten and formalize the professional response and to make social workers much more accountable for their actions, so that practice is more prescribed, planned and achievable. There has been an increasing emphasis on the need for using the full authority of the law if children are to be protected. In this sense, there has been a move towards what might be described as 'defensive' social work. Greater intervention in cases of 'suspected' child abuse means that more children and families are 'at risk' of being subject to intervention. While this may protect more children, it also means that non-abusing families may be 'falsely accused'. But this more intensive response is also an attempt to defend social work from possible criticism by ensuring that at least the procedures are correct - and are correctly followed.

More recent debates in research and the child-abuse literature have clearly had an impact on the way the problem is officially defined and responded to. It has been increasingly argued that the 'physical trauma dimensions of abuse' do not take account of the more damaging effects that result from neglect, emotional abuse and the fact that older as well as younger children are 'at risk'. More recently, increased concern has been expressed about the effects of sexual abuse. There has been a broadening of the definition of the problem. This is well illustrated by Helfer and Kempe.

The term 'battered baby' has been dropped. When coined fifteen years ago, its purpose was to gain the attention of both physicians and the public. We feel now that enough progress has been made to move on to a more inclusive phrase - child abuse and neglect. The problem is clearly not just one of physical battering. Save for the children who are killed or endure permanent brain damage (and these remain a prime concern), the most devastating aspect of abuse and neglect is the permanent adverse effects on the developmental process and the child's emotional well-being (Helfer and Kempe, 1976, p xxi).

It is important to note the shift in DHSS circulars relating to the problem. In 1970 it was 'battered babies', in 1974 'non-accidental injury to children', and since 1978 'child abuse'. In fact, while the 1986 draft circular is headed 'child abuse', its primary focus is 'child protection'. It defines child abuse (for inclusion on registers) according to the following criteria.

Parents or carers (i.e. persons who, while not parents, have actual custody of a child) can harm children either by direct acts or by a failure to provide proper care, or both. These include:

(a) Physical injury
Any form of physical injury, including deliberate poisoning, where there is definite knowledge, or a reasonable suspicion, that the injury was inflicted, or knowingly not prevented, by any person having custody of the child.
(b) **Neglect**
The persistent or severe neglect of a child (for example, by exposure to any kind of danger, including cold and starvation) which results in serious impairment of the child's health and development.

(c) **Emotional ill-treatment**
The severe adverse effect upon behaviour and emotional development caused either by persistent or severe neglect or rejection, on the part of the parent or carer.

(d) **Sexual abuse**
The involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, which violate the social taboos of family roles, or which are against the law.

(e) **Potential abuse**
Children in situations where they have not been abused but where social and medical assessments indicate a high degree of risk that they might be abused in the future, including situations where another child in the household has been harmed, or the household contains a known abuser.

These categories of abuse are not necessarily exhaustive, nor are they mutually exclusive. And all of them may result in a failure of the child to thrive. The term 'child abuse' in this guide is intended to cover all these categories. (DHSS, 1986a, pp 1-11)

This broadening of the official definition of child abuse clearly extends the need for professional involvement, for a psycho-social assessment of the parents, and family background becomes even more crucial. Public, political and professional concern is now focused on something much wider than 'battered babies'.

More particularly, developments in policy and practice guidelines have all been based on the assumption that they will enhance the central aims of prevention, prediction and early identification of potential cases of abuse. It is assumed that, by using established scientific knowledge about who abuses their children, we can monitor and reduce the problem in an individualized way. These are issues I shall return to later.
It is evident, however, that these developments in the more specific area of child abuse have contributed to important changes in child-care policy and planning. As we have seen, the case of Mana Colwell connected with debates about fostering and adoption, the nature and direction of decision-making in child-care practice, the importance of the 'blood-tie', and the most appropriate use of statutory interventions.

The 1975 Children Act can clearly be seen to be the result in part of the social reaction to the Colwell scandal. The Act emphasized the needs of the child over and against those of the parents, and represented a less optimistic view about the solution of child-care problems. In effect, it put into operation the main recommendations of the Departmental Committee on the Adoption of Children (The Houghton Committee) which had reported in 1972. It attempted to increase the rights of foster parents, to provide greater security for children in care and to bring adoption (as an option for children unable to live at home) into the mainstream of child-care work. The Act attempted to give far greater control to local authorities over the lives of children in their care, to allow for an easier severance of parental ties and also to give greater security to children in the substitute homes. The emphasis was on the child as a unit distinct from his or her family. As a consequence the notion of the 'parental blood-tie', which assumes a special bond between the natural parent and child, was subject to critical examination.

The most cogent exposition of this argument was by John Howells (Howells, 1974) who argued that the death of Mana Colwell could be attributed to misconceptions about the appropriate care of children by social workers. He felt that the tragic death of Mana Colwell was symptomatic of a much more basic problem. A tradition had been established that separation from parents should be avoided at all costs. (You may remember from Unit 15 that this commitment derived from criticisms of the failings of institutional care for children, and especially the emotional damage associated with separating a child from its mother — Bowlby's idea of 'maternal deprivation'.) Howells argued that social workers should be less sentimental when working with deprived families and not be afraid to remove children from home.

Certainly this more alert and decisive approach has been applied to children of all ages and very different circumstances and not simply those at risk of abuse. The whole field of child care has become more infused with a resolute approach to families which relies on 'positive planning' and a greater reliance on the law. An analysis of national child care statistics shows that since the Colwell Inquiry local authorities have increasingly relied on statutory powers and have been far more unhappy with care arrangements based on voluntary contact where the parents are influential participants in deciding when, where and how they use care facilities in a mutually negotiated way.

For example, the use of the statutory Place of Safety Order for juveniles increased from 214 in March 1973, to 759 in March 1976. Since 1976 the figures have been collated on an annual basis, but it is still evident that the number of orders taken out has more than trebled since 1973. (A Place of Safety Order is a legal mechanism for removing a child from a situation of risk to a 'safe place' — defined as a community home, police station, hospital, surgery or other suitable place. Any person may apply to a magistrate for such authority, but in practice it is usually a local authority social worker, NSPCC officer or, in rare cases, the police.)

Have a look at Table 1. What is the change in the proportion of children who are in care on a voluntary basis between 1972 and 1983? (‘Voluntary’ means not subject to a court order or a ‘parental rights resolution’. A parental rights resolution is the legal means by which responsibility for a child who entered care on a voluntary basis is transferred from the parents to the local authority.)

What do you think the significance of the change in these figures might be?
Table 1  Children in care 1972–1983

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Total (thousands)</td>
<td>90.6</td>
<td>93.2</td>
<td>95.9</td>
<td>99.1</td>
<td>100.6</td>
<td>101.2</td>
<td>100.7</td>
<td>100.1</td>
<td>100.2</td>
<td>96.9</td>
<td>93.2</td>
<td>86.6</td>
</tr>
<tr>
<td>(b) Per 1000 of population under 18</td>
<td>6.5</td>
<td>6.7</td>
<td>6.9</td>
<td>7.3</td>
<td>7.4</td>
<td>7.5</td>
<td>7.6</td>
<td>7.7</td>
<td>7.8</td>
<td>7.6</td>
<td>7.4</td>
<td>7.0</td>
</tr>
<tr>
<td>Children in voluntary care (i.e not subject to a court order or parental rights resolution)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Total (thousands)</td>
<td>35.9</td>
<td>36.6</td>
<td>37.7</td>
<td>37.4</td>
<td>34.5</td>
<td>31.3</td>
<td>28.3</td>
<td>26.6</td>
<td>25.9</td>
<td>23.9</td>
<td>22.5</td>
<td>20.7</td>
</tr>
<tr>
<td>(b) % of all children in care</td>
<td>41.0</td>
<td>39.0</td>
<td>38.9</td>
<td>37.7</td>
<td>34.4</td>
<td>31.0</td>
<td>28.1</td>
<td>26.6</td>
<td>25.9</td>
<td>24.7</td>
<td>24.1</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Source: DHSS (1986b)

In recent years many social services departments have introduced child-care policies which take seriously the notion of what is often called 'permanency planning' (Parton, 1985b). There are a number of principles involved. There is emphasis on the need for social workers to assess thoroughly a parent's ability to provide care as early as possible, so that short-term plans can be made if the parents cannot meet the children's needs. If children do come into care they should be rehabilitated with their natural parents through intensive work within a definite timescale - usually six months. If this is not possible then strenuous efforts must be made to plan for their future with long-term foster or adoptive parents. Developing proper monitoring and support systems for the professional and not being afraid to use the courts and the law is also stressed. The keystone to good child care is 'permanence'.

Not only should children be kept out of care but they should be discharged as quickly as possible, and if they do come in for any length of time this should preferably be on a statutory order. The net result is that while there are fewer children in care, an increasing proportion of those that are come under some form of statutory control.

As a consequence, local authority care is viewed as a 'channel' for securing a permanent home, either with parents or substitute families. When decisions about termination of parental contact with the child have to be made this should be at an early stage, so that when a child remains in care for more than a year 'this is an occurrence which should attract the same kind of high-level concern and should be subject to the same monitoring procedures as when a child is battered' (Haskell and Monaghan, 1982, p.8). What is clear is that such policies explicitly aim to bring 'child-care planning into line with child-abuse procedures'.

It is evident, therefore, that the policies and practices developed to 'manage' child abuse have had implications for child-care policy and practice more generally. The more alert, anxious and decisive approach has been applied to children of all ages and very different circumstances.

What are the reasons for which you think children come into care – as well as child abuse and neglect? Make some notes for yourself and compare them with my comments and the table below.

You need to relate the arguments and information in this unit to Unit 15, which is more centrally concerned with all aspects of child care. It is important to recognize, however, that policy and practice for child care more generally, and child abuse more specifically, are interrelated. Table 2 shows the DHSS figures giving the reasons for children being in care. While Section 1(2)(a) and Section 1(2)(b) refer specifically to children being in care for neglect and ill-treatment, clearly there is a degree of arbitrariness as to how the figures are collated. For example, it may be a matter of chance as to whether children are recorded as being in care for illness, unsatisfactory home conditions or deserted by parent – all factors may be present.
<table>
<thead>
<tr>
<th>Reason</th>
<th>Wales</th>
<th>England</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Section 2 of the Child Care Act 1980</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term illness of parent or guardian</td>
<td>97</td>
<td>2,270</td>
<td>2,367</td>
</tr>
<tr>
<td>Long-term illness or incapacity of parent or guardian</td>
<td>77</td>
<td>2,173</td>
<td>2,250</td>
</tr>
<tr>
<td>Confinement of mother</td>
<td>2</td>
<td>201</td>
<td>203</td>
</tr>
<tr>
<td>Family homeless (eviction or other cause)</td>
<td>59</td>
<td>713</td>
<td>772</td>
</tr>
<tr>
<td>Parents dead (no guardian)</td>
<td>36</td>
<td>698</td>
<td>734</td>
</tr>
<tr>
<td>Abandoned or lost</td>
<td>83</td>
<td>1,806</td>
<td>1,889</td>
</tr>
<tr>
<td>Death of parent, other parent unable to provide care</td>
<td>97</td>
<td>1,741</td>
<td>1,838</td>
</tr>
<tr>
<td>Deserted by parent, other parent unable to provide care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including child illegitimate, mother unable to provide)</td>
<td>257</td>
<td>6,418</td>
<td>6,675</td>
</tr>
<tr>
<td>Parent or guardian in prison or remanded in custody</td>
<td></td>
<td>750</td>
<td>775</td>
</tr>
<tr>
<td>Unsatisfactory home conditions</td>
<td>280</td>
<td>7,360</td>
<td>7,640</td>
</tr>
<tr>
<td>Other reasons</td>
<td>566</td>
<td>7,975</td>
<td>8,541</td>
</tr>
<tr>
<td>Sub-total</td>
<td>1,579</td>
<td>32,095</td>
<td>33,674</td>
</tr>
<tr>
<td>On remand or committed for trial or sentence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Section 23) or detained in care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Section 29(3)) under the Children and Young Persons Act 1969</td>
<td>39</td>
<td>674</td>
<td>713</td>
</tr>
<tr>
<td>Subject to an interim care order</td>
<td>43</td>
<td>1,190</td>
<td>1,233</td>
</tr>
<tr>
<td>Care Order under the Children and Young Persons Act 1969</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1(2)(a) neglect or ill-treatment, etc</td>
<td>1,000</td>
<td>16,008</td>
<td>17,008</td>
</tr>
<tr>
<td>Section 1(2)(b) neglect or ill-treatment of another child in household</td>
<td>58</td>
<td>1,781</td>
<td>1,839</td>
</tr>
<tr>
<td>Section 1(2)(bb) member or likely member of household convicted of offence against children</td>
<td>15</td>
<td>202</td>
<td>217</td>
</tr>
<tr>
<td>Section 1(2)(c) moral danger</td>
<td>51</td>
<td>933</td>
<td>984</td>
</tr>
<tr>
<td>Section 1(2)(d) beyond parental control</td>
<td>132</td>
<td>2,709</td>
<td>2,841</td>
</tr>
<tr>
<td>Section 1(2)(e) not receiving efficient full-time education</td>
<td>169</td>
<td>2,707</td>
<td>2,876</td>
</tr>
<tr>
<td>Section 1(2)(f) or 7(7) guilty of an offence</td>
<td>519</td>
<td>7,810</td>
<td>8,329</td>
</tr>
<tr>
<td>Section 15(1) in place of supervision order</td>
<td>47</td>
<td>1,314</td>
<td>1,361</td>
</tr>
<tr>
<td>Section 25(1) or 26(2) transfer of care order</td>
<td>2</td>
<td>38</td>
<td>40</td>
</tr>
<tr>
<td>Sub-total (excluding remand and interim care orders)</td>
<td>1,993</td>
<td>33,502</td>
<td>35,495</td>
</tr>
<tr>
<td>Court Orders under</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 43(1) of the Matrimonial Causes Act 1973</td>
<td>292</td>
<td>4,413</td>
<td>4,705</td>
</tr>
<tr>
<td>Section 10(1) of the Domestic Proceedings and Magistrates Courts Act 1978 (2)</td>
<td>22</td>
<td>343</td>
<td>365</td>
</tr>
<tr>
<td>Section 7(2) of the Family Law Reform Act 1969</td>
<td>32</td>
<td>1,345</td>
<td>1,377</td>
</tr>
<tr>
<td>Section 22(2)(b) of the Guardianship Act 1973</td>
<td>21</td>
<td>651</td>
<td>672</td>
</tr>
<tr>
<td>Section 17(1)(b) of the Children Act 1975</td>
<td></td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Others</td>
<td>23</td>
<td>616</td>
<td>639</td>
</tr>
</tbody>
</table>

Notes
1. The original reason for coming into care is shown for children who were received into care under Section 2 of the Child Care Act 1980.

Source: DHSS (1986b)
6 CHILD ABUSE AS DISEASE

As you will remember from Block 1, the way in which we define and explain a problem is crucial for what is then seen as the best way of overcoming it in policy and practice. In child abuse it is very clear that the dominant explanation in official reports, guidelines and circulars is based upon what I shall refer to as an individual ‘disease’ model (1985a). I shall demonstrate that not only has this model been dominant but that the model itself has fundamental difficulties in helping us to understand what is the best way of overcoming and reducing child abuse. These difficulties help us to appreciate why social workers often feel they are being asked to perform tasks which are virtually impossible to carry out in the way assumed.

As has been seen, child-abuse inquiries and circulars have argued that the use of registers, case conferences and improved inter-professional co-ordination will enhance the central aims of predicting, preventing and identifying individual children who may be in actual or potential danger of child abuse. It is assumed that child abuse is some sort of disease or pathology which affects a minority of abnormal parents and families.

In 1984, the death of Jasmine Beckford led to the establishment of a further inquiry, chaired by Louis Blom-Cooper, QC. The Beckford Report explicitly applies the ‘disease’ model, not just to the Beckford family, but to policy and practice towards child abuse more generally. The individual disease model first articulated by Henry Kempe in 1962 (Kempe et al., 1962) and which has been central to subsequent research and debates about the nature of the problem and what to do about it is taken on in its entirety in the report.

As long ago as the landmark article of 1962 by Dr Kempe and his American colleagues, ‘The battered child syndrome’, it was noted that although the knowledge of psychiatric factors in child abuse was limited they were probably of prime importance in the ‘pathogenesis of the disorder’. The authors thought that parents who inflict abuse on their children do not necessarily have psychopathic or sociopathic personalities or come from some borderline socio-economic groups, although most publicized cases have fallen into one of those categories. But they averred that in most cases some defect in character structure was probably present. As one member of the Denver programme under Dr Kempe observed in 1976, child abuse is a ‘disease whose carrier is the parent and whose victim is the child’ (Panel of Inquiry, 1985, pp 87–8).

The disease model is used for evaluating the work done with the Beckford family and to construct a framework for dealing with such cases in the future. In the process we are provided with a body of knowledge which is presented as fact and scientitically proven. If every practitioner learned and applied this knowledge, child abuse could be identified, predicted and prevented. It was the failure of the social workers to be aware of and to apply this knowledge which was held to have let down Jasmine Beckford so crucially (see the extract opposite from the Star).

Essentially there are four assumptions which underpin any disease model:

1. The disease is defined in terms of a deviation from normal functioning (usually biological).

2. The disease is caused by a specific and identifiable entity, e.g. a virus or bacteria.

3. Each disease has specific and distinguishing features that are universal to the human species.

4. The medical experts, whose job it is to tackle the disease, base their practice on scientific knowledge and are thus objective and neutral.

Therefore when this model is applied to child abuse it is assumed that it is an illness of sufficient unity to be put into a diagnostic category in its own right and that the pathology resides primarily in the parents but manifests itself in the relationship with the child. While allowing that in some cases it may be an expression of family stress, it is psychological or interpersonal family factors which are seen as the primary causes. There is a defect in the character structure or
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Source: The Star, 3 December 1985

personality which, perhaps in the presence of added stress, gives rise to physical expression. The model thus views 'abnormalities' in parents as the causes of child abuse, and starts by asking the question, "What type of individual or family would harm their children?" In the process, the way the problem should be responded to is defined in terms of individualized identification, prediction and treatment. The primary purpose of research is to discover the characteristics and symptoms that differentiate the abusing parent from the normal. The central task for practitioners is to be aware of these 'known characteristics of child abuse' so that they can identify and predict actual and potential abuse in their practice.
At various points in the Beckford report the characteristics of the Beckford family are demonstrated to be consistent with the research findings of what constitutes an abusing family. But at each point the social workers failed to recognize the signs and hence failed to recognize that this was a ‘high risk’ child-abuse case. A major failure was simply that the social workers were unaware of the ‘facts’ known about child abuse, so that when they came across them in the Beckford case they did not recognize their significance. However, this failure is not seen as something particular to the social workers in this one case, but as typical of the lack of such knowledge among social workers generally (Parton, 1986)

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Before you move on, write down for yourself any factors you feel may be associated with child abuse

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The evidence presented to the Beckford Inquiry by Professor Cynil Greenland, an expert witness, seems to have proved important in outlining both the disease model and the characteristics of parents that make them potential abusers. There is substantial reference to his evidence in the report.

Based on his research of 168 cases of child abuse deaths, studied over many years (Greenland, 1980, 1986) he has developed a checklist of ‘high risk’ families:

1. The parents are aged under 24
2. One parent is not the biological parent
3. There is a previous record of abuse or neglect of the children
4. The parents were abused themselves in childhood
5. The parents are of low intelligence, inadequate education
6. The parents are socially isolated
7. The parents abuse alcohol or drugs
8. The mother is pregnant or has recently given birth

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Stop for a moment and compare these eight points with your own list. Do they differ? If so, where are they different and why do you think they are different?

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As Professor Greenland has commented, the Beckford family scored high on this list and could be checked off on nearly every factor. The ability to identify and predict abuse and thereby prevent it before it happens is central to what all those involved in the child-abuse system should be doing. By applying this science of child abuse, the children concerned can be protected, and for some children this clearly means being removed from home permanently. Quoting Henry Kempe, the Beckford Report comments that ‘if a child is not safe at home, he cannot be protected by casework’ (Panel of Inquiry, 1985, p 288). Thus, once a ‘high risk’ child is identified, attempts to maintain the child at home or to rehabilitate once the child has been removed are foolhardy.

The crucial skills and decisions therefore are concerned with identifying the ‘high risk’ case. At the level of common sense, we would probably all agree with such a position. Upon closer inspection, however, it does not appear so straightforward. Even the report is less than categorical as to how and whether this can be done, and whether theory and research provide the tools whereby practitioners can act in the way that is assumed to be necessary.
At no point are we offered a definition of what constitutes child abuse. Increasingly, however, it is implied that there are different forms of child abuse. The crucial decision is to differentiate the 'high risk' from the rest. In doing so, children can be protected and scarce resources can be directed to where they will be most effective.

Again, however, the report explicitly shies away from offering a definition of 'high risk'. In fact it is admitted that perhaps the process of identification, prediction and prevention, seen as so crucial in differentiating the 'high risk' from the rest, may not be so straightforward.

The proportion of 'high risk' cases out of all proven cases of persistent child abuse will be small, and the task of identifying may not be easy. But the attempt to isolate such cases from the majority of child-abuse cases must always be made. To the question, can 'high risk' situations be identified in advance, Professor Greenland told us that he could give an answer, 'a cautious yes, in some cases'. He went on to say that it seemed prudent to classify all non-accidental injuries to young children as 'high risk' cases, since 80 per cent of all children unlawfully killed by their parents had been previously abused (Panel of Inquiry, 1985, p. 288).

What we are told, therefore, is that differentiating the hard core is crucial, but that this is not easy. Again, we may not want to argue with either statement. However, Professor Greenland's resolution seems highly contentious. It may well be proven that 80 per cent of all children unlawfully killed by their parents had been previously 'abused', but does that really mean that every identified case of abuse is, by definition, 'high risk'? There is a problem about prediction here. If Professor Greenland's evidence was that 80 per cent of abuse cases ended in unlawful killing, that might justify treating all abuse cases as 'high risk'. But unlawful killings are only a very small proportion of known abuse cases, and of this small proportion only 80 per cent have a history of abuse. Looked at that way, known abuse is of only very limited value as a predictor, because it does not identify what makes some cases of abuse end in death. Equally, it leaves 20 per cent of unlawful killings unaccounted for (i.e. they do not have a pre-history of abuse).

If I were a practitioner I would not find such statements very helpful. I am not convinced that we have the knowledge to fulfil the tasks of identification and prediction in the clinical and scientific way that the report suggests. In fact, I get the impression that the inquiry team are not convinced either, as one of their recommendations is that 'research designed to refine the techniques for predicting accurately those children who will continue to be at risk is urgently required, and we recommend that such research should be undertaken by medical sociologists' (Panel of Inquiry, 1985, pp. 288–9).

What the report recognizes is that at the level of theory, research and practice there are enormous problems with the application of the individual disease model to child abuse. Not only is there little agreement about the nature of child abuse and how it can be explained and defined, but there is little consistency concerning the characteristics of the perpetrators that has been identified so that it can be predicted and prevented in an individualized way. It is not just that research has failed to reveal any consistent patterns among violent parents that practitioners could take up, but that a clear-cut psychological distinction between abusers and non-abusers does not exist. That is, the central assumption of the disease model – that one can distinguish between 'normal' and 'abnormal' parents – does not hold up in practice.

### 6.1 Problems of prediction

Gelles, reviewing some of the earlier research, noted that of nineteen personality traits identified as characteristic of abusers, only four were cited by two or more authors and argued that 'it was impossible to determine whether certain factors were causally associated with child abuse, as even in some of the current essays which purport to document numerous psychological traits associated with child
abuse, I find profiles of my students, my neighbours, my wife, myself and my son' (Gelles, 1973, p 615)

Certainly much of the research, particularly in the 1960s and early 1970s, does not meet even the minimal standards of evidence necessary in scientific investigation

Much of our existing knowledge has been gathered from descriptive studies which lack controls and proper sampling procedures. This has enabled authors to make claims and counter-claims about the importance of different variables in the absence of any sustained efforts to discover which are directly and which are artefactually related to abuse (Allan, 1978, p 58)

More recently there have been a number of authors who have made attempts to apply a more rigorous methodology to their research and who are far more qualified and cautious in their conclusions. It is now generally agreed that the notion, derived from the disease model, that there is a single cause or cluster of causal variables, is not the case. They suggest that it is at best seen as the result of multiple interacting factors, including the parent's and children's psychological traits. Not only does the label 'child abuse' include a wide range of different behaviours and manifestations, but uniform sets of associations between different sets of variables and different types of abuse have not been established. While we may know something about who abuses, we do not know why, nor do we know when, how often, with what degree of certainty, and with what implications for the child

Nowhere are the problems more cogently demonstrated than with attempts at predicting 'high risk'. In recent years there has been much interest about the general feasibility of predicting dangerousness in individuals and families. However, it is now recognized that research on the prediction of future violence does not instil confidence in either the reliability or the viability of the assessment process. Whatever is done, prediction rates rise no higher than two wrong judgements for every right judgement. The empirical support for the prediction of violence is very poor. As a consequence there are inevitable problems of wrongly identifying some (false positive) and failing to identify others (false negative), as you can see from Table 3. The table sets out the possible outcomes of using a predictive factor (or set of factors) to identify the likelihood of violence. We have called our hypothetical factor for the prediction of violence 'factor X'.

<table>
<thead>
<tr>
<th>Prediction</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abuse</td>
</tr>
<tr>
<td>Parents without 'x'</td>
<td>False negative</td>
</tr>
<tr>
<td>(: i.e. predicted no abuse)</td>
<td>(abuse not predicted)</td>
</tr>
<tr>
<td>Parents with 'x'</td>
<td>True positive</td>
</tr>
<tr>
<td>(: i.e. predicted abuse)</td>
<td>(abuse predicted)</td>
</tr>
</tbody>
</table>

The problems of the predictive model are not only of academic importance. Each false prediction may have severe social consequences. When applied to child abuse, it means that some children will be falsely identified as being 'at risk' (: i.e. the 'false positives'). But they will nevertheless be removed from their parents and taken into care. Others will be missed (the 'false negatives') and will therefore suffer abuse, and perhaps even death, at the hands of their adult caretakers.

These problems at the level of theory, explanation and research have crucial implications for the way social work effectiveness is assessed. The disease model, and the assumptions surrounding it, form the dominant way of viewing child abuse, even though, as we have seen, its real ability to explain and predict abuse is very limited. But because it is the dominant model, it has created the expectation that child abuse is both explicable and predictable – and therefore that it ought to be preventable. Consequently, social workers face a major problem.
for it is they who have to work in this gap between expectations and real knowledge. They are expected to be able to predict and prevent, but they do not have access to the knowledge or skills which might enable them to do so.

In such circumstances it is perhaps not too surprising if social workers are caught in a crossfire. On the one hand they are criticized for not identifying abuse and protecting children in situations where they have suffered (our 'false negatives'). On the other hand they are accused of removing children and putting them in care when they were safe and happy at home (our 'false positives'). We do not have the scientific knowledge to overcome such problems easily. At this point you should read the article from the Observer reproduced overleaf.

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It would be useful to make your own summary of the main elements of the disease model of child abuse. What are the main problems of such an approach?

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The disease model of child abuse emphasizes the problem as an individual or family pathology with its roots in the personality or psychodynamics of abusing parents. Notions of individual treatment, prediction and prevention are given pre-eminence. While social factors are taken into account, these are seen in terms of the characteristics or factors associated with the abusive individuals and families.

The major problems are that:

1. There is little agreement on the definition of child abuse.
2. Research has not provided the factors which allow us to discriminate the actual or potential abuser from the rest.
3. It is not possible to predict and prevent in the individualized way suggested.
4. The model ignores the social arrangements in which people live, and denies that such arrangements play any significant role in causing the problem.

Ideologically, the disease model and its implications for policy and practice are important. Child abuse is seen as a problem with a minority of parents who are unusual, pathological or at least different from the normal. Abuse results from some individual or family defect and so must be remedied by particular means or exceptionalist solutions which are tailored to the individual case. As a result, other parents are seen as normal and the wider society is not seen as problematic. Wider social arrangements are absolved of any responsibility in causing the problem. In effect the model has acted as a barrier to developing different explanations and possibly more effective measures. In focusing on child abuse as a problem which originates in the psychology of individuals, we have ignored the economic, social and cultural realities within which it takes place.

Such an approach legitimates the role of the liberal state in its relationship with the family. A central dilemma for the liberal state in capitalist society is to ensure that the general quality of the child population is improved while maintaining child-rearing as essentially a private responsibility within the family. If the state is to support ideas of individual freedom, responsibility and the primacy of the private nuclear family in bringing up children, it cannot become all-encompassing and hence a threat to those same freedoms and responsibilities. The dominant solution is that the state only intervenes when the family is seen to have failed in its child-rearing. If the state is to uphold the role of the private family as being the dominant and best way of bringing up children, it should only take over responsibility for the deviant and pathological. It has to be assumed that such cases will be a minority and qualitatively different from the vast majority of families which are bringing up children successfully.
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What I have argued so far is that child abuse is an important social problem to which we need to respond. However, policy and practice depend upon an individual disease model of child abuse and this poses major difficulties, both for our understanding of the problem and hence the expectations of and practice of social workers. What I shall argue in this section is that it is the economic, social and psychological pressures upon certain families, and particularly upon women, which precipitate abuse. It is crucial that the social context of child abuse be recognized in exploring the social dimensions of abuse we can then see that it is a problem which does not simply result from the behaviour of certain abnormal families. It is a problem which affects wide sections of the population. Therefore to develop our understanding in theory and practice it is important to begin any explanation by analysing ‘normal’ family life, rather than individual or family pathology. Child abuse arises from the severe social and economic stresses which predispose certain individuals to abuse. The crucial factor is to understand the nature of these social and economic stresses.

As we have seen, going back to the original article by Kempe et al. in 1962, it has been claimed that child abuse is not associated with poverty and social deprivation and that it is found equally in all sections of society. The reason why there is such a disproportionate number of poor families represented on child abuse registers and known to health and welfare agencies, it is claimed, simply reflects the fact that such families are more easily identified and officially labelled. The social processes of identification are clearly important. For example, Dingwall, Eekelaar and Murray (1983) have studied how cases are defined and responded to in everyday professional practice and have concluded that single women and the ‘rough’ indigenous working class are the most vulnerable to compulsory measures.

However, Pelton (1981) has argued that this ‘myth of classlessness’ not only acts to provide a major legitimation of the disease model but also deflects attention from crucial elements of the problem. He provides three telling arguments as to why the ‘classlessness’ assumption should be rejected and suggests that there are clear associations between poverty and child abuse.

Firstly, while increased public awareness has led to far more known cases of abuse and neglect in all social groups, the proportions from different social classes have changed very little, and failed to increase the proportion of reports from those above the lower classes. Secondly, child abuse and neglect are related to degrees of poverty even within the lower social classes, so that the highest incidence of the problem occurs in families experiencing the most extreme poverty. And thirdly, even among the reported cases, the most severe injuries have occurred in the poorest families. The vast majority of the fatal victims are from poor families. While not arguing that the problem does not occur in other classes and groups, it does appear that abuse and neglect are strongly related to poverty, both in terms of prevalence and severity.

Similarly, Garbarino’s research (Garbarino and Gilliam, 1980) has demonstrated that high risk families tend to be clustered in areas that are ‘socially disrupted’. He compared neighbourhoods with high rates of officially reported child maltreatment with neighbourhoods that had low rates and concluded that the former were characterized by low levels of ‘neighbourly exchange’, residential instability and transience, restricted interaction among children, deteriorating housing, poor relations with institutions such as schools, and a ‘pervasive pattern of social stress’. All these ‘social deficits’ were associated with ‘economic deficits’.

Since the early 1970s, Murray Straus, Richard Gelles and Suzanne Steinmetz have developed what they call ‘a radical sociological perspective’. They argue that social factors cannot be seen as merely one of the sets of factors which account for intra-family violence to be added to non-social factors such as neurological defects, personality traits and mental illness. They are convinced that at least 90 per cent of the violence which takes place in American families grows out of the very nature of the family and the larger society, rather than individual aberrations. Their analysis is
related specifically to physical abuse and has developed from their national survey of 2143 families for which they defined violence as "an act carried out with the perceived intention of physically hurting another person."

They argue that child abuse, far from being a rare and isolated event, is a chronic condition for many children. Violence towards children is an extensive and patterned phenomenon in parent/child relations. More generally, they maintain that physical violence between family members is a normal part of family life in most societies, and in American society in particular.

If the family is seen as a set of power relations (as well as other sorts of relationships), then, as Unit 2 argued, children are the least powerful — and therefore most vulnerable — in those relations.

They have also attempted to identify the social factors that are associated with violence towards children. They stress, however, that their profile is not intended to be used for predicting child abuse, as this would result in millions of instances of false labelling. While it was found that parents at all income levels used severe violence towards their children, the distribution was far from equal. They found that there was an inverse relationship between income and parental violence, so that those with the lowest incomes had the highest rate of violence. The poorest families had rates of abusive violence that were twice that in the highest income groups.

Similarly, manual workers had rates of abusive violence towards their children that were 45 per cent higher than where the breadwinner was a white-collar worker. In part, this relates to the differential incomes between blue- and white-collar workers. They also found that unemployment was significant in that in families where the breadwinner was unemployed, the rate of physical violence was 62 per cent greater than for other families. While in homes where the breadwinner was only working part-time, the rate of violence was nearly double that where the breadwinner was in full-time work.

The most critical commentator on established child-abuse policy and practice is the American, David Gil. He demonstrates that the degree of stress and frustration encountered by families is governed by their position in the social structure. Inequality experienced as poverty and social isolation is seen as the primary determinant of abuse. Gil's conclusions are based on his nationwide study in 1967 and 1968 which aimed to provide a comprehensive demographic picture of child-abusing adults and their victims (Gil, 1970). The operational definition used in the survey included only incidents of child abuse which resulted in physical injury of some kind.

A standardized reporting form was developed for use by central registries of child abuse in each state. Approximately 6000 cases were studied in 1967, with a new and slightly larger sample in 1968. A sub-sample of 1380 abusive parents was also analysed for more detailed socio-economic data. The results demonstrated quite clearly that child abuse was more likely among lower-class parents, for over 48 per cent of the abusers had an annual income under five thousand dollars, while the proportion of all US families under that income level was 25.3 per cent. The results also showed that abusive adults tended to be poorly educated.

Summarizing the characteristics of the families as reflected by indicators of educational achievement, occupational position and status, income and assistance status, number of children and housing, Gil concluded that families with a low socio-economic background were over-represented especially among non-white families.

While there is no comparable research in Britain, Creighton (1984) has provided evidence that the number of cases recorded on NSPCC registers not only relates to social class but also to the severity of social stress (see Figure 1). The incidence of abuse in families where the male caretaker is unemployed seems particularly significant. The relationship between abuse and unemployment seems to follow the recent dramatic rise in joblessness (see Figure 2).
Figure 1
Stress factors affecting families of abused children
Source Creighton (1984)

Figure 2
Percentage of males unemployed (by year)
Source Creighton (1984)
Straus, Gelles and Steinmetz (1980) argue that the explanation of violence towards children lies in the combined effect of the high level of family conflict, the training in violence and the link established between violence and love by physical punishment, and the implicit cultural norm which gives the parent the right or obligation to hit children if they are not doing as they are told. The distribution of violence results in part from the cultural norms and values concerning violence in different groups and classes, and also from the very different social stresses evident in those groups and classes. For, as Straus argues elsewhere,

families are expected to provide adequate food, clothing and shelter in a society which does not always give families the resources necessary to do this. Also stressful is the expectation that families bring up healthy, well-adjusted, law-abiding and intelligent children who can get ahead in the world. The stress occurs because these traits and the opportunity to get ahead are all factors which are to a greater or lesser extent beyond the control of any given family (Straus, 1980, p.23)

What I have demonstrated so far is that the social context, in terms of poverty and class, is crucial for understanding the nature and social distribution of child abuse. It is a potential problem for many children and is rooted in social inequalities and social values.

Elizabeth Elmer’s research lends considerable support to this line of argument (1977). She compared seventeen abused children with seventeen children who had suffered accidents eight years after all were originally examined. Each was matched according to age, race, sex and socio-economic status. A second comparison group, matched according to the same variables, consisted of children with no recorded history of abuse and no reported accidents resulting in hospital treatment before the age of one year – the process by which the other two groups were chosen. The study was designed to identify possible physical, developmental and behavioural differences between the groups in an attempt to identify the longer-term consequences of abuse. It was hypothesised that the abused children would score lower than the non-abused across the range of variables including height, weight, language development, intellectual functioning, emotional development, school achievement, aggressive behaviour and poor self-concept.

However, few differences were found and these were minor and inconsistent. All the children showed developmental and social problems and appeared depressed, anxious and fearful. At first the researchers were ‘disbelieving’ and made various attempts to check the methodology and to re-work the data. In the end, however,

It was impossible to avoid the conclusion that abuse as one method of deviant child care did not appear to make a significant difference, at least in the population under study. In addition, our clinical observations had shown unanticipated pathology among most families in all the groups and evidence of considerable psychological damage in many of the children. What could be the common factor contributing to these widespread difficulties? We believe this factor is membership of the majority in the lower social classes, which connotes poverty and all its well-known companions – poor education, menial jobs, inadequate housing, under-nutrition, poor health and environmental violence (Elmer, 1977, pp 83-4)

Elmer saw the same behaviour in all her groups – abuse, accident and comparison – and ‘deduced that we are learning more about lower class children in general, and less about abused children in particular’.

Stop for a moment and make a note of what you think are the main points of these arguments about the social context of child abuse. My own summary follows. What problems do you think these arguments raise for the role of social work in child abuse?
There are four main dimensions to the social context of abuse which have been set out in the unit so far

1. Research suggests that while abuse may be spread across all social classes, its distribution is strongly linked to class, being both more frequent and more severe in lower class families.

2. Poverty is linked to other aspects of social inequality (ranging from unemployment, through housing, to social isolation), and areas which might be described as ‘multiply deprived’ seem strongly associated with higher rates of child abuse.

3. Forms of violence within family relationships may be associated with the normal (i.e., culturally accepted) patterns of family life and relationships, rather than being the product of pathological abnormality.

4. The high levels of stress produced by the combination of high expectations placed on family life and levels of material deprivation which make it difficult to fulfill those expectations may account for the higher levels of violence and abuse among poorer families.

Clearly not all children who live in poverty are subject to the kind of treatment so graphically illustrated in tragic cases such as those of Maria Colwell or Jasmine Beckford. Locating the problem in its social context, however, demonstrates clearly some of the problems faced by social workers. Firstly, if we are serious about trying to overcome child abuse, it is clearly not sufficient simply to assume that it is a relatively small, individualized problem. It fails to recognize the importance of inequality and the sense of frustration, repression and aggression that results.

Therefore to expect social workers, who are only able to provide such an individualized or at least small-scale response, to tackle it without more wide-scale social rearrangements is naive. Secondly, as you will have seen in other units, social workers spend the majority of their time working with people who are deprived, marginalized and often socially isolated. Many of their actual and potential clients will have the same sorts of characteristics which are associated with child abuse. As I have shown in the previous section, the task of separating the ‘high risk’ from the rest is not only complex, but a task almost certain to be doomed to fail in some instances.

Locating the problem in a social context raises even more fundamental issues. The construction of the problem in terms of individual disease blinds us to the abusive but non-individualistic practices of industrial, corporate, and state agencies. In seeing abuse as being manifested and caused at the individual level we do not take seriously the abuse perpetrated on children by other institutions and the wider society.

In more recent years Gill has criticized traditional definitions which see child maltreatment as occurring and having its primary genesis within families. He defines child abuse as ‘inflicted gaps or deficits between circumstances of living which would facilitate the optimum development of children to which they should be entitled, and their actual circumstances, irrespective of the sources or agents of the deficit’ (Gill, 1975, p. 346). In many respects, Gill’s argument about the conditions for the ‘optimum’ development of children echoes many of the issues raised in Unit 2 on children’s rights. You may wish to look back to section 4.4 of Unit 2 in particular, and consider whether the infringement of the rights set out there would be considered as forms of ‘abuse’.

Thus Gill argues that any act of commission or omission by individuals, institutions or the whole society, together with their resultant conditions, which ‘deprive children of equal rights and liberties and/or interfere with their optimal development, constitute, by definition, abusive or neglectful acts or conditions’ (p. 347). Child abuse can be manifested at both the institutional and societal level as well as within families, but rarely this is seen as legitimate for discussion within debates about its nature, extent
and causes. But the influences of schools, institutions, unemployment, social security systems, racial discrimination, class differentials have far more deleterious effects upon the life chances and development of children than the traditional concerns of child abuse literature, policy and practice. So, for example, the higher rates of neonatal mortality among children in social classes IV and V is equally ‘abuse’, as is the complicity of the pharmaceutical industry in the maiming of children from poorly tested anti-depressants or contraceptives.

Gil argues that not only can abuse be manifested at different societal levels but it must not be assumed that because the abuse is identified at one level, usually with the individual and the family, that it should be explained at that level. Its genesis may reside elsewhere in the social structure. Gil suggests that whether, and to what extent, human needs are met depends on society’s policies concerning resources, work, production and rights and the social philosophies which shape them. Thus when a social arrangement consistently frustrates the human needs of large sections of society, energy which is blocked by ‘structural violence’ might erupt as ‘reactive, personal violence by individuals and groups’.

The key analytical focus for Gil has increasingly become the structural obstructions to human development, including the development and control of resources, organization of work and production, socialization, the distribution of rights, and values.

Certainly, the assumption that child abuse is only to be found in the family is politically useful to a society which does not want to consider a comprehensive social policy towards children, and in the process constructs social workers as being responsible for the problem.

The present approach legitimizes the division between the role of the private nuclear family, and hence women, as having prime responsibility for caring for children. If it were seriously admitted that there may be many more children actually, or at risk from, suffering from child abuse, not only would this act as a major criticism of the utility of this family form but it would make new demands upon the state. The state would have to take much greater responsibility for children, with the result that either far more children would have to be removed and put into ‘care’ or much greater resources would have to be made available for caring for all children. Either would seriously question the role of the liberal state. However, because these issues are not recognized, social workers are left to resolve them in their everyday practice – and are heavily criticized when they are seen to fail.

Q: What might some of the policy and practice implications be of taking seriously the social context of child abuse?

I have only crudely outlined some of the social structural dimensions of child abuse. In doing so the emphasis has been on class and very little has been said about the implications of other dimensions – particularly gender (see Gordon, 1986, and Ong, 1996, for an illustration of how gender has been made central by two authors). However, the first element would be a recognition that the type of narrow, individualistic forms of intervention now current may at best be only a partial solution and at worst may be missing the point we would need to take seriously fundamental social reforms which would change the situations of whole classes, groups and communities. For example, early marriage is often noted as a contributing factor in child abuse. But early marriage itself reflects particular class and gender divisions in society which exclude some people from significant life chances. As a consequence, while early marriage might be associated with child abuse, both reflect processes which are not readily observable. However, if we ignore them we are at risk of ‘blaming the victim’ and privatizing what are essentially ‘public ills’. Primary prevention is thus concerned with improving the situation for all children and those responsible for bringing them up. Further, we may seriously question whether the private nuclear family is the most appropriate way of doing this.
CONCLUSIONS

I began this unit by outlining the factors that were important in making the issue of child abuse such a significant one over the last twenty years. In the process I demonstrated that certain assumptions and explanations of the problem have proved very influential in deciding what should be done. A 'disease model' of child abuse has been dominant. As a consequence responsibility for its existence is seen to lie with certain individuals and families, and responsibility for its identification, control and reduction with social workers. Thus whenever things are seen to go wrong those held up for public scrutiny and pillory are the parents and social workers concerned.

The way the problem has been constructed draws attention to individual patterns of behaviour, individual personalities and family relationships and not the economic and socio-cultural processes which direct and mediate such patterns of behaviour. Thus prevention is concerned with identifying potential abusers and rehabilitating families in an individualized way. I have demonstrated that such an orientation is not only inadequate but fundamentally misconceived and inhibits understanding. As a result, particularly unrealistic expectations have been made of social workers in a situation where they have neither the resources nor the knowledge to carry out the role.

Children have continued to die and major public inquiries into the social work provided have ensued.

One result is that it has encouraged a style of social work with families which is more defensive, less prepared to take risks and relies more on the use of statutory interventions.

Finally, I have shown that the issue of child abuse illustrates in perhaps its starkest form many of the tensions and contradictions of modern social work. It is naive to assume these can and will be easily overcome, for in many respects it is these dilemmas which are at the heart of modern social work practice and which make it so exhilarating and daunting at the same time to those involved.
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Figures
Figures 1 and 2 Creighton, S J Trends in Child Abuse, 1984, NSPCC