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THE COVER DESIGN: The four sections of the front cover represent the four cornerstones of the Māori concept of health: te taha tinana, te taha hinengaro, te taha wairua and te taha whānau. If these faculties are adhered to and kept in balance then life will be in balance. Also appearing in the design is a stylised face with eyes at the top, nostrils in the middle and mouth represented by four "teeth" at the bottom. The kanohi is representative of all who work in the varying fields of the Children, Young Persons and Their Families Service.



When the family cannot care, who looks after the children?

The Children, Young Persons, and Their Families Act of 1989 clearly intends that families and whānau should be responsible for their children. It was anticipated that all children referred to the Children, Young Persons and Their Families Service (CYPFS) because of care and protection concerns would be provided with care and safety by their extended families or whānau. While this is undoubtedly the guiding principle for the majority of children, there are exceptions. Social workers have been confronted with the fact that some parents or families are unable or unwilling to have care of their children. Alternative placements with new families have been necessary, and sometimes short-term placements have extended into long-term placements.

Any child who has had to leave biological parents because the family cannot care or provide for them is a disadvantaged child. In taking a child into care, that young person should not be further disadvantaged by remaining in state care any longer than is necessary. Every child should have the right to permanence, stability and quality care in a family that functions outside of state dependence. The current catch-phrase of *Welfare to Well-being* is very applicable.

In the Auckland Metro district, the needs of this group of children and young people are addressed by the Permanent Placement Unit (PPU) which operates out of the Grey Lynn office (and has recently been extended to cover South Auckland Care and Protection). The PPU has been in operation since 1981 although it first started as the Special Needs Adoption Unit. It was originally set up in response to the needs of children in foster care who were destined to remain in the care of the Department of Social Welfare until their eventual discharge. Adoption was seen to be

the appropriate way a child could be secured permanently in a family.

Many of the children who were placed by the Unit knew their parents and had contact with them. The Guardianship Act offered a more realistic way of securing a child's permanence with alternative parents and at the same time enabled the biological parents to be reinstated as guardians of the child. The new caregivers had custody of the children and therefore were responsible for the child's day-to-day care and support. Access with biological parents was maintained according to the child's needs and with the objective of promoting the optimum conditions for developing bonding and attachment with the new caregivers.

Shaping the way

While permanency planning is a function of other social work teams around the country, the PPU is the only specific unit of its kind in New Zealand. This has had advantages and disadvantages. The advantages are that we have been able to sculpture a unit to meet our own local needs while working within the parameters of CYP&F Act and the practices of care and protection social work. The disadvantages are that we have been unable to compare practices with anyone else and have had to rely on our own experiences, successes and sometimes failures.

The criteria of referral to the Unit is:

1. That the site office has searched unsuccessfully for a family/whānau placement.
2. That the child is under nine years of age. (We sometimes make exceptions.)
3. That the child is parentable, and they do not require 24-hour hospital care or costly medical remedies. We *do* place Downs Syndrome children, spina bifida children, children with foetal alcohol syndrome,

Attention Deficit Disorder, and the like.

We are strongly of the opinion that if children cannot live with family/whānau, they need and deserve the best possible caregivers available (CYP&F Act s13 f (iii) and h.) To this end, the first task of the PPU social worker is to establish the problems, needs and difficulties of the child. The time-frame for the social worker to achieve this task is one month.

Having established the needs of the child, we then seek to find suitable parents who have the skills and abilities to meet those needs. The selection process is rigorous and extremely thorough. The issues for PPU children and young people are that they need permanence, security, predictability, acceptance and to belong to a family-like environment, with attention given to their particular needs and problems.

Caregivers must be committed to remain in the child or young person's life until independence, have the skills and abilities to do the task, and possess the resources – both financial and material – to achieve this. They also require support and a sense of achievement that the task can be done or has been accomplished, regardless of the outcome. "Ideal" or "successful" outcomes are not always possible, given the problems these children and young people have.

There are five major advantages to permanent placement:

- Referral of a child to the PPU when they are unable to be placed with family/whānau frees the social worker to do other care and protection tasks.
- The child acquires permanent caregivers to whom they can attach, become bonded and who they know will always be there to care and provide for them.
- The child is kept in contact with their biological family so that they are aware of their origins, heritage, etc.

Social Work Now 1997

Deadline for Contributions

August issue: 4 June

December issue: 15 September

- The child has the chance to have a regular life, knowing where they will be in the future and that they legally belong to a family.
- The Service is no longer required to spend its very limited resources on board payments or social work time, as financial responsibilities become the province of the new caregivers.

Our success rate is very high, in spite of the exceedingly damaged children we place. They act out the hurt, rejection, anger and frustration of their early years, in an environment of safety and security provided by committed caregivers.

While the notion of commitment may be a lesser value in today's society, its value in a child's life is essential and has no substitute. In the end, it is also a matter of pay now or pay later. If a holistic notion of the child in society is adopted, the best resources should be made available to children and young people who have had the misfortune to be born of parents unable, ultimately and despite all best efforts, to take care of them. Inadequate solutions only increase the young person's potential for dependency and more financially costly care to the community, in the years to come. ■

Rita Derrick, Supervisor, Permanent Placement Unit, Grey Lynn, Auckland



The Children's Issues Centre

IT HAS BEEN 18 months since the Children's Issues Centre at the University of Otago was officially opened. In that time we have become an established interdisciplinary research and information dissemination centre for professionals working with children. Social workers are an important part of that group. Our small staff of six includes people with interests in a range of disciplines concerning children from social work, education and health to psychology and law. We also work on projects with researchers from other departments in the university and with community agencies.

We have found that a useful way of giving prominence to children's issues is to convene national seminars on specific topics in different parts of the country. These are an excellent way of bringing together interdisciplinary groups of practitioners, policy makers and researchers to share knowledge, set up collaborations and influence future policy and practice. To date, three national seminars have been held on the effects of divorce/separation on children; assessing and improving early childhood centre quality; and quality and safety in out-of-home care. Proceedings from the seminars are published to enable the findings to be shared with people who may not be able to attend. Social workers may be particularly interested in the proceedings of the last seminar on quality and safety in out-of-home care. We also have a series of free seminars in Dunedin, the next one is by Nicola Taylor on "The Voice of Children in Family Law". (These are also often available as publications.)

In February, we launched a journal, *childrenz issues*. The theme for the first issue was on children's perspectives, with articles on education, welfare and legal matters.

Our next big event is a child and family policy conference from 2-4 July 1997 in Dunedin entitled "Enhancing Children's Potential: Minimising risks and maximising resiliency". A call for papers has been distributed but please contact the centre (fax 03 479 5039, phone 03 479 5038) if you would

like to receive a copy or be put on our mailing list. Speakers include Professor Martin Richards from Cambridge, Professor Clyde Hertzman from the University of British Columbia and Dr Tara Scanlan from UCLA.

We have an active programme of research with each project supported by an interdisciplinary team. These studies include Access after Separation or Divorce, Placement in State Care and Protection, Transition to School, Evaluation of the Targeted Individual Entitlement (TIE) Scheme, and the Family Support scheme (with Plunket) which evaluates and reflects on the process of delivery of the Parents as First Teachers Pilot Project.

If you are interested in any of our activities or if there is anything we can do to help you, please contact us.

Anne B Smith Director, Children's Issues Centre

Conference on supervised access

I AM WRITING to let you know of a conference on children's supervised access aimed at all those involved in children's supervised access: CYPFS staff, lawyers, counsel for the child, service providers, counsellors and psychologists, and staff in related services such as Women's Refuge and Stopping Violence Services.

Issues to be addressed include the development of services standards, protocols between services and the family court, training of services staff, safety issues for staff, child abuse, and family violence. Confirmed speakers include Justice Mahony, Chief Family Court Judge and Brenda Pilott, Manager of the Family Violence Unit at the Department of Social Welfare.

The conference is being jointly organised by Barnardos and the Salvation Army from 30 June to 2 July at the Salvation Army complex in Henderson. Registration forms can be obtained from: Elizabeth Dyer-Grey at the Salvation Army's Community and Family Services in Henderson, phone and fax (09) 837 4471; or Heather Roberts, Barnardos

National Office in Wellington, phone (04) 385 7560 or fax (04) 385 3769.

Heather Roberts Barnados, Wellington

Evidence of professional development

I HAVE JUST read the latest edition of *Social Work Now* and want you to know how impressed I am by the quality and professionalism of the articles. When the publication commenced I wondered if the initial enthusiasm would last. But now, two years later, I believe it well established as a very important part – and indeed evidence – of the professional development of social workers.

I congratulate all who have played a part in the production of the journal and urge all social workers to read and contribute to it. The existence of this journal illustrates the professional maturity of the workforce of the Children, Young Persons and Their Families Service. I am proud to have such a development in the Department. ■

Margaret Bazley Director-General,
Department of Social Welfare

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Sub-themes

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- Policy and systems: the place of the child
- Cultural differences: unity and diversity
- Advocacy for children

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The initial programme, registration and call for papers will be available in September 1997.

***Social Work Now* welcomes letters to the editor and discussions on issues raised in the journal.**

Write to: The Editor, *Social Work Now*, Private Bag 21, Wellington. Shorter letters are preferred and we reserve the right to edit letters for sense and length. Please include your work address and a contact phone number.

Children with disabilities, whose responsibility?

Janet Thomson looks at the history and current situation with regards to the state's role in caring for children with disabilities

Policies supporting children with disabilities have been influenced in their development by a variety of social pressures. This paper backgrounds some of the policy changes involving both the health and welfare sectors, before examining the interface between the Children, Young Persons and Their Families Service (CYPFS) and health services in supporting families who care for children with disabilities.

Responsibility for children with disabilities in New Zealand has rested variously with parents, the state and voluntary agencies. Changes in public attitudes and beliefs about children with disabilities have led to shifts in social policy which, in turn, have shaped the nature of service delivery and established the respective roles of the three stakeholders. While children with disabilities are nowadays clients of the health sector, social workers are still involved with disabled children when determining whether care and protection issues exist.

The history

When responsibility for the welfare of disabled people living in the community was returned to the health sector by the Department of Social Welfare in 1992, the move signalled a new phase in the provision of services to people with disabilities. Philosophies of normalisation¹, first promoted as a basis for service provision to disabled people in the early 1970s, had established community care as a successful alternative to the hospitalisation and institutional care of people with disabilities. The policy changes later

introduced in 1992 developed a new basis for these services so that all people with disabilities, including children, might have the means of living an independent life in the community.

The role of institutions

Prior to the shifts in social policy in the 1970s, most children with disabilities had been cared for in institutional settings. Those with physical disabilities, visual or hearing impairments lived in specialist residential settings, while those with intellectual disabilities lived in psychopaedic or psychiatric hospitals. The Wilson Home, Homai College, Van Asch College, and Templeton and Kimberley Training Centres have long histories of caring for particular groups of disabled children. While it was accepted that those with physical, visual or hearing impairments might benefit from an education and vocational training, people with intellectual disabilities were not only denied access to schooling but were never allowed to leave the confines of the institution.

The Mental Defectives Act passed in 1911 had made it illegal for intellectually disabled people to remain in the care of their families. Here was the influence of eugenic theory, which had underpinned much of the health, education and welfare legislation in New Zealand from the 1880s. Eugenists believed human characteristics (in particular poverty, criminality, insanity and all manner of disabilities) were inherited. The only way to improve society therefore, was to segregate these people from their families and, by

controlling their fertility, ensure their gradual extinction and ultimately the progress and prosperity of society.

By 1911, eugenists had narrowed the focus of their concerns to the “mentally defective”. The later development and application of intelligence tests identified many in society previously unrecognised as “mentally defective”. These people came to be regarded as the source of society’s many ills. Particular attention was paid to “feebleminded”² “socially defective” women who (until 1928) were refused the right to marry and, once admitted to institutional care, were routinely sterilised.

Children were admitted to institutional care as young as five years of age. Conditions within were dehumanising; clothing was supplied by the institution and privacy was at a minimum. All activities for inmates were segregated. Decisions were made by the staff, individuals had few opportunities to make choices and this created dependency. Institutional life lacked meaningful relationships and individuals developed little sense of personal identity. Life expectancy was not long and contagious illnesses often claimed the lives of inmates whose physique and health were frail.

However, an anomaly arose from the 1911 legislation. Not all those diagnosed as mentally defective were admitted to institutional care, simply because there were too many to place in the existing facilities. As a result, some of those labelled feebleminded were legally permitted to remain in the community with their families, but they were made wards of the Director-General of Mental Defectives. Because of the stigma attached to “mental deficiency” at the time, some families hid their children at home away from friends and relatives, and often withdrew from community life altogether.

The role of voluntary organisations

Through the post-war years of the 1940s and 1950s, some families who had intellectually disabled children began to express their dissatisfaction with the care provided in institutions. These parents believed their children had a better chance of developing

their full potential if they lived with their families, and had the opportunity of attending school and becoming involved in their community, as their siblings did. The Intellectually Handicapped Children’s Parents’ Association (IHCPA), as it was then known, made strenuous efforts throughout the 1950s and 1960s to lobby the government for changes to the mental health legislation that had stood, without substantial amendment, since the first decade of the twentieth century. They wanted services that would support them in caring for their children at home. The Department of Health refused to concede to their demands, believing that large institutions were still the best place to provide the care these children needed. The two amendments to the mental health legislation in 1954 and 1957 made only minor concessions towards the goals these parents wanted.

In contrast, families with physically disabled children began receiving the support of Crippled Children’s Society (CCS) field officers from 1949. Similarly, an advisory service to the parents of pre-school children with hearing impairments commenced in the mid-1950s, and the first group of hearing impaired children began their education in a normal school setting around the same time. Children with visual impairments were integrated into regular classrooms from 1962. Society was more accepting of children with physical disabilities, visual and hearing impairments, and the support and service provisions available to them in the community reflected these differences in social attitudes.

A role for the community

It was not until 1974 that the Department of Health made any significant shift in its policies concerning the care of people with intellectual disabilities. It took criticism from experts of professional standing and several official reports, the last of which was the Royal Commission of Inquiry into Hospitals and Related Services in 1973, before the Department imposed a moratorium on the building of further psychiatric and psychopaedic hospitals. The idea that institutional care was more expensive than community-based services

had also gained acceptance, which, together with new financial constraints on government spending, changed policy almost overnight. The outcome was the community care programme, a joint venture between the Department of Health, Social Welfare and IHC. Hospital boards constructed residential accommodation in the community, with funding provided by the Department of Health, and asked IHC to run the programme. Hundreds of people with intellectual disabilities began to be transferred from psychopaedic institutions and psychiatric hospitals into the community. The focus was now on their welfare, rather than on treating disabled people within a medical model of sickness.

In support of these moves, new and related policies were developed. The Disabled Persons Community Welfare Act, passed in 1975, made legal provision for disabled people to receive assistance through the Department of Social Welfare outside of the benefit system, to enable them to live and work in the community. Amendments were also made to social security legislation in 1972, 1975 and 1978, providing parents caring for disabled dependants at home with benefits and allowances that gave them the financial means to do so. New organisations, such as the Multiple Sclerosis Society and the Parents Association of Neurologically Impaired Children, emerged in the 1970s as the second tier of disability groups developing community-based services. But by the end of the 1980s, there were still as many people with disabilities living in institutions as there were living in the community. The cost of caring for both groups was escalating, and it was clear that the country's economic environment could no longer sustain it. Another model of management needed to be found that would address these issues of funding and service delivery, so that all disabled people could live independently in the community.

The role of the state

The philosophy of normalisation remained the basis of new policy initiatives and, in a marriage of convenience with libertarian³ economic and social policy, drove the restructuring of the disability sector. These policy initiatives also reflected the growing influence of the disability rights movement. Disabled people wanted some input into the formation of social policy, as it related to them, and the policy environment at this time was receptive to their demands. They wanted changes to the organisation of the health and welfare services they received, and an equitable share of the resources. And so the New Deal shifted funding from disability organisations to disabled individuals, and introduced the concept of service brokerage to develop choices in the services available to

Particular attention was paid to “feeble-minded and socially defective” women who (until 1928) were refused the right to marry.

disabled people and their families. The funding and delivery of disability services returned to the health sector, and the support to families with disabled children continued through the disability organisation of their choice, funded

by the regional health authorities (RHAs). Children with disabilities who were unable to return to their families left institutional care to live with other caregivers, or to live in small, sometimes purpose-built homes in the community. Other legislation of this period made particular provisions for children with disabilities. The 1989 Education Act gave disabled children the same rights as the non-disabled to enrol at any state school. The 1989 Children, Young Persons, and Their Families Act (CYP&F Act) established a process whereby children with disabilities who required a placement away from their families could be cared for by an approved child and family support service or social service (with the appropriate facilities to provide care), or with other caregivers (ss141 and 142 agreements.) Children with disabilities were

subject to the same family group conference (FGC) process and review procedures as other children, whether or not there were care and protection issues involved (*Exchanges* 1996). (Even where there are only disability issues, an FGC under s145 is still required when a child and family support service is organising the provision of care for the disabled child.) In 1994, much of the funding and infrastructure that had (from 1975) delivered services to disabled people through the Department of Social Welfare, was transferred back to the health sector.

The role of CYPFS

The Department of Social Welfare however, retained a residual role in relation to some children with disabilities after this transfer.

Families with disabled children under the age of 17 years also involve CYPFS when care and/or protection issues emerge around the child. It is this interface area with the health sector that has been open to misinterpretation by some child and family support services in the past.

Children with disabilities are clients of the health sector. After an initial assessment, the appropriate services are secured and funded through one of the four RHAs. However, when children with disabilities are the subject of care and protection concerns, they are entitled to the involvement of CYPFS staff to establish the validity of these concerns and subsequently to take action to ensure their care and protection needs are met.

For some families, the issues are only around the on-going care of the child. The parents may be ageing, or constant lifting may have led to a permanent back injury for the primary caregiver, or care issues may have been compounded by related family issues such as divorce or bereavement. In these situations, extra support for the family may be found through RHA funding (residential support subsidy, home support, shared care, and carer support). The family remains involved in

making major decisions about their child, and CYPFS' only role, through an FGC, is to underpin the arrangements made by the family in placing the child with other caregivers, if this proves necessary. Presently however, each of the four RHAs have different interpretations of what constitutes a family crisis and what resourcing can be made available to a family in such circumstances. This can put pressure on CYPFS to become involved in providing extra resources.

Other disabled children may belong to a family where their parents are experiencing marital conflict, where both parents have a mental illness or where the parents are of limited intelligence themselves, where the parents are dependent on drugs or alcohol, or where a disabled child may have been physically or sexually abused by a parent. In these

situations CYPFS has a definite role in protecting the child from further abuse, ill-treatment, or neglect. This may result in one of a number of interventions on the part of CYPFS, either

short-term (if the child moves to an alternative placement or it is appropriate that the child returns home), or long-term if there are court orders (particularly when guardianship comes to be vested in the Director-General). A social worker's assessment of the incident, the parents' demonstrated ability and willingness to change, and the likelihood of the incident re-occurring will determine this time frame. Children with disabilities are at just as much risk of inadequate parenting as children without disabilities, and CYPFS' role is to ensure that both groups of children are cared for and adequately protected from further harm.

In some situations, both care and protection issues arise when the nature and extent of a child's disabilities become so challenging that parents are unable to continue functioning in their parenting role. The stress of this situation can result in either ill-treatment of the child, or a type of near-abandonment of the child because of the

The stress can result in either ill-treatment of the child or a type of near abandonment...

constant, unchanging demands of a seriously disabled child on top of the normal pressures of family life. For these families there is usually an interim support role for CYPFS, and a longer term role for the disability sector through the RHA. An FGC (referred under ss18 and 19 of the CYP&F Act) is a prerequisite in such circumstances. An FGC would determine CYPFS' role and responsibilities, the resources needed to support the child's placement, and from whom these are to be secured. In some instances where care and protection issues have been identified, and the child remains at home, CYPFS may choose to retain an on-going monitoring role without providing any additional financial resources to the family. When care and protection issues are resolved, CYPFS involvement ceases in favour of continued financial support from the RHA through the disability organisation concerned. There will be other occasions when on-going concerns for the child's well-being demand a longer-term involvement of CYPFS through sole guardianship, additional guardianship or

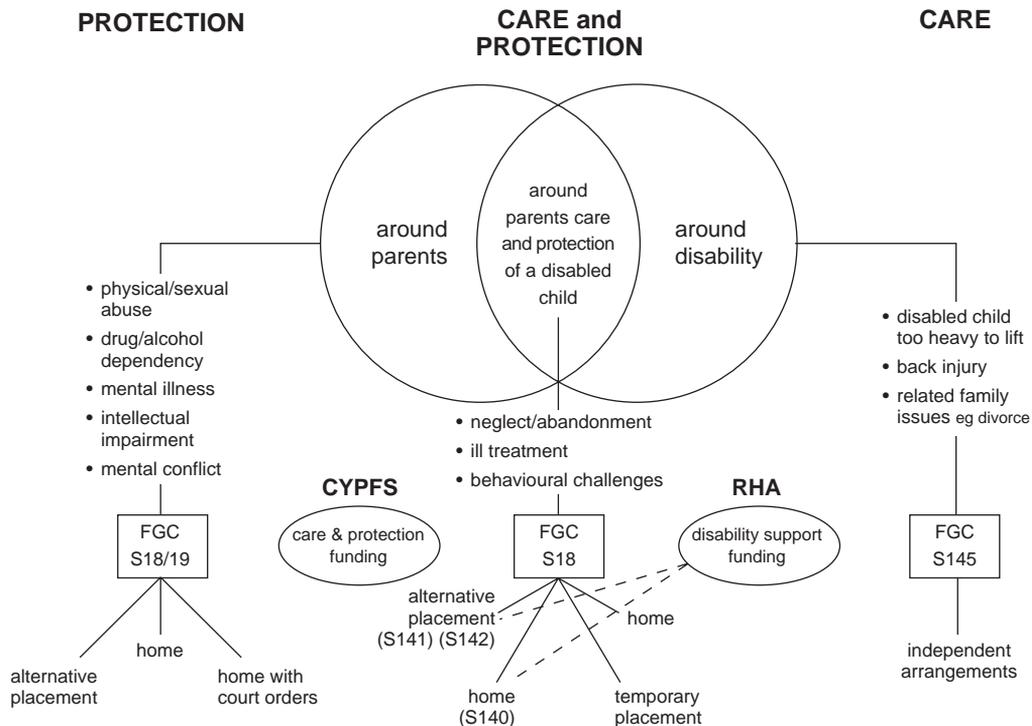
custody orders. Making explicit the guidelines around CYPFS involvement is critical (CYPFS Guidelines 1996).

Guidelines for social workers

Some organisations supporting children with disabilities have argued that care and protection issues exist for any disabled child being placed out of home. This line of argument may be used as a means of securing extra resources. The seriousness of the child's disability in itself is not a care and protection issue, nor does inadequate resourcing through the disability sector constitute a care and protection concern. But these factors may indicate care and protection issues when considered alongside other information about the family. Key indicators in establishing care and protection issues might include:

- What are the key issues for this family?
- Have the parents involved extended family?
- What is the effect on siblings?

fig 1 Care and Protection Issues



- Are there extra support networks in place?
- Are other disability organisations involved?
- Have other placements been considered?
- What are the parents' attitudes to the child; do they care, have they neglected/rejected/abused the child, are they absorbed in their own issues?
- Are they able/capable of taking responsibility for the child's safety?
- Do they have an understanding of the child's developmental needs?
- Are they able/capable of providing adequate care/oversight of the child?

(See **fig 1** *Care and Protection Issues*)

Children in institutional care never had to face the risks associated with living in the community. But neither did they have the opportunity to experience the quality of life that community care affords them. Current social policy supports the care of children with disabilities in their community. But the family's role in caring for them must be supported by adequate resources and the commitment of the agencies involved, to ensure these children are never reinstitutionalised. ■



Janet Thomson is a social worker at Porirua CYPFS. She returned to the Service after a number of years working in the disability field. Her interest in services to families of disabled children led to the completion of a Master in Social Work through Massey University, in which she examined the development of the current policy for people with intellectual disabilities. In CYPFS this has involved a focus on the care and protection of disabled children.

Notes

¹ Normalisation is described as "making available to all mentally retarded (sic) people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of society" (Nirje 1980).

² These were people considered to be on the borderline of an intellectual disability.

³ Libertarian economic policy championed individual freedom, minimal state intervention and the supply and demand of the market, with an agenda of trimming the function of the Welfare State (King 1987).

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The policy and practice of recording iwi affiliation

Planning for iwi social services demands reliable information. **Oketopa-Kuni Shepherd** checks out how iwi affiliation recording measures up

“Ko Tihirau te maunga,
Ko Whangaparāoa te awa,
Ko Kauaetangohia te marae,
Ko Hoani Waititi te tangata,
Ko te whānau-a-apanui te hapu,
Ko Oketopa-Kuni Shepherd ahau”,
Tēnā koe, kōrua, koutou rānei.

The Department of Social Welfare has a well-documented commitment to the development of iwi social services, two of which have now been approved in Taranaki and Waikato. Good planning and the proper resourcing of iwi social services depends, however, on the gathering of reliable information about the iwi affiliations of children and young people notified to the Children, Young Persons and Their Families Service (CYPFS).

Te Punga, the DSW's bicultural strategy document published in December 1994, stipulates as a requirement for Year One that managers and staff will identify the iwi affiliations of all Māori customers. This requirement has a precursor in Circular Memorandum 1992, which states the instructions of the then Minister of Social Welfare that iwi affiliation must be recorded, and it is reiterated in the practice handbooks published in 1996.

It is imperative that CYPFS social workers collect information about their clients' iwi affiliations to ensure that:

- Māori children and young people are given the opportunity to be referred to an iwi

social service on the basis of their affiliation to the iwi who has mandated the iwi social service.

- The transfer of functions and resources occurs on the basis of the numbers of cases being transferred to any iwi social service.
- CYPFS will be able to meet policy obligations to iwi social services to provide aggregate information on Māori clients ie numbers by iwi and the agencies to which they are referred when removed from whānau care.

For all this, the recording of iwi affiliations has not progressed well. A SWis printout of the national aggregate for the period 1 July 1996 to 31 December 1996 shows a very poor performance. Of 11,140 clients identified as Māori, primary iwi affiliation is recorded in only 5916 cases (53.1 per cent). Of the total, only a very small number of clients (316) were recorded as either not knowing their iwi affiliation or not wishing to disclose it.

The aim of the Porirua Iwi Affiliation Project was to collect iwi affiliation information on all Māori children and young people who had come to the notice of the Porirua site during the 1995/96 year. The project was prompted by an August 1996 analysis of the SWis statistics for Porirua for the period 1 July 1995 – 30 June 1996 which showed that only 16.5 per cent of all Māori clients' iwi affiliation was known or recorded.

The experience of the Porirua project worker highlights some of the problems which all CYPFS staff may be experiencing.

Methodology

Project worker Oketopa-Kuni Shepherd was given full access to case notes of all clients. Particular attention was given to identifying:

- Which clients were Māori and how readily that information could be identified on the SWis system;
- How many Māori clients' files had their iwi recorded on SWis or on any other record held by the social workers; and
- The limitations (if any) in recording iwi affiliation information.

The next stage was to identify the hapū and iwi to whom Māori children and young people belonged. This was done by direct contact with whānau members. Sixty per cent of all whānau contacts were made to maternal grandparents (kuia and koroua). The remaining 40 per cent involved contact with other whānau members and kaumātua.

Obtaining iwi affiliation information

In all cases, the initial contact with whānau was made by phone. It was obvious from the beginning that face-to-face contact would more readily establish the rapport and trust required for people to impart the information required but this was a luxury denied the project worker. Many whānau members lived in distant centres. There was also a tight timeframe on the project. Wherever possible, however, follow-up meetings were arranged as and when possible.

There was no difficulty finding the "most important person" to be the first point of contact. However there were very different experiences with rural and provincial whānau as opposed to urban dwellers.

As expected, establishing telephone rapport with whānau in rural and provincial areas was difficult. Māori people are very reluctant to discuss whānau matters, and particularly with strangers, over the phone. Fluency in te reo enabled the project worker to overcome most people's reservations, although in some cases, broaching the issue in te reo drew hostility from people unable to speak te reo.

Once it was established, however, that the

caller was Māori, rural and provincial respondents readily provided iwi affiliation information. In some cases they would cite the whakapapa of the child or young person. Reo speakers in particular welcomed the fact that efforts to identify iwi affiliation of their children and young people were at last being made.

There was a 100 per cent success rate in obtaining information through whānau in rural and provincial areas. In fact, once the importance of the exercise was understood, these people took the opportunity to express their broader issues and concerns about the welfare of their children. The overwhelming concern was about their mokopuna being removed from whānau and placed with Pākehā organisations. They emphasised the importance of exploring whakapapa so that Māori children who are removed from their immediate whānau can be placed with members of their wider whānau.

Eliciting information from whānau living in urban centres was more difficult.

Identification of iwi affiliation of Māori children and young people was able to be obtained in only 70 per cent of the contacts made with urban-dwelling whānau.

The reasons for the lack of information offered by Māori living in city areas are not clear. However, two koroua were not supportive of involving anyone other than immediate whānau in the problems inherent in the notification to CYPFS about care and protection or offending issues. Their concern was that whānau would feel whakamā about their raruraru being brought to the attention of hapū and iwi.

Iwi affiliation breakdown

Thirty-two iwi were identified with CYPFS Porirua/Paraparaumu clients of the 1995/96 year (489 iwi affiliations for 360 children and young people.) At least ten iwi, however, were not included on the SWis iwi pop-up list. As a consequence, children and young people who belong to those ten iwi were not able to have their details recorded.

Some caution must be attached to drawing assumptions from the information gathered. There was a very tight time frame on the

project and it is possible that children and young people with two iwi recorded in the SWis system may have been double-counted as a result. Irrespective of whether or not that is the case, the figures do provide very good percentage indicators of iwi representation through the children and young people brought to the attention of CYPFS Porirua and Paraparaumu.

It is of interest, in terms of the future development and resourcing of iwi social services that, of the 32 iwi affiliations recorded for the two sites, 90.2 per cent of the children and young people on the Porirua/Paraparaumu client lists were taura here iwi.

Looking for the problem

Obtaining the iwi affiliation information for Māori clients of CYPFS Porirua/Paraparaumu was time intensive. It took one whole day to make the necessary contacts for 12 children and young people, to read case files, make initial and follow-up contacts and record the information. The time required could be a factor that contributes to the current failure to record ethnicity and iwi affiliation.

In theory, however, all CYPFS staff should be able to gather information about iwi affiliations. The requirement that it be done dates back to 1992 and the development of iwi social services has been at the forefront of CYPFS planning for two years .

On the basis of this, it could reasonably be expected that all staff will have been encouraged to develop the necessary skills to achieve this. The national experience, however, indicates that CYPFS staff are not all able – or willing – to do this work. In some instances not even Māori ethnicity was identified in the Porirua case files.

Essential knowledge

Given some of the difficulties that the project worker encountered, it is clear that iwi affiliation information is more likely to be readily offered if the CYPFS worker seeking it is:

- Māori
- Mature (meaning, in Māori terms, older than 35 years)
- Fluent in te reo
- Able to apply Treaty of Waitangi principles into social work practice
- Comfortable in both Māori and Pākehā worlds
- Knowledgeable about whānau and hapū structures
- Able to liaise with tangata whenua, taura here and whānau and hapū.

It becomes more difficult if research is necessary to identify a Māori client's iwi affiliation, when whānau and known extended whānau do not know themselves. In the view

Māori people are very reluctant to discuss whānau matters, and particularly with strangers, over the phone.

of Māori consulted by the project worker, to embark on the research required the CYPFS person would need to be iwi Māori and older than 35, preferably a native speaker, knowledgeable about tikanga and

knowledgeable about their own whakapapa.

This has daunting implications for Pākehā and other non-Māori staff but it is not to suggest that non-Māori staff are unable to do the work. It would seem essential, though, for Māori to work beside non-Māori colleagues in this sphere, until such time as non-Māori staff gain skills and confidence and establish networks.

There are drawbacks to this mentoring approach. It would involve a duplication of resources and it would be pointless if phone contact is the only viable option. What is certain though, is that the appropriate skills cannot be acquired by theory.

The training problem has been forwarded to the Wellington Area Management team which will consider recommendations to the CYPFS national office where the professionalisation of social work staff is currently being revamped to be more CYPFS-specific in its focus.

Porirua staff views

The main response from Porirua staff was to request training to enable them to develop the skills to collect the relevant information from whānau, hapū and iwi. Staff said that they most needed training and guidance in the matters of tikanga including marae kawa, whakaiti, and concepts of whakamā; correct pronunciation of Māori; better understanding of Whakapapa and Whakawhānaungatānga; and in the practical application of *Puao-te-Ata-tu*, *Te Punga* and the Treaty of Waitangi.

It should be noted that even with such training, the ability of social workers will not be enhanced to the extent that they are able to deal with iwi Māori people who may be hostile (depending on the circumstances) in respect of identifying iwi affiliation of Māori children and young people.

Some staff report that they believe they are able to work comfortably in all cultures, and this may be true in some of the cases. However, in the majority of cases where neither ethnicity or iwi affiliation was recorded for Māori children, this occurred from choice or because of ignorance of the Department's policy on the recording of iwi affiliation data and its importance in terms of the development of iwi social services. The reasons for the non-collection are complex and will vary from site to site.¹

One wider observation is that some social workers remain uneasy in their attitudes toward whānau, hapū and iwi, and are more inclined to seek placements of Māori children and young people with institutions with well-established track records, generally, non-Māori organisations such as Open Home and Barnardos.

This is another problem which cannot be overcome by training. Rather, a clear policy position is required that stipulates that social work staff must, wherever possible and practicable, place Māori children and young people who must be removed from their immediate whānau, within their whānau, hapū or iwi. Further, the policy should clearly require that social workers provide evidence that they have exhausted all possibilities within whānau, hapū and iwi before

considering placements with Māori and non-Māori individuals or organisations.

Staff recruitment

The project worker has some doubts about the degree to which any current assessment of cultural competence of incumbent staff meets the actual needs of CYPFS requirements. Planning for future endeavours to identify Māori children's and young people's iwi affiliation requires that new staff recruited into CYPFS be assessed for their cultural competence.

It is suggested that role plays could be used to enable applicant social workers to show how they would approach a Māori whānau to identify its iwi, in addition to how they might carry out their social work duties with a Māori whānau.

A checklist that elicits information about applicant social workers' attitudes to Māori would also be useful. A good checklist would be able to identify applicants' ability to translate Treaty of Waitangi principles (particularly Tino Rangatiratanga) into practice. Examples would include knowing that whānau means more than the immediate family; willingness to approach whānau (in the widest sense) even if immediate whānau are opposed to this; being able to outline how they would go about locating whānau, hapū and iwi members – what channels they would go through; and making the connection between wellness and knowledge of whakapapa and tikanga for Māori children, young people and whānau.

SWis matters

Māori children and young people can, and many do, whakapapa back to more than one iwi. The SWis system does not, however, allow for the capture of more than two iwi to whom a child or young person may belong. Two issues arise from this. The first is that whānau are asked to make a choice about who they wish to have *above all other iwi* noted on their child's or young person's file. If they do not wish to make that choice, they may choose to have none at all rather than exclude any iwi. In this respect the information system may not meet the needs of Māori.

Secondly, an important practice issue is that the SWis recording limitation restricts the pool of people when contacting whānau, hapū and iwi members to contribute to a family group conference.

The failure to record iwi affiliation risks sidelining people who are entitled under the provisions of the Children, Young Persons, and Their Families Act 1989, to have input into the welfare decisions made about their children and young people. Whānau, hapū and iwi are entitled members of a family group conference as prescribed by the Act, which further requires that "all reasonable steps be taken" to involve entitled members in a family group conference. If a child's iwi affiliation is not recorded, it is unlikely that all entitled members will be contacted.

Other agencies

CYPFS has no direct control over the extent to which other agencies such as the police, courts, health and education collect iwi affiliation information. But it would be a worthwhile endeavour to request that they make every effort to do so for the Māori children and young people they refer to CYPFS. It is possible that CYPFS community liaison social workers could encourage this to happen.

Iwi social services

With the development and establishment of iwi social services whānau, hapū and iwi will be strengthened and empowered and whānaungatānga can be employed as a relevant and useful component of social work. The social, emotional and psychological and general welfare of Māori children and young

people can only be enhanced when their physical well-being is vested in the greater number of people who have a kinship connection to them.

Recommendations

The Wellington Area Management team is making three recommendations to national office:

- That specific training be provided to all social work staff, to enable them to collect iwi affiliation information.
- That such training be included in the professionalisation strategy.
- That social worker recruitment procedures incorporate a process for assessing an applicant's practical ability to work with Māori whānau, hapū and iwi. ■



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Note

¹ Rotorua social work staff, who have one of the highest iwi affiliation collection rates in the country, comment that the collection of ethnicity data depends on the circumstance of each case. They confirm that it is not easy. Clients can be discomfited by embarrassment if they are unable to provide the information. Asking people who are whakamā about CYPFS intervention to identify their iwi affiliations can also be insensitive, especially when care and protection issues are concerned. Initially the social worker will prefer to concentrate on establishing a relationship with the whānau and ensure that the child is safe. It may be several months before a social worker feels it appropriate to seek iwi affiliation information.

Emotionally competent child protection organisations: Fallacy, fiction or necessity?

In this exclusive excerpt from a new book, UK social work authority **Tony Morrison** examines the health of child protection agencies

A couple of years ago a middle manager summed up the culture of her social care organisation in terms that have resonated with every audience that I have subsequently shared it with. She described herself as paid for 'doing' – outputs, tasks, etc; as far as 'thinking' was concerned she should do that at home, or at the weekend; but as for 'feeling' she should not bother to do that at all. In other words her organisation, typical of many social care organisations in the early 1990s, was one in which two thirds of the domains of human experience, ie thinking and feeling, were off organisational limits. The consequences for any social care institution are deeply damaging in terms of critical reasoning, planning, working relationships, reflective analysis, staff stress and motivation. The consequences within a risk management environment, such as child protection are more worrying still: blunted emotional responsiveness, reduced sensitivity, inadequate reflection, and dangerous decision-making.

Emotional competence is therefore not simply a challenge for individual managers or practitioners, it is also a corporate issue for organisations. Indeed one might ask whether individuals at any level in the organisation can remain emotionally responsive and

literate in an agency environment that is emotionally illiterate, blunted, or sometimes more deeply disturbed.

Professional Accommodation Syndrome

[Under such conditions...] the front line of today's child protection work, is potentially a partnership between two parties, families and professionals neither of whom feel understood, valued, respected, prepared, or supported. This has potentially highly damaging consequences not only for practice, as we have seen, but also for the well-being of staff. To explore this I will to refer to, and elaborate on an earlier model, the Professional Accommodation Syndrome (Morrison, 1990 and 1993) for understanding the interaction between the primary stress of working with abused children, and the secondary stress stemming from the agency's response to these primary stresses.

In 1983 Roland Summit published a seminal paper, the Child Sexual Abuse Accommodation Syndrome which offered a model to explain both why children took so long to disclose sexual abuse, and the reasons for some children subsequently retracting their statement.

Briefly stated he showed how the sexually abused child, living in a family system regulated by the perpetrator's dominance and by secrecy, feeling helpless and entrapped by the abuse, sought to resolve this psychological crisis by shifting responsibility for the abuse from the adult(s) to the child. The function of this accommodation is that by choosing to

This abridged chapter is taken from *Protecting Children: Challenges and Changes*, edited by Bates J, Pugh R and Thompson N. Published by Arena, Aldershot at the end of April 1997, the book will be available from Bookstall Services, 86 Abbey Street, Derby DE22 3SQ, UK. Fax 01332 368079.

take responsibility for their own abuse the child can attempt to regain some control over the situation eg: 'It's too awful to contemplate that my father is abusing me, and that my mother knows about it (even if this is not true) as I am powerless to act. If I assume instead that it is *my fault* (which is what my father has been saying to me) then, if I am good, and do what my father says, eg keep the secret, then maybe it will stop.'

The effect of accommodating in this way is unfortunately further entrapment in the abusive relationship and ensuing delays in disclosure. Because of this, and the conditions under which a disclosure may emerge, (family crisis, running away, psychosomatic complaints) the eventual disclosure may be seen by professionals as unconvincing and thus

be disbelieved. Faced with ambivalent professionals and the mounting family crisis surrounding the disclosure, for which the child is now also made responsible, the solution is for the child to retract.

The perpetrator's denial and the rule of secrecy are thus sustained, both of which serve to deepen the child's future vulnerability to abuse. The inadequate response of the professional system acts as a secondary form of victimisation, and worsens the damage done by the original primary source of victimisation.

However Summit's powerful model can be adapted to understand more general processes of victimisation and staff stress, and it is particularly useful for child protection staff because it draws on the dynamics of abuse. It can be applied to managers, teams and organisations, not just in social work agencies but in virtually any care setting. Thus in its re-worked version the **Professional Accommodation Model** works as follows, based on the same five stages.

1) Secrecy

Many staff hesitate to speak about the impact of the work on them because they feel or know that the agency or colleagues covertly or

overtly denies them permission to do so.

2) Helplessness

Staff who feel helpless in relation to their work, or in the face of stress arising from it, feel a sense of shame. They experience the agency's rejection and dislike of their helplessness, and receive the message that those in the helping professions are paid to be copers. The agency's belief system is that uncomplaining workers are OK. Myths exist that trained staff should act logically, rationally and objectively. Gender stereotyping in agencies sees women who express stress as 'hysterical', or 'victims', and men as 'wimps' or 'little boys'. Factors of race, disability or sexuality create yet other pejorative stereotypes.

3) Accommodation and entrapment

Staff are trapped in a dilemma in which telling the truth about their stress is seen as 'unprofessional', whilst maintaining the denial is seen as coping and

'professional'. In the face of this, staff are forced to accommodate by then deciding that the fault lies not with the agency's insensitivity, or with the nature of their work, but with themselves for feeling as they do, failing to cope, and generally not being sufficiently robust. The answer appears then to lie in suppressing their feelings, invalidating their experiences, and working harder.

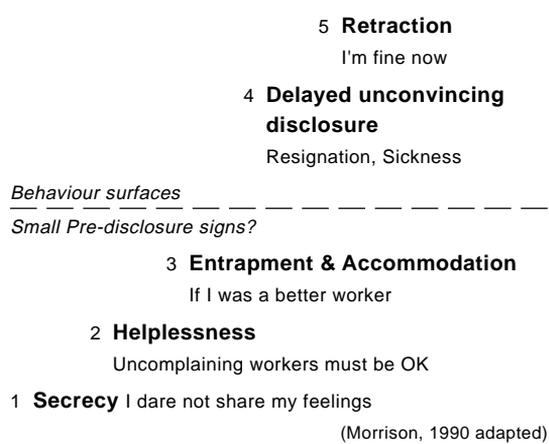
4) Delayed or unconvincing disclosure

Disclosure of the distress may eventually be triggered by conflict, training, illness or talking with colleagues. Where conflict is the trigger, this may be in the form of unpredictable behaviour such as atypical aggression, lateness, sickness or sudden resignation. If the behaviour is only understood at a superficial level, and not as a signal of more prolonged underlying distress, it may result in actual or perceived responses such as: 'she should never have been a social worker/ teacher/ nurse anyway – or 'if you can't stand the heat get out of the kitchen'. The

Staff who feel helpless in relation to their work, or in the face of stress arising from it, feel a sense of shame.

difficulty for managers and the agency is that as Fig 4 shows, it is not until this point that any obvious signs of problems appear, and the fact that the presenting behaviour may well be a problem in its own right. The surface behaviour may, however, be like the tip of the iceberg, below which there may lie a history of distress which has progressed through secrecy, helplessness and accommodation, whose diagnostic signs have been both subtle and ambiguous. If the worker does leave the agency, she/he may well take to the new job these unresolved experiences, which will, unbeknown to the new employer, render this worker additionally vulnerable to stress. Some career patterns seem to be driven by a series of ever more rapid cycles of delayed disclosure – flight.

fig 4 Professional Accommodation Model



5) Retraction

The delayed or confusing nature of the disclosure, if followed by insensitive, ignoring or disbelieving responses in the agency, leaves the worker psychologically and professionally abandoned, fearing that she/he will now be written off as incompetent. In the face of this threat to their whole career the only solution appears to be retraction: 'I'm fine now, it was just the time of the month' or 'I'm fine now, it was nothing to do with work'. Secrecy resumes and the entrapment deepens as a result of the experience of being punished for disclosing, which of course confirms the original belief

system about the agency.

This model suggests that with the exception of traumatic forms of primary stress, for instance assault by a client, that **the critical dimensions of stress in child protection work do not arise primarily from work with clients, but in the agency's responses to the strong, but normative feelings and fears which such work engenders.** Normative anxieties become pathologised in such agency cultures, and solutions, if restricted to the provision of counselling, serve to reinforce the same message that only 'inadequate' workers complain.

Towards emotionally competent organisations

Although approaches to organisational theory have tended to stress directional and structural aspects as being crucial to organisational well-being, other literature (Menzies, 1970; Vince and Martin, 1993) has emphasised the emotional and cognitive life of the organisation operating at both conscious and unconscious levels. These approaches drawing from group analytic and open systems theories, explore the impact on the agency of group interactions and the acting out of images and fantasies about the institution carried by the members of the organisation which influence much of their organisational behaviour. To put it more simply such approaches integrate the *feeling* and *thinking* aspects of the agency's life with the *doing/task* focus. **Indeed the premise is that more, rather than less, is achieved if feeling and thinking are attended to, because the organisation and its staff are not wasting precious energy and resources on organisational, social and personal defence systems (Menzies, op cit), such as denial or projection, which in fact only worsen existing problems and demotivate the workforce.**

One way of conceptualising the nature of healthy organisations is to return to the Professional Accommodation Syndrome and explore strategies for the creation of positive agency cultures which need to underpin child protection work. Thus if we look again at the Professional Accommodation Syndrome from this angle, we can begin to identify a number of strategies (Fig 6).

fig 6 Professional Accommodation Syndrome: Strategies

-
- 5 **Prevention**
Prevent secrecy, Maintain openness, Identify patterns
 - 4 **Restoration**
Understand problem, Identify process, Act to restore worker
 - 3 **Clarity** What is/is not my responsibility
Identify distortions
 - 2 **Empowerment** Role clarity, competence, training, feedback
 - 1 **Openness** It's OK to show feelings and talk about stress
(Morrison, 1997)
-

1) From secrecy to openness

If secrecy is where problems start, then the promotion of openness, by a variety of means, is the first objective in a healthy organisation.

In this culture anxiety and stress is openly acknowledged and seen as normative, allowing for the expression of healthy uncertainty, and difference, where problems and 'mistakes' are opportunities for learning, not punishment. Risks are taken and innovations are attempted. The unresolvable nature of many issues is openly acknowledged and struggled with, from which unexpected or creative resolution may come. In consequence of which staff are empowered to tackle further demands.

In other words the organisation is managed in ways that acknowledge anxiety as an institutional, and not just as an individual phenomenon. This approach is therefore not primarily about the provision of staff counselling services, although this has a place, but is much more about the quality of management, so that the organisation knows what its job is, knows where it is going, and equips its staff to get there. This happens through the provision of an effective infrastructure for practice: goals; values;

If secrecy is where problems start, then the promotion of openness, by a variety of means, is the first objective in a healthy organisation.

leadership; structures; policies; resources; and effective human resource management. Time does not permit a discussion of these elements but clearly agency culture and structures are interdependent. Healthy processes will not happen in agencies that do not know where they are going or how they want to get there.

However one specific element that does require mentioning is the critical role of supervision in the creation of a positive climate for practice. It is essential to reaffirm as a profession that supervision is the worker's most important helping relationship, and is for the organisation the most important process by which thinking feeling and doing are integrated. At an individual level supervision is the vehicle through which anxiety is contained and held. It is also, far

more than training, the primary means for the development of competence and self efficacy in staff. Openness cannot thrive in the absence of skilled and sensitive supervisory processes (Morrison, 1993).

2) From helplessness to empowerment

Helplessness needs to be combated through a range of empowerment strategies, central to which must be the notion that a primary buffer to stress and burn out is self efficacy. It is of little value to allow staff to ventilate feelings, if they are not enabled to acquire sufficient knowledge and skills to do the job. They will remain helpless in the fact of their incompetence. However empowerment is also about acknowledging, valuing, and utilising difference within the workforce, and therefore it is concerned with making explicit issues of inequality and power. Working together means contact between differing emotional realities, different systems of meaning and different types of bias. Consequently women and men, black and white, disabled and able bodied, gay and straight have to address differential experiences of power and powerlessness as aspects of the organisational practice and learning (Vince and Martin, 1993).

3) From accommodation to clarity

Accommodation and entrapment is essentially a process of cognitive distortion whereby responsibilities and distinctions between 'me' and 'not me' become blurred and confused. The result is individuals taking too much responsibility for processes that are not within their control: 'If I had visited that child, she wouldn't have been abused'. However because these are cognitive processes they may be well hidden, and revealing only the most subtle of clues. The underlying strategy here must be about making the staff's thinking, beliefs, assumptions, fantasies or fears explicit so that they can be tested against external realities, facts, values, limitations, policies and expectations. Only by doing so can clarity and an appropriate sense of role and responsibility be regained. At an organisational level continuing attention to role clarity is essential given that role ambiguity and confusion are highly correlated with stress and burn-out.

4) From delayed disclosure to restoration

At this point there is a dual need. Firstly the presenting behaviour needs to be understood, as a potential sign of distress, and as a consequence of going through the previous stages. However it is also possible that the worker's problems in fact do not originate within the workplace, but elsewhere such as at home. It is very important then that a sensitive and intelligent analysis is sought as to the reasons for the behaviour, in order that the worker feels that any cry for help is heard, and to identify any organisation/supervisory deficits or problems that have contributed. Secondly it is vital to restore that worker to positive functioning as quickly as possible, even if this includes making clear the need to change the behaviour, alongside the provision of support, training, co-work or possibly counselling where appropriate. The over-riding aim is to prevent a move to retraction.

5) From retraction to prevention

Once retraction has occurred, the aim is primarily preventative to open up communication and make opportunities for openness and sharing of feelings more

accessible in the future, accepting the worker's current statement that everything is now OK. Particular attention should be paid to the quality and safety of the supervision relationship, and any specific support needs required by the worker. It may be useful to examine with the worker whether they have had similar experiences in other settings which have not been resolved. However as with the previous stage every effort needs to be made to enable the worker to regain their confidence and sense of self efficacy in the workplace as soon as possible. This may mean a sensitive review of the size and appropriateness of their workload.

Many of these strategies need to be implemented at a corporate level, for Pearlin and Schooler state: "Work problems are intertwined with the social structure and organisation of the workplace, and thus require collective, rather than individual solutions." These must start at the organisational level and clearly senior managers have a major responsibility, but the strategies must also work their way down to smaller work units. At a strategic level there are four priorities as far as combating stress is concerned:

- i) Raising awareness about the stress.
- ii) Developing interpersonal management skills.
- iii) Redesigning unhelpful structures.
- iv) Training.

(HEA, 1988).

At a team level one simple suggestion is for each local site/team to use the Professional Accommodation model to analyse unhelpful processes, and then to generate a Team Health Plan based around the five stages described above: openness – empowerment – clarity – restoration – prevention.

Conclusion

Plainly there are no quick fixes or standardised remedies for the complex emotional turbulence of child protection work. What is clear however is that such processes are best understood as a triangular interaction

involving agency, clients and workers. As such the question is not whether organisations should be concerned for their emotional health but how to grow healthy organisational environments. This chapter has sought to provide models that may catalyse discussion, energy and action towards a vision of emotionally competent organisations. But through it all we should keep Tonnesman's words in mind:

'The human encounter in the helping professions is inherently stressful. The stress aroused can be accommodated and used for the good of our clients. But our emotional responsiveness will wither if the human encounter cannot be contained within the institutions within which we work. Defensive manoeuvres will then become operative and these will prevent healing. By contrast if we can maintain contact with the emotional reality of our clients and ourselves, then the human encounter can facilitate not only a healing experience, but also an enriching experience for them and us' (Tonnesman, 1979). ■

Tony Morrison is a UK academic and independent social care trainer and consultant. He recently visited New Zealand to carry out a series of workshops for CYPFS.

Notes

- 1 With the author's permission, this article has been abridged from Tony Morrison's chapter 'Emotionally Competent Child Protection Organisations: Fallacy, fiction or necessity' in *Protecting Children: Challenges and Changes*. Other work includes: *Supervision in Social Care* (1993) Longmans; *Sexual Offending Against Children* (1994) eds Morrison T, Enoga M and Beckett R, Routledge; and *Making a Difference: Training in Social Care* (1988) with Howarth J, in press, Routledge.
- 2 References have been omitted due to lack of space, but are available from *Social Work Now* or *Protecting Children: Challenges and changes*.

Understanding child abuse tragedies

Sheryl Wilson looks at an analysis of recent research into child deaths in the United Kingdom and discusses the implications for CYPFS

Like other areas of human service work, social work needs continual revision and input from research and experiential analysis in order to establish and maintain its credibility and accountability as a professional discipline. This is particularly important in the current cost cutting, increasingly individualistic and hostile public environment and the intense media scrutiny. Recent research in the United Kingdom by Peter Reder, Sylvia Duncan and Moira Gray highlights new and important findings for social work practice, both about situations which place children at risk and how these should be reviewed. Although centred in the British experience, their research has important implications for the Children, Young Persons and Their Families Service (CYPFS), in the focus of its own case reviews and in the ability of the organisation to learn from such situations.

From their "...respective backgrounds in psychiatry, psychology and social work [and]... a common interest in applying systems ideas to clinical work" (1993a), the team re-examined 35 reviews where children had died from abuse or neglect by their primary caregivers over the past 20 years. Their analysis focuses on the relational and communication processes which were present in each fatal situation. The authors believe these processes have been largely overlooked in earlier work but are just as critical to sound social work practice as competent organisational procedures and structures. Previous reviews have been limited

by their attribution of blame to particular individuals or groups and "...this preoccupation has impaired their capacity to understand how events unfolded in the way that they did" (1993b). By attempting to analyse the interaction of the systems surrounding the children, the authors attempted to find new ways of understanding the context in which they died.

Their methodology includes comprehensive analysis of the reviews and extensive use of genograms to graphically illustrate family structures. They also mapped family relationships over a period of time in order to show the different meanings that the child held for their parents at different times.

The research identifies common themes in the interactional patterns between the family and professional systems which the authors consider contributed to the fatal situations. Overall, they identified three spheres of major interactional significance:

- Those perceived to be present within the dynamics of the family itself.
- Those which existed between the family and the professional systems.
- Interactions which manifested in the inter-professional relationships¹.

Relationship and interactional patterns within the families

Interactional patterns within the families were largely characterised by:

- Issues of dependency and/or control

impacting on the ability of individuals to provide appropriate care for, and control of, their children. Appropriate care, according to the authors' definition, refers to the ability to anticipate "the child's age-appropriate needs and providing for them through ante-natal care, feeding, warmth and protection." (1993a) Control involves "ensuring the child's safety and setting limits to behaviour in a caring way consistent with the child's level of development" (1993a).

- These issues were found to be significant problems in the majority of the cases reviewed, where most parents were unable to meet the child's needs. Reder et al state that many of the parents "found the ordinary dependency needs of their children difficult to anticipate or meet and additional demands intolerable" (1993b). "The fatal episodes were probably precipitated by extra dependency demands placed upon the parents, such as threatened separation between the couple, regression of the child or the presence of a young and needy infant in the family" (1993a).
- 71 per cent of the time natural parents were involved in the deaths of the children².
- Children were regarded as property and their natural parents frequently demanded them home from foster or other alternative care. The authors state, "The period immediately following the children's return home after being in care was often particularly dangerous" (1993b).

Interactional patterns between the family and professional systems

The principle patterns of interaction between family members and professionals were also primarily characterised by care or control

conflicts in the following categories:

Dependency

Dependency occurs when the professional focus shifts towards meeting the dependency needs of the adults to help them improve their ability to care for children. This approach can remove the focus from the child and often obscure the risk to the child and their need for monitoring and protection.

Closure or withdrawal

This is defined as the process by which families withdraw from the professionals (and others) in tense or crisis situations. The authors consider it to be an attempt by families to assume control over their lives and it was evident in over 50 per cent of the cases reviewed. It was, they concluded, the most important indicator of danger to the child: "The association between escalating abuse of the child and parental withdrawal from contact with professionals and others in the outside world was striking" (1993b).

Dependency occurs when the professional focus shifts towards meeting the dependency needs of the adults to help them improve their ability to care for children.

Closure may take many forms. The authors state that "[the families'] curtains were always drawn, the children stopped playing outside and no longer attended school or nursery. The parents failed appointments with professionals" (1993a).

They conclude by stating that, "only in retrospect was it possible to know that the closure was terminal. [Therefore]...all episodes of closure should be considered potentially fatal... Workers should be particularly concerned that the risk to a child is increased when a family in which abuse has previously occurred shows any form of closure" (1993b).

Control issues and closure

"A disturbing phenomenon [of closure] was that... professionals made more determined efforts to see a child after a period of closure, only for the child to be killed within a few days" (1993b). The authors discuss the effects

of professionals attempting to take a more assertive position in their interaction with families and conclude that this action has the potential to actually increase the danger for the child. They go on to state that since it was not possible to predict how a particular family would respond to an increasingly assertive stance from the professional network, increased intervention in these situations had to be carefully considered. Where control needed to be asserted, a lot of control should be used: "Taking a little control may be more dangerous than taking none at all" (1993b).

Flight

This phenomenon is characterised by frequent physical movement of families and is considered to be a form of closure. This behaviour usually leaves professionals disorganised in their attempts to monitor or intervene for the child's safety.

Disguised compliance

Disguised compliance refers to a pattern of interaction which serves to negate professional authority and attempts to assert control by the apparent agreement and compliance of the family. This behaviour is also considered to be a form of closure.

The "Not exist double bind"

This occurred in situations where the child seemed to have ceased to exist in the caregivers' minds and they stopped providing the essentials of life, which eventually and inevitably led to the child's death. This phenomenon is often characterised by reports of the child not being seen, withdrawn from school, etc. The double bind described by the authors occurred when the children had actually died, but professionals remained unaware and became psychologically convinced that the child was alive through reports of parents and/or others. They were "led to the belief that there was no need to worry because the child existed" (1993a).

Interactional patterns between professionals

The major interactional patterns between

professionals were characterised by a wide range of issues, including the following:

Problematic communication

Especially in the sharing of information.

Insecure work setting

The authors comment that, "It is salutary to reflect that the years covered by our review have been characterised by repeated reorganisations in health, social services, education and local government" (1993a). They go on to cite many examples of the probable effects such conditions can contribute to a situation of chronic stress for professionals, which can lead to their becoming dangerous professionals. The situation in New Zealand social work closely parallels this.

Absence of the key worker

In 33 per cent of the cases, critical events occurred at a weekend or public holiday or when a pivotal worker was away on leave.

Closed professional systems

"A group of workers," say the authors, "developed a fixed view about a case and was inaccessible to contrary information or observations. This ... may have comprised a whole agency or a number of professionals or... a single worker" (1993a).

Polarisation of views

This resulted in less and less sharing of information.

Exaggeration of hierarchy

This happens when workers' status relative to each other becomes confused and each comes to believe that others have higher status than them. The authors maintain that in some cases "workers' assumed positions in an inter-professional hierarchy became exaggerated. Professionals with a lower perceived status deferred to the opinions of others who were perceived as hierarchically superior. "Alternatively, the power or status associated with a particular role dominated the case and overshadowed the thinking of other workers" (1993a). An example of this type of interaction within CYPFS would be the common phenomena of social workers deferring to legal opinions in a social work context.

Concrete solutions

The authors refer to an undue reliance being “placed on very practical measures as a means of dealing with or monitoring problems which were essentially emotional...which often became the main intervention for some families” (1993a). For example, the setting up of day care provisions for a child as the major intervention in a case of physical abuse. The authors suggest that the need to offer practical help should be seen as “part of a broader intervention, rather than it being an end in itself” (1993a). These interventions are also discussed by Armytage and Reeves when they argue that this type of strategy often “fails in high risk cases because it transforms complex and chronic family situations into technical problems requiring various forms of intervention on an ad hoc basis” (1992).

Role confusion leading to inaction

“Each worker [believes] that responsibility lies with someone else” (1993a). A clear example exists within CYPFS in relation to the often confused roles between key and co-workers on a case, which can lead to no effective action at all, as each assumes that the other worker is completing the necessary tasks.

Information treated discretely and in isolation from other information

When this happens, no coherent overview emerges.³ For example, when a focus on the current intake does not take note of the history of other intakes and/or information. As the authors state, “The assessment process only has meaning when all information is pooled together and allowed to contribute to an overall and multidimensional picture. Details about the past history and the present circumstances need to be integrated to provide a context for understanding all new knowledge” (1993a).

Selective interpretations

Selective interpretations, which were recognised in the reviewed cases, were

manifested in a variety of ways. Described as similar to the rule of optimism⁴, the workers think the best of parents and this optimistic presumption colours their assessment. This phenomenon also occurred when “workers accommodated to conditions of hygiene and care by parents that later were recognised as appalling” (1993b).

Pervasive belief systems

When pervasive belief systems were in existence and influenced decisions made about children. An example of this might be the belief, held until recently in New Zealand, that parents always love their children.

Warning signals

Warning signals were given by some parents in the reviews, although these only became clear

When parents who have previously abused their child hint that abuse is recurring, it should be taken seriously.

in retrospect. The authors concluded that when parents who have previously abused their child hint that abuse is recurring, it should be taken seriously. Reder et al mention that some

“practitioners have understood, that, because the parents have verbalised their tensions, they are less likely to enact frustrations through abusive behaviour. There seems to be little substance in this belief and we infer that both covert and overt warnings of risk should be taken as sign of danger to the child and not the reverse” (1993a). There are some parallels in the context of suicide risk prediction, where talking about committing suicide does not prelude the possibility that an actual attempt will be made.

Implications for CYPFS

If CYPFS is to benefit from the reviews it conducts after child deaths, it will need to develop further initiatives to promote the widest and most constructive learning. Reder et al highlight the profound and often damaging effects of poor and ineffectual interactional patterns between professionals, with clients and within the client families themselves. This awareness must be

incorporated into the organisational knowledge base in an on-going way.

The following points highlight some of the areas which need to be incorporated into our daily practice on a consistent and continuing basis along with suggestions on how this may be achieved.

Casework practice

Focus on analysis and assessment

One of the most fundamental ways that the findings of this research can be adapted into the practice of the Service is through the development and application of a more sophisticated level of analysis for assessment, investigation and reassessment. The authors maintain that the importance of history cannot be overemphasised. For CYPFS this means that social work must be encouraged and enabled to develop a practice base to provide the means for wider analysis and understanding of the common casework issues and situations. It must allow staff time to consider how to approach complex cases in considered and informed ways.

Focus on risk management

The findings show that insufficient emphasis was placed on risk assessment in many of the cases. This is a critical part of the analysis process when patterns and evidence of risk need to be analysed, both over time and across the many systems that interact within the child's life, including the interactional patterns identified by Reder et al. CYPFS needs to provide adequate resourcing and training to ensure competent and effective risk analysis – especially with the introduction of the Manitoba Risk Estimation System.

Psycho-social assessments

The importance and effectiveness of full psycho-social assessments has been widely demonstrated in social work practice. They are a very useful means of collating the analysed and accumulated information on a client as well as providing an overview of their historical and current issues. CYPFS needs to develop a policy and practice in regard to their widespread and consistent use as major tools in analysis and assessment. It

also needs to provide sufficient resourcing to enable their development, both in terms of personnel and appropriate electronic systems.

Sighting the child

We must continue to reiterate the critical need to sight the child initially and on a continued basis where intervention continues.

Care and control conflicts between professionals and family members

These were identified as major contributory factors in the fatal situations and have special and important significance for a statutory agency. It is critical for social workers in this Service to have a clear understanding and awareness of these conflicts, including the vested interest people often have in lying to a statutory worker⁵.

Statutory mandate

The research also clearly highlights how important it is for CYPFS social workers to have an explicit and unequivocal understanding of the statutory mandate to protect children and the rights and powers given to them to enact this.

Changing the intervention stance

The research indicates that where the professional intervention changes toward a more controlling and increased involvement in the life of a family, when closure or other risk patterns are emerging, this may actually increase the risk to the child/ren, as it adds to the level of stress or crisis in the family. This highlights the need for careful case analysis to detect and identify these patterns as they emerge. Careful planning for further intervention needs to take place at that time and the research suggests that, where a more controlling intervention is warranted, then a lot of control should be taken rather than a little.

Care and control conflicts within the family

The authors stress the critical need for a means to assess the way that care and control conflicts dominate family relationships. They suggest the framework developed by Reder and Lucey (1991) which includes the assessment of factors such as parental relationship with the child, the parents' relationship to the role of

parenting, influences from the family context and contact with the external world. Some of this analysis is contained in the MRES system, although the Reder and Lucey framework appears more extensive. The two systems could be used in combination.

Case conferences

The Service needs to develop a policy and practice which includes more extensive use of case conferences to ensure wider and more effective communication practices between all professionals involved. Effective case conference discussion, planning and recording should help to preclude most of the problematic communication problems highlighted by the British research.

Key and co-working practices

These must become clearly delineated in each situation to reduce role confusion within the Service. All decisions about task responsibility must be clearly recorded in a transparent and accessible way in conjunction with the case manager.

Use of genograms

The work of Reder et al highlights the usefulness of genograms in the analysis process. Genograms graphically represent the family structure, enabling a visual and immediate picture to disseminate information and ideas. Many adults learn through graphic means and genograms could form an important and much more widely used methodological tool in case work analysis⁶.

Training opportunities

Once available and collated, it is important that case review analyses and findings are translated into the appropriate training packages for dissemination to social workers throughout New Zealand.⁷ CYPFS needs to encourage the development of training packages that would enable whole teams, patches and/or sites to participate simultaneously. This would lead to a greater rate of absorption of the new information and skills into practice methodology. When one or two individuals attend a training course the benefit they receive is often lost following their return to the workplace.

Case review practice

Case review terms of reference

The British research strongly indicates the need for case reviews to include a greater focus on an analysis of the interactional and communication patterns as significant contributory factors in child abuse tragedies. This focus should be actively incorporated into the terms of reference for case reviews on a consistent and on-going basis⁸.

Distribution of case review analyses and findings

Where recent similar tragedies have occurred in New Zealand, a number of case reviews have taken place. Most of the feedback in these situations has been limited only to those directly involved, except in some situations where the case has attracted significant media attention. While it is important that the feedback process be handled sensitively for all those directly involved, important learning opportunities are missed when this process is inconsistent and limited to a small number of people.

The practice of social work demands accountability and scrutiny, increasingly in a public arena. As an additional form of practice, case reviews have validity if they are conducted in ways that are consistent and have a "greater correlation between the recommendations which evolve from individual inquires and corresponding action and if they can be seen to play a constructive part in protecting the lives of vulnerable children" (Armytage and Reeves 1992).

Staffing issues

Support for staff

The authors contend that most social work is carried out in an emotional and stressful context, where "neither society nor government demonstrably value[s its...] efforts" (1993a). It is critical, therefore, for a social work agency to demonstrate that it values and supports its staff to help counter the "backdrop of appalling resources, severe underfunding, little social or political encouragement and ever changing organisational structures" (1993a). These issues also concern New Zealand social workers, hence it is important that this organisation demonstrably values and

supports its staff and the work they are engaged in.

Stressful work

There must be recognition of the inherently stressful nature of social work and the debilitating effects of this on a worker's ability to recognise danger for children. "Increasing attention needs to be paid ...to supporting staff and legitimising structures that reduce stress" (1993a), to include such basic factors as regular individual supervision, monitoring of staff morale, provision of outside consultation and improved recruitment and retention practices.

Health and safety factors

These are critical issues for the social work profession, where work is carried out in highly stressful and often dangerous situations, both within and outside the office. The Service has attempted to implement a Dangerous Situations strategy to address some of these factors, but this remains inconsistently applied across the country. The issues of social work safety need to be given the highest priority.

After-hours service

The British findings clearly highlight the need for an effective after-hours service to ensure workers have full access to casenotes, electronic recording system, supervision and other essential resources. This is vital to ensure that all assessments or judgements about new interventions are made in the context of full knowledge of the preceding interventions and by staff members who have not already worked a full and busy day. This need was also acknowledged in the recently published Auckland Metro report. ■



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Notes

- ¹ Those familiar with the writing and teaching of Tony Morrison will recognise some parallels in his work on professional dangerousness.
- ² Reder et al note that this is at variance with the belief that stepchildren are particularly at risk.
- ³ A significant factor identified in a number of case reviews conducted in this country following the deaths of children.
- ⁴ Dingwall et al (1983).
- ⁵ Highlighted by Ian Hassell in his review of the death of Craig Manukau.
- ⁶ Readers attention is drawn to an article in the third issue of this journal, 'Family Trees Revisited' Scott S et al pp 24-27.
- ⁷ I am aware that most training units across the Service nationally have incorporated the work of Reder et al and other New Zealand analyses into training packages. The suggestions made in this article are in no way meant as a criticism of this work, rather an extension of it.
- ⁸ Chief Social Worker Mike Doolan highlights this problem in *Exchanges* 10 May 1996 and suggests some resolutions for CYPFS.

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Overseas adoption: Profile of a parent

Susan Smith offers a demographic analysis of people wishing to adopt a child from overseas

Over recent years, many assumptions and attitudes have grown up around inter-country adoption not the least because of increasing media debate and public discussion. Generalisations about the people who participate in this type of adoption abound and as social workers we are by no means immune to these opinions. This paper is an attempt to give social workers a clearer idea of the characteristics of people who adopt from overseas.

The research

The data comes from 85 homestudies completed in Aotearoa/New Zealand for prospective inter-country adoptive parent/s between 1 July 1995 and 30 June 1996. A homestudy is used to help match children with adoptive applicants in the child's birth country. It contains basic demographic details surrounding the prospective adoptive family and more in-depth discussion of child rearing patterns, motivation and attitudes towards other cultures. It will also recommend approval, or otherwise, of the applicants, although a positive recommendation does not guarantee an adoption will proceed. Data on how many of the 85 applicants have progressed beyond the homestudy stage is not yet available, however the studies will hopefully form the basis of a future longitudinal study.

International demographic data

Prior to discussing the findings, it is useful to consider the current international research which shows that there is a characteristic group of inter-country adoptive applicants. The following tables (*see over page*) contain

demographic information on the adoptive parents in a selection of studies. The research is from a variety of countries and the data was collected as a background to the main impetus of the studies. Although they have not been collected in directly comparable units, the results give a good indication of who the adoptive applicants are. This enables the findings to be used as a framework against which the homestudy findings can be considered.

The tables suggest that internationally there is a typical group of people who apply to be inter-country adoptive parents. The majority are between the ages of 30 and 40 years (although significant numbers of people older than 40 also apply.) A high proportion of applicants are tertiary educated and in highly skilled occupations. The income ranges reflect this, with incomes noted to be well above the average in most countries. Applications are predominantly received from couples, most of whom are married and have been so for some time. Single applicants seem to constitute around five to six per cent of applications. Most have had prior parenting experience and – for many – this is with children born to them.

The motivation for inter-country adoption is a complex issue and difficult to define. Not surprisingly therefore, few of the studies attempted to include it. As many of the applicant families already had their own birth children, childlessness did not appear to be a primary motivating factor.

Only one study commented on the applicants' attempts to adopt locally and showed a slight trend towards trying this option first.

Adoptive parents in overseas research

Study	Demographic Information		
	Age	Marital Status	Children
Harper (1986:29) <i>NSW, Australia</i>	parents older than usual		60% had children born to them 50% had other inter-country adopted children 20% had children adopted locally or fostered
Harvey (1983:59) <i>NSW, Australia</i>		few were previously divorced	most had previous experience with children
Hoksbergen, Juffer & Waardenburg (1987:22-6) <i>The Netherlands</i>			The families of the study on average had 2 children 24% had ≥ 1 born to them 76% of families only had adopted children 8% had only one adopted child
Jaffe (1991:173) <i>Israel</i>	average age of male 38yrs and of female 37yrs	95% married and on average for 8 years 5.4 % single applicants	66% had one other child 5% had two or more children
Marcovitch (1995:1001-2) <i>United States of America</i>	mean age: female 38 yrs male 41.6 yrs < 30 yrs: female 4% male 2% 30-39: female 63% male 56% 40-49: female 31% male 36% > 49: female 2% male 6%	93% married 1 defacto 6% single	62.8% already had ≥ 1 child (either adopted or born to them)
Rorbech (1991:129-30) <i>Denmark</i>		majority of applicants were two parent families	most already had children, half of whom were born to them
Saetersdal & Dalen (1991:88) <i>Norway</i>		most applicants were married and had been for over ten years.	one third of applicants had no children half of the couples already had children born to them one third of the couples later had more children, majority of whom were adopted
Textor (1991:113-4) <i>West Germany</i> 31.5% > 40 years old	1.5% < 30 years old 67% 30-40 years old		
Tizzard (1991:747) <i>United Kingdom</i>	Generally older than other parents		
Verhulst, Althaus & Versluis-den Bieman (1995:153) <i>The Netherlands</i>			

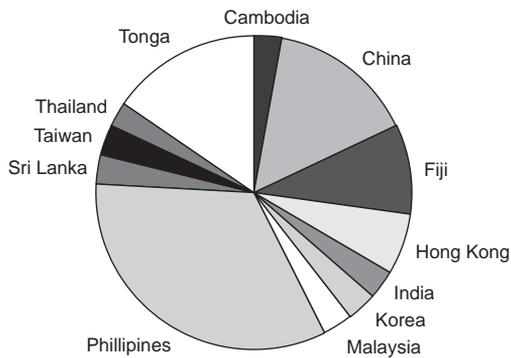
Study	Demographic Information			
	Occupation and/or Education	Income	Motivation	Local Adoption Pool
Harper (1986:29) <i>NSW, Australia</i>				
Harvey (1983:59) <i>NSW, Australia</i>		somewhat privileged	few couples were infertile	
Hoksbergen, Juffer & Waardenburg (1987:22-6) <i>The Netherlands</i>	educational levels markedly higher than Dutch population norms low women 20% men 9% middle women 57% men 41% high (University) women 23% men 50%		75% motivated by internal reasons; family orientated; involuntarily childless or educating a child considered part of life fulfilment 25% motivated by external reasons; refusal to contribute to an already over-populated world or wish to assist children of poorer nations.	
Jaffe (1991:173) <i>Israel</i>	70% post High School education 41% University 9.5% reached Grade School level	incomes above average		30% on local waiting list 30% rejected from local list 40% not applied locally
Marcovitch (1995:1001-2) <i>United States of America</i>	tertiary educated: 72.2% female 76% male employed: 63% female 98% male	< \$US 50,000 21% \$US 50-69,000 29% > \$US 70,000 50% (> \$100,000 27%)		
Rorbech (1991:129-30) <i>Denmark</i>				
Saetersdal & Dalen (1991:88) <i>Norway</i>				
Textor (1991:113-4) <i>West Germany</i>	45% University graduates	lower-middle 3% middle 22% upper-middle 65% upper 10%		
Tizzard (1991:747) <i>United Kingdom</i>	more highly educated than other parents	generally middle class		
Verhulst, Althaus & Versluis-den Bieman (1995:153) <i>The Netherlands</i>	using a 6 step occupation scale (low) 1 - 6 (high) 1 - 2: 8.8% 3 - 4: 24.7% 5 - 6: 66.5%			

Homestudy trends

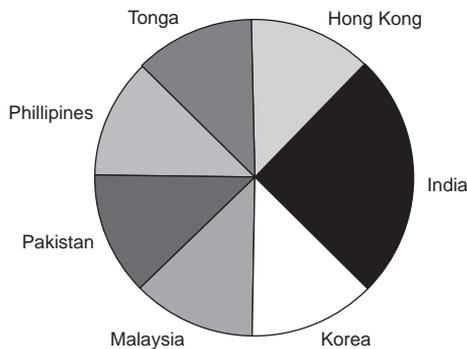
The Aotearoa/New Zealand homestudies included a range of adoption requests from applicants wishing to adopt relatives (39 per cent), non-relative adoptions of children of a similar culture (nine per cent) to non-relative adoptions of children of a different culture (52 per cent). The range of countries being applied

to varied markedly between these different categories, with only Hong Kong and Fiji appearing in all three adoption groups. This may be a reflection of the number of immigrants from these countries within Aotearoa/New Zealand, together with their comparative accessibility.

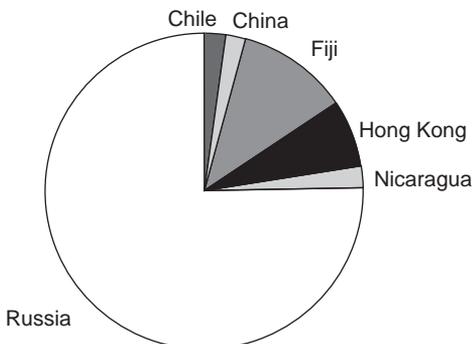
Country Distributions in Relative Adoptions



Country Distributions in Non-Relative Adoptions (Culturally Similar)



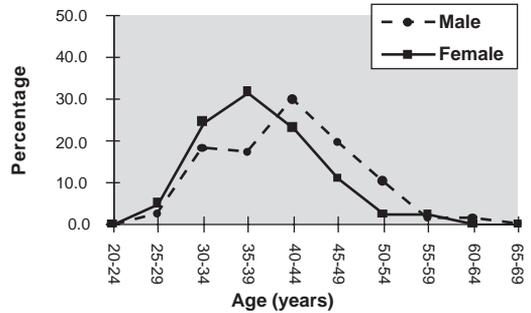
Country Distributions in Non-Relative Adoptions (Culturally Similar)



Age

The prospective adoptive parents' ages held closely to the international sample. The average for women was 39 years (range 25-57) and for men 42 years (range 26-63).

Age Distribution of Inter-Country Adoptive Applicants



Marital status

Of the individual applications, all were from women and totalled nine per cent of the homestudies. Couple applicants had been together on average for ten years (range 1 to 24 years). Of the homestudies that included information on previous marriages, 59 per cent of couples were in their first marriage (for both partners). The other 41 per cent had a combination of previous marriages, ranging from one to three. Since only one of the international studies commented briefly on previous marriages, a comparison with these statistics would be of limited use.

Children

Two-thirds of the applicants in the homestudies had prior parenting experience which, again, is very similar to the international research examples.

Source of children

Source of children of applicants	Percentage %
No children	39
Present marriage only	39
Previous marriage/s only	17
Present and previous marriage/s	5

Origins of children

Origin of children of applicants (61% of sample with children already)	Percentage %
Children born to them only	71
Adopted (local) only	2
Adopted (inter-country) only	14
Born to them and adopted (local)	7
Born to them and adopted (inter-country)	4
Adopted (local and inter-country)	0
Born to them and adopted (local and inter-country)	2

Applicants in present and previous marriages had equivalent proportions of children adopted or born to them. However all inter-country adopted children were adopted within the current marriages. The most common number of children (mode) within these families was one (with the total range being from one to eight children). The number of children currently living with the families was also most commonly one (this range was 0 to 8).

Occupation

The New Zealand Standard Classification of Occupations (1995) was used to assess the distribution of occupations of the prospective applicants. This system is used for the New Zealand census and works by assigning a value to occupations according to their pre-assessed skill level. The classification system has nine major occupational groupings and, as data on employment within the homestudies was limited, the use of the more detailed divisions was not considered feasible.

The nine major occupational groups are:

1. Legislators, administrators and managers (highest level of skill).
2. Professionals.
3. Technicians and associate professionals.
4. Clerks.
5. Service and sales workers.
6. Agriculture and fishery workers.
7. Trades workers.

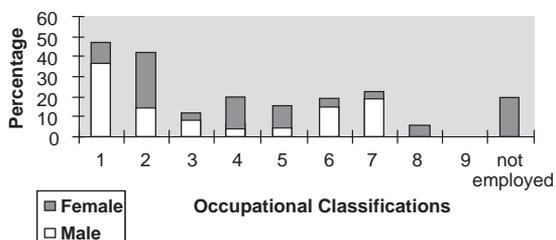
8. Plant and machine operators and assemblers.
9. Elementary occupations (lowest level of skill).

A tenth group was included to encompass those who were not in paid employment. These occupational groups are illustrated in the two graphs that follow.

Distribution of Occupations in Relative Adoptions



Income Range of Adoptive Applicants in Relative and Non-Relative Adoptions



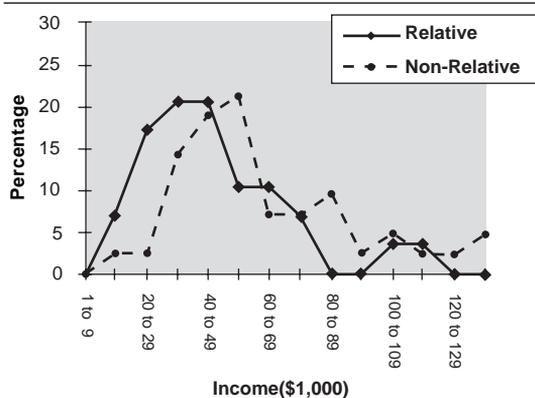
A comparison of the two graphs clearly shows a skewed distribution in favour of level one and two occupations in the non-relative adoption group, and of the lesser skilled levels in the relative group.

Income

Income levels were determined in relation to each homestudy. Single applicants, therefore, were not differentiated as their one income still constituted the source of total financial support for any child. The average income was \$56,100 pa. If the group was divided into relative and non-relative adoptions, the income levels showed significant disparity. Adoptive applicants in relative adoptions had an average family income of \$46,200 pa. While the average family income in non-relative adoptions was

\$62,800 pa. This was, therefore, consistent with the greater proportion of highly skilled occupations among those applying to adopt a non-related child born overseas.

Income Range of Adoptive Applicants in Relative and Non-Relative Adoptions



Motivation

As mentioned earlier, the collection of data on motivation is extremely problematic. Rarely is it explicitly stated and the interpretations of any social worker writing the homestudy is likely to be subjective. The motivation categories fall broadly into seven areas, with some applicants stating more than one reason.

Motivation 101 answers

Physical (medical inability, primary infertility, secondary infertility, hereditary birth disorder)	46
NZ life (education, health care)	18
Family (bereavement, disturbed family life, family commitments, illness, gifted)	14
Local pool (few children, perceive themselves too old to be considered)	10
Concern for others	6
Cultural (similar to parents, other inter-country adopted children in family, language)	5
Specific gender	2

Local adoption pool

Since issues around adopting from a local pool have been shown to be a motivating factor for inter-country adoptions, it is interesting to note how many of the applicants had attempted to adopt locally. While unfortunately only 56 of the 85 homestudies included this information, nine of these applicants (16 per cent) had been or were currently in the local pool. Of the ten homestudies which stated that availability or access to the local pool were elements that had influenced their decision to look abroad, only one was in the local pool and had been for nine years.

Further demographic information

Additional data was collected from the homestudies which, although not able to be compared with the international research included in this paper, does help to give an understanding of the New Zealand applicants in inter-country adoption.

Religion

37 of the 85 homestudies included a reference to the applicants' religious beliefs (44 per cent). However it was not noted whether these were actively practised. Stated faiths included Anglican, Assembly of God, Bahai, Baptist, Catholic, Christian, Church of Christ, Hindu, Jehovah's Witness, Latter Day Saints, Muslim, New Life, Presbyterian, Protestant, Reform, and Sikh.

The adopted child

The majority of the applicants had a specific child they wished to adopt (64 of 85). Approximately half of these were applicants wishing to adopt a relative. Of those who did not have a specific child stated, a few did have a preference for gender (one boy, five girls).

Most (74 per cent) of the prospective adoptive applicants applied for only one child (range 1-3). Applicants who had not parented before were more likely to apply to adopt more than one child.

Discussion

85 homestudies is not a large enough sample to suggest a definitive trend in Aotearoa/New

Zealand. However, they do represent all the homestudies produced in a distinct financial year and – when used in combination with the international research comments – do provide a fair picture of the people applying for inter-country adoption.

While the data generally mirrored the international information, the main difference was in the analysis of income and occupation. In Aotearoa/New Zealand, two distinct groups of prospective adoptive parents were shown. The income and occupational levels of those considering adopting a non-related child conformed to the international statistics. But parents wishing to adopt a related child were shown to have, on average, a family income that was a third lower. This was supported by occupational distribution which noted 70 per cent of these applicants in lower skilled jobs (levels 6-9) or not employed. By comparison, the data indicated that only 30 per cent of applicants seeking non-relative adoptions were in similar occupational levels or without current employment. It may be that the outside pressures of family commitments caused applicants seeking relative adoptions to pursue an inter-country adoption with less regard to their financial ability to provide. Alternatively, the countries which non-related adoptions tended to be from, by their geographical location or access-associated fee structure, may have precluded those with lower incomes from applying.

The purpose of this paper is to provide social workers with a guide as to who are the people applying to adopt children from overseas. While every family involved in inter-country adoption has a unique story, this demographic information can serve as a baseline against which we can reflect upon our personal views and challenge some of the assumptions we may hold. ■



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Note

In the next issue of *Social Work Now*, Susan Smith researches the literature to gauge the issues which can affect an inter-country adoption post-placement.

Linking residential and community treatment for adolescent sexual offenders

Ian Lambie, John McCarthy and Marlyn

Robson summarise some of the main issues in linking treatment in the proposed specialist unit to community programmes

The recommendations arising from this article are:

1. Family therapy is essential in comprehensive treatment programmes for adolescent sex offenders.
2. A need exists for specialised caregivers in safe houses to enable adolescents assessed as inappropriate for residential treatment to be placed in the community for short and medium term stays. These placements would allow the young people on-going contact with their families while therapy continues.
3. Specialised community treatment programmes are needed to provide relapse prevention treatment for adolescents once they have been discharged from the specialist residential treatment programme.

It is argued that the current mobile team project operating provides an ideal model for future services.

It is recognised that a small number of adolescents will require treatment within a specialist residential facility.

Introduction

Over the past ten years there has been increasing recognition worldwide of the need and benefits of providing treatments for sex offenders as well as of the range of sexual offenders, and their differing treatment requirements. These include female, intellectually disabled and

adolescent sex offenders.

In 1986, the American National Task Force on Juvenile Sexual Offending was set up (ATFJSO 1993) to provide direction for standards of assessment and treatment for adolescent sex offenders. It recommended a broad spectrum of services to cater for this offending. A comprehensive range of treatment services is important to enable each adolescent to receive the appropriate care for their specific offending. These services would cater for the needs of both the clients and their families, while not excluding the safety of the community.

Linking residential and community placement with the mobile team project

In New Zealand, as in many countries, the treatment services for adolescent sex offenders have lagged behind those of North America. The earliest programmes to provide comprehensive treatment for adolescent sex offenders in New Zealand were the Leslie Centre in Auckland (now operating as SAFE) and the STOP adolescent programme in Christchurch. Both programmes, although different, provided services that encompassed the core treatment recommendations of the American Task Force for family, group and individual therapy.

Adolescence and the needs of families

Adolescence is a time to explore identity and

independence and to start to detach from the family of origin. It is the time to develop age-appropriate peer relationships both of the same and opposite sex. In doing this, adolescents are able to develop an understanding about intimacy and sexuality. Another task is for young people to achieve training and a work direction to support themselves and their future family. These are the normal tasks that adolescents need to accomplish in order to function in society, and treatment programmes need to take cognisance of them.

Despite the fact that adolescents are wanting to develop a sense of independence from their family, they obviously still remain very connected to them. It is impossible to treat the offending without providing assistance to their family as well.

Each adolescent also has a need for connectedness or attachment to significant others and this needs to be assessed and encouraged where appropriate (Fredrich 1995).

The extended family system of the adolescent sex offender has shaped their beliefs and behaviour patterns. There may also be multigenerational abuse and/or dysfunction that influence the developmental history of those individuals who become victims or perpetrators. Family members are role models for future relationships, and/or allow a system that supports the occurrence of sexually deviant experience and behaviour.

Families may be supportive – or otherwise – of treatment, but therapists must (and usually can) engage families in treatment. Regular family therapy sessions are an essential part of any adolescent treatment programme and the effectiveness of work with the young person is often directly linked to the family's attitudes and beliefs and to their willingness and ability to attend counselling with their child. Where family engagement fails, and especially where there is multigenerational abuse, helping an offender separate from their family of origin and then dealing with the ensuing issues of

grief and loss becomes the primary task. If multigenerational abuse does exist, the aim must be to prevent this continuing in the next generation.

In discussing the treatment settings of adolescent sex offenders, our aim is to canvass a range of community and residential-based options cognisant of the importance of integrating these services to meet the particular needs of adolescents and their families.

Safe placement options in the community

It has long been accepted as good social work practice in the sexual abuse field to separate the offender and the victim following a disclosure of abuse. However a major barrier to this is often the lack of appropriate community

placements for the offender. Often the adolescent is unable to be placed within their wider family due to the presence of other children. Ideally, the adolescent should not live with other young children, at least until appropriate treatment is underway and safety concerns have been

fully addressed. It is important to note that all young children are at risk, not just the initial victim.

Some adolescents may not have offended to the level where admission to a specialist residential treatment facility is indicated. Additionally, there may be many more adolescent sex offenders than available spaces at such facilities. The proposed national treatment centre is designed to treat around 12 adolescents at any one time. In 1993, the police dealt with nearly 250 children and young people for sexual offences (Erickson 1995). A problem remains over what to do with the adolescent who cannot be safely placed in their family but is also unable to be placed in residential treatment.

Sexually offending adolescents are currently placed in residences such as youth

It has long been accepted as good social work practice in the sexual abuse field to separate the offender and the victim following a disclosure of abuse.

trusts, general foster care, or those of the Children, Young Persons and Their Families Service (CYPFS). None of these provides the adolescent with the treatment environment required to facilitate therapeutic change. Youth trusts and general foster care are often the refuge of young people who are *victims* of sexual offending. To place an adolescent sex offender into these situations creates unnecessary danger and discomfort for those victims. Particularly vulnerable are younger sexual abuse victims whose acting out behaviour may well be sexualised. In such an environment, the adolescent offender is set up to fail as the chances of reoffending may be greatly increased.

Non-specialist secure institutions are also currently not well-equipped to deal with the needs of this client group. Full disclosure of all offending by the adolescent is a crucial initial stage in the treatment process. Yet the admission of sex crimes against children can create danger for inmates in custody, making a full disclosure most unlikely. If adolescents in secure facilities do make this disclosure, even in a confidential treatment setting, it could leave them at risk of physical assault from other inmates.

Often the same staff are expected to fulfil conflicted roles – both custodial and therapeutic – creating confusion for staff and adolescents alike and making it difficult for a climate of trust to develop. The overt authority of the institution may increase the adolescent's sense of aggression, once again making the fostering of a therapeutic relationship extremely difficult.

An alternative option is the development of a small number of specialist caregivers in communities where the adolescent can live safely, have their behaviour monitored, and attend appropriate community-based treatment. Such placements would need to be staffed through a careful selection process and by people experienced in caring for adolescents. They would need specific training regarding the dynamics of sexual offending and may, from time to time, be involved in the adolescent's treatment.

Supervision and support of these caregivers

would be essential and, ideally, provided by the staff of the community treatment programme attended by the adolescent. At all times, close liaison between caregivers and treatment providers would be essential. The placements should contain no children less than 12 years of age, nor any children who have been sexually victimised. To ensure the safe monitoring of the adolescent's behaviour, the numbers residing in a house should be kept to a minimum (for example, a maximum of four to six adolescents in each house).

These facilities would also allow the adolescent to remain in a more true to life living environment where risky behaviours can be monitored more realistically. In addition, should eventual family reunification be part of the plan for the adolescent, such a placement allows for an easier transition back into their home environment.

Another potential use for these placements would be as a transition stage between specialist residential treatment and eventual return home. In this way they become part of a treatment continuum offering a range of options to better cater for the particular needs of the adolescent.

Issues arising from treating adolescents in a residence

Generalisation and maintenance of behaviour in the community

While community treatment can cater for the majority of adolescent sex offenders, there is an identified group of high risk, hard core offenders who for reasons of public safety, and to ensure that their particular needs are met, require long-term, residential treatment. This need was echoed in a report commissioned by the Department of Social Welfare (Erickson 1995).

Epps (1994) describes several effects of institutionalising adolescent sex offenders including loneliness at being removed from family and friends, and being deprived of age-appropriate situations to which they can fantasise and masturbate. It is well recognised (eg Bullock, Hosie, Little and Millham 1990; Hansen, Watson-Perczel and Christopher 1989; Epps 1994; Fagan 1990) that one of the

most intractable issues facing the treatment providers of residential programmes is that of generalisation and maintenance of behaviour once treatment has terminated there. Generalisation is the transferring of behavioural change occurring in one setting to another. Epps (1994) cites generalisation and maintenance as being one of two institutional problems that arise in the residential treatment of sex offenders (the other being staff motivation). Fagan (1990) found that of 227 adolescent offenders at three year follow-up, those less likely to reoffend had services targeted at community reintegration. He concludes by saying, "Inadequate care and supervision following release apparently increase recidivism probabilities, especially in contrast to reintegration services with intensive treatment in a transition residence and close supervision in the community."

In settings where young adolescent sex offenders are placed in institutions for community safety, the problem of generalisation is difficult to address. However a number of techniques can be employed to increase generalisation. These include: the implementation of procedures and policies that encourage and facilitate family, significant others and friends to visit the adolescent; having regular, supervised outings outside the residential centre; and including family and significant others as part of the adolescent's treatment while in residence and in community follow-up. The highest risk of recidivism is constantly cited as being in the initial six months following release (Greenfield 1985; cited by Fagan 1990). Therefore, by applying intensive follow-up particularly in the early stages post-residence, the likelihood of reoffending is reduced. Emshoff, Redd and Davidson (1976) also found that providing social work services on follow-up enhanced generalisation of the adolescent's behaviours.

It is evident then, that a need exists within

residential treatment programmes to provide community after-care following an offender's completion of a residential programme. In addition it is imperative that on-going follow-up and relapse prevention treatment occurs within specialised community sex offender programmes. Such programmes have already been established under the mobile team project. For those adolescents receiving residential treatment, ensuring that intensive community treatment and follow-up occurs is not only increasing the cost effectiveness of the residential-based treatment but also increasing the likelihood of community safety through lower rates of recidivism.

Linking residential and community placement with the mobile team project

Until a national residential treatment centre for juvenile sexual offenders is set up, some of the CYPFS government funding has been redirected to the Community Funding Agency (NZCFA) for a mobile teams

By applying intensive follow-up particularly in the early stages post-residence, the likelihood of reoffending is reduced.

project. These teams are providing treatment for abusers, some of whom may be deemed serious enough to warrant residential treatment, until the new unit in Christchurch opens. Three main teams operate out of Auckland, Wellington, and Christchurch with others in a range of smaller centres such as Thames, Tauranga, Whangarei, Hamilton, New Plymouth, and Dunedin. The mobile teams have enhanced treatment services in some rural areas through subcontracting and have also enabled the three main contractors (SAFE, STOP Wellington and STOP Christchurch) to develop existing services. So an additional benefit has been to strengthen existing services and develop new ones.

Of equal importance is the model which the mobile team project provides for the future linking of services between the specialist treatment unit and community programmes. It could provide the residential centre with

established service providers in the community who are skilled in the treatment of adolescent sex offenders. It can ensure appropriate programmes for adolescent sex offenders in the residence through skilled assessments by clinicians who are the first point of contact for referral. In addition, it can provide community-based follow-up for the residential centre. It is hoped that by ensuring a range of treatment services the treatment of adolescent sex offenders in New Zealand will be enhanced. ■



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Marlyn Robson is a family therapist in private practice. She works on the SAFE adolescent sex offenders programme and has worked with adolescent sex offenders for the past four years. Marlyn has run training workshops at a national and international level on adolescent sex offender treatment.

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Note

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The importance of being mentored

Angela Keenan discusses the value of a mentor relationship

I mentor and I am mentored. In fact, I've been mentored for years. I was initially mentored by a dedicated and experienced school teacher. Then for some nine years I was mentored by one of my university lecturers, who now couples as a great colleague and good friend. In business I have been mentored by a management consultant who coached me in lifting my business game. I've also had mentors for sport. A fine New Zealand Davis Cup tennis player provided me with a fitness programme when I was just 13 and, while it has been somewhat adapted to suit an ageing player, the core strategy remains with me today.

Over more recent years there has been some role reversal. I have mentored young teachers, a couple of post graduate university students, a handful of training consultants and several people experiencing career transition.

I mentor because I am motivated by positive thinking and concern for others, as well as the opportunity to coach. It is also because I am able to help and support someone with what they need. While I always regard being asked to mentor as a privilege, if I know I cannot help someone to achieve their goals, then they are best mentored by someone who can.

A mentor listens, encourages and supports; they uncover resources and options, ask questions and tell stories; they limit advice, eliminate "should" and – above all – keep confidences. Confidentiality is paramount to the relationship: trust is a given. If trust is broken, so is the relationship.

The mentoring process

In the context of developing a mentoring relationship with an aspiring social worker, our

first task is to schedule some uninterrupted time to get to know each other. Initially, regular and flexible contact is important – both formal and informal. For example, seeing each other once a week, using e-mail, sharing family dinners, visiting work environments together and shadowing at appropriate meetings can all be worthwhile.

Such liaisons provide ample opportunity for the mentor to listen to career concerns and aspirations. We work together to identify and understand competencies and capabilities. This leads us to evaluate appropriate social work options, discuss further learning opportunities and then plan a strategy for career direction. Often the immediate goal is securing social work employment that fits with current work experience, qualifications and family life style.

This might sound easy, but often there are differences in language, customs and values; there is an organisational culture, a work ethic and a professional disposition that may all need some social work alignment.

Central to achieving the immediate goal of social work employment, is developing a network of professional contacts in this field. It is also important to promote intentional learning through coaching and stretching experiences, to polish documents such as a curriculum vitae, and to engage in psychodrama to prepare for interviews, counselling sessions and client meetings.

My mentor responsibilities include discussing strengths and developmental needs. I will provide honest and specific feedback on technical and interpersonal competence as perceived by potential clients, colleagues and decisionmakers.

We must make a real effort to share more than just how to do things the right way. Sharing with my mentoree how I have done things wrong will create opportunities for analysing the realities of social work challenges such as juggling the dimensions of caseloads, report writing, conferences, meetings and part-time study. This is when mentorees stretch and reach for answers, they learn and come up with more questions.

Storytelling also helps build rapport. We share real life stories as personal scenarios while anecdotes offer valuable insights. We also need to make a conscious decision about the mix of social work and personal information we choose to share.

My mentoring relationships also facilitate my own learning. I appreciate receiving honest and specific feedback and realise my mentoree is not the only one being mentored. For example, I've learned how vital it is to have the knowledge and skill to help and to make sure I have the time that it takes to be a real mentor.

I prefer a mentoring relationship that is not imposed or prescribed. I like it to emerge and close naturally. Once you feel you have done what you can, then step aside. Knowing how far to go and when to quit is important.

One recent mentoree, who embarked on career transition, has become a success in their own right. At the time of writing, they are enjoying a satisfying and rewarding work

experience. Through their own sincere determination to succeed they have evolved a developmental view of continuous learning and of the integrity of leadership.

Recently, after this mentoree asked if I would meet with one of their friends, it transpired that it was not my particular skills they needed; which takes me back to where I began. Mentoring is a privilege. Only do it when you sincerely believe you can contribute, add value and make a difference. ■



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She has a strong interest in staff coaching and development and, having completed her Masters honours degree in programme evaluation in the New Zealand business training environment, has a passion for programme evaluation, education, training and customer relationships.

Note

The original basis for this article first appeared in *Update*, the monthly Wellington newsletter of the NZ Association for Training and Development, PO Box 2203, Wellington.

Court reports and a parent's right to read them

Does a parent's right to read specialist court reports on their child overshadow the child's right to have the court protect its best interests?

Stewart Bartlett examines the evidence

In *DSW v H* (Family Court, Upper Hutt, CYPF No.478043, 7 March 1997) Her Honour Judge Moss faced up to the conundrum presented by ss191 and 192 of the Children, Young Persons, and Their Families Act (CYP&F Act) 1989.

Those provisions deal with reports provided to the court by people such as psychiatrists, psychologists and medical practitioners (s178) and social workers (s186). They provide a code governing the disclosure of reports prepared by these groups for the court, to people who have an interest in the proceedings.

Mr H was a man who had suffered historically from paranoid disorder with attendant violent psychotic episodes. In 1988, he attacked his wife with a knife and, after crashing through a window, hit her with a vase. These events were witnessed by the couple's two young children. He was imprisoned. After his release from prison he had some access to the children, but this was terminated after he described to them how "he would enjoy killing their mother slowly".

Proceedings under the CYP&F Act were instituted and a series of reports on both the children and their father were commissioned by the court. Access remained an on-going issue, as did the emotional well-being of the children. In 1996, the court asked for a psychiatric report on the children which contained quite intimate information on them. When the court later refused to release it to Mr H, he objected, claiming access to the report as of right.

Mr H was certainly not being vexatious in

asserting an automatic right to the psychiatric assessment of his children. Indeed, he had a previous family court judgment confirming his unchallengeable right to receive the report. In *DSW v B* [1993] NZFLR 494, Judge Pethig considered ss191 and 192. Those sections state:

Section 191 Access to reports

1. Subject to s192 of this Act, a copy of every written report furnished to the Court pursuant to s178 or s181 or s186 or s187 of this Act shall be given by the Registrar of the Court:

- a) To every person entitled to appear and be heard on the proceedings to which the report relates, and to any barrister or solicitor appearing for that person;
- b) To each lay advocate, barrister or solicitor, or other person representing a child or young person to whom the proceedings relate or a parent or guardian or other person usually having the care of the child or young person;
- c) To the Director-General;
- d) To any person whom the Court considers has a proper interest in receiving a copy of the report.

2. Every such copy shall, wherever possible, be supplied not later than one working day before the sitting of the Court.

Section 192 Court may order report not to be disclosed

The Court may order that the whole or any part of a report given to any person pursuant

to s191(1) of this Act shall not be disclosed to any person specified in the order where it is satisfied that such disclosure would be, or would be likely to be, detrimental to the physical or mental health, or the emotional well-being, of any child or young person or other person to whom the report relates.

Judge Pethig believed there was no ambiguity about the sections. In his view, s191 compelled the registrar to give such reports to all those persons referred to in s191. The court could only prevent further wider distribution of the report by making an order under s192. Despite the reluctance one could sense in the judgment in *DSW v B*, it came to a conclusion that has caused obvious difficulties in the CYP&F Act jurisdiction.

Unfortunately, it was also the only major consideration of these sections prior to *DSW v H*.

The difficulties are as follows. Many psychological and other specialist reports contain highly sensitive and personal information about various individuals, often children. A *carte blanche* dissemination of this information to parents of children who are the subject of such reports, regardless of their potential harm to their children, or whether they have had contact with these children for years, is most difficult to reconcile with the child-centred philosophy of the care and protection provisions of the CYP&F Act. Nonetheless, it is entirely consistent with the requirements of natural justice that courts are quick to uphold.

In order to come to a different conclusion, the court in *DSW v H* had to find an ambiguity in the relevant provisions. Legal theory dictates that the absence of ambiguity renders any alternative interpretation generally unavailable to the court.

I believe the judge found more than an ambiguity – she found a riddle of which the Gollum would have been proud.

Section 191 tells the Registrar to give the

report to all the people referred to within that section. Section 191 however is made subject to s192. Section 192 tells the court it may order that the report “given to any person pursuant to s191(1) of this Act” shall *not* be disclosed to any person specified in the order. (Plain English is not always a feature of the parliamentary edict.)

Having decided that the provisions were ambiguous, the court applied the principles of the CYP&F Act to determine what Parliament intended by ss191 and 192. The paramountcy of the child, it decided, dictated that by making s191 subject to 192, Parliament intended to allow the court to prohibit disclosure of reports to other parties, even

parents of the child, in the appropriate circumstances. Given the paramountcy principle, Parliament could not have intended to prevent the court from exercising such discretion when necessary.

It should still be pointed out that the

test as to whether a report should or should not be distributed is *not* the “best interests” of the child, but the standard referred to in s192 – that is, where the court is satisfied “that such disclosure would be, or would likely to be, detrimental to the physical or mental health, or the emotional well-being, of any child or young person or other person to whom the report relates.” That is a demonstrably more difficult standard than the best interests of the child.

I believe this result is a sensible one. The court refers to an earlier decision of Judge Inglis QC in *Skedgwold v Evington* [1993] NZFLR 641 in which he said: “The paramountcy of the welfare of the child can in an appropriate case override the rules of natural justice as they apply in ordinary civil and criminal litigation.” It is not, in my view, an unfair criticism of the CYP&F Act to suggest that when it is going to remove

Many psychological and other specialist reports contain highly sensitive and personal information about various individuals, often children.

sacrosanct rules of natural justice, it should do so in a bold and unmistakable fashion and not shroud its intent in the mists of a riddle. ■



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Power Parenting for Children with ADD/ADHD

by **Grad Flick**

The Center For Applied Research in Education, New York (1966)

Reviewed by Doug McCall

Mention the words Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and you'll probably get a range of mixed and often emotional reactions. Comments like, "It's flavour of the month", "It's an excuse for bad parenting" or "I wouldn't give my child Ritalin", are common responses. The reality is that the New Zealand public – including many professionals – seem to be poorly informed about ADD/ADHD. As a result, parents whose children suffer from ADD/ADHD tend to get little support in coping with this difficult disorder.

Grad Flick's book *Power Parenting for Children with ADD/ADHD* is a self-help book written primarily for parents. However it would also be useful for anyone supporting a family where ADD/ADHD is an issue. Dr Flick is an American clinical psychologist who – along with his wife – specialises in the assessment and treatment of children, adolescents and adults with ADD/ADHD. They are also the parents of a child with a learning disability and ADD.

The first two chapters provide an excellent, balanced and easy to understand description of the disorder. Flick explains how to diagnose ADD/ADHD and clearly indicates what behaviours should *not* be attributed to it. I would recommend these two chapters as a starting point for anybody wanting to learn more about ADD/ADHD and also to those who are cynical about the validity of this disorder.

The important point about any intervention with individuals with ADD/ADHD is that medication alone is not the cure. In fact there is no cure. This makes management of the disorder really important. Flick writes 14 chapters on how to manage ADD/ADHD although, perhaps because he is a psychologist, he gives little attention to aspects of medical management. This is not to say he minimises the importance of medical intervention; he concentrates more on behavioural

management. Much of this information is not new and involves helping parents to acquire skills in behavioural modification. I usually find that learning behavioural modification skills from a book is both boring and confusing. However Flick, through the use of short, well-written chapters that include some good cartoons, provides an excellent description of time-honoured behavioural strategies.

Schools are commonly places where ADD/ADHD can really make its presence felt. This is much to the distress of already overburdened teachers. This book offers two chapters of practical ways parents and teachers can learn to better manage the difficult aspects of this disorder within the school.

Overall the book is well-written and presented and I would recommend it. It provides wonderful resources, strategies and easy to reference information. The book however, does require the reader to have a reasonable level of reading skill, and the energy, time and ability to understand some complex concepts.

Single Parent Families

by **Kris Kissman and Jo Ann Allen**

Published by Sage Publications, London (1993)

Reviewed by Ted Bagot

At last, an holistic social work approach to single parent families. Why has it taken four years to get here?

In my house we get Sage Publications lists on a quarterly basis, although we've never been able to afford the sometimes very interesting titles offered. However, now – more than ever – clinicians, social service providers and professionals in associated fields are facing issues related to diverse family structures; in particular, the single-parent family.

Unfortunately, current family-centred literature does not devote a great deal of space to intervention and assessment of those families who, in New Zealand (and paralleling other Western countries), comprise well over 25 per cent of all families.

This book covers issues such as special treatment methods for single-parent families based

on such factors as gender of the head of household, ethnicity, age and sexual orientation. Special emphasis is placed upon interventions with mother-headed households, simply because the majority (90 per cent) of single-parent families are managed by women. This figure is based upon a USA study. There was not time to check the New Zealand statistics but no doubt they are similar.

Emphasis is placed upon the importance of social policies and services that help single parents to meet the challenging dual roles of caregiving and wage earning.

The "work fare" programme given so much media coverage at the recent *Beyond Dependency* conference in Auckland is briefly mentioned. Even in 1993 when the book was published, the minimum hourly rate mothers had to earn in order to rise above the poverty level in the US was \$US6. They needed this income plus access to adequate child care and adequate health services, to become independent of the state.

The book is helpful for those practitioners who seek feminist-based, gender-sensitive, practical suggestions on how to help single parents obtain the resources they need in order to gain control over their environment.

An interesting term used throughout the book is "binuclear" rather than "single parent". This new term (to me) takes into account the involvement of the absentee father in the lives of his children; a term NZ families may well get used to in the near future.

Single Parent Families is well set out, generally with short and to the point chapters on the many topics covered. It has an extensive reference section for those wanting to read further on related issues.

Multicultural Families: Child Rearing Practices

Editor **John Buckland**

Published by Auckland Multi-Cultural Society Inc (1995) \$14

Reviewed by Casey O'Brien

This book appears primarily to have been

compiled as resource material for the school curriculum, although the material does have an application for social work practice.

The central focus of the book is captured in the editor's foreword when he states:

All of us face the challenge as parents, as neighbours, as teachers, as professionals or as service workers to seek to understand and appreciate the qualities of other New Zealanders.

All of us can learn from the preferred lifestyles of people of other cultures and the values they express in marriage and upbringing of children.

If we ignore this challenge we will have ourselves to blame if people become more isolated, fearful or exposed to aggression and violence.

The book's title does it something of a disservice in that the content it covers is not solely centred on child rearing practices. Initially, the reader is given a snap-shot of child rearing practices for 21 different ethnic groupings living in New Zealand. However, as a general comment, the brevity of information regarding some of these cultures is disappointing.

There is also a commentary on issues of discrimination and racism, both of which are clearly defined.

A major strength of the book is that it outlines, through practical exercises, ways in which any ethnic grouping could evaluate its own discrimination and prejudice against another culture/s. Once these have been identified there are also suggestions on how to develop action plans to address the discriminatory practices.

The book is a valuable reference point for social workers motivated towards gaining *basic* knowledge of cultural difference in child-rearing practices, together with an understanding and appreciation of the qualities of other cultures. The material is very readable and well formatted with many illustrations.

Social workers committed to addressing issues of discrimination will also find the content of the book useful.

The Snake-stone

by **Berlie Doherty**

CollinsPublishers (1997) rrp \$9.95

Reviewed by Judy Chisholm

This story about a teenage adopted boy captures the reader from page one with his questions. "Do you ever think about being born? No, I don't either. But what I think about is this – did my mother want me?"

This is an interesting question for any person to ponder, but for a teenage reader who is adopted it holds special significance.

The story traces the boy (James to his adopted parents, Sam to his birth mother) in a journey to discover his "unknown past". Again, this is would be an interesting adventure for most readers, but it's a journey of significance for one who is adopted.

The text flows well and is cleverly written with the use of a different typeface to intertwine the story of the boy with occasional excerpts from his birthmother.

The scene seems well set but the actual adoption storyline is a little disappointing. Set in England, the theme of closed adoption could be viewed as outdated by New Zealand standards. The characterisation seems unnecessarily stereotyped and the simplistic ending addresses few of the adoption issues raised.

However, none of these factors would probably deter a young reader from the challenges set by the boy.

The Snake-stone has value as an affordable, thought-provoking discussion resource for anyone working with adopted youngsters. Adventure-type books for teenagers with a pertinent and digestible adoption theme are a scarce commodity.

The emotional dilemmas of adoption are realistically and sensitively portrayed through the feelings and actions of the boy. Association with some of his feelings could well assist a troubled youngster to identify and safely explore their own adoption issues.

This book would also make enlightening reading for adoptive parents on identity and relationship issues.

The story is unusual in posing more adoption questions than it answers, beginning with the question James asks about his mother. Which mother, one might ask. It then follows a journey to find his unknown past and ends with the single sentence, "I was home". But where and who is home?

At least the intriguing significance of the snakestone for James and his birthparents is revealed. Perhaps, as the title suggests, therein lies the true key to this story!

Money to Burn

by **Duncan McKay**

Published by HarperCollins, Auckland (1997)
rrp \$12.95

Reviewed by Amanda Drummond

"From a hospital ward, Ben, a badly-burned teenager must speak of things he'd sooner forget: A desperate crime, a dangerous friend, a cruel parent, a shocking accident. Forced to revisit his past, can Ben now find a future?"

This is a book that I wanted to read more and more. I found the first chapter a bit boring but as I read on, it made more sense. The moral of the story is that money cannot replace a feeling of being loved and wanted.

The book tells the story of Ben who lives with his sister and his father. Ben's father drinks a lot and hits his family. Ben's sister, Maria, takes off to get away from her father and goes to Australia. As Ben loves his sister very dearly he wants to go all the way to Perth to find her.

On his birthday, Ben's father gives him a model airplane. Unfortunately Ben finds it hard to build and his father – thinking Ben doesn't like the gift – gets angry and builds the plane himself. Later, when Ben picks it up to put its sticker markings on, he drops and breaks the plane and ends up with a hiding from his father. Whenever the father hits Ben, I can understand how Ben is feeling.

The crux of the book comes when there is a robbery at the bank and the occupants of the getaway car throw a bag of money out of the car. Ben gets the money but he has to burn the base-

ball jacket his sister gave him, which he loves, so he won't be identified.

I think this book is mainly aimed at people who come from broken homes. It highlights the violence that occurs in some situations and how this affects young people. I hope Ben grows up to be like his sister, and not like his father. I think Duncan McKay should write more books like *Money to Burn*. ■

The reviewers

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Social Work Now

Aims

- to promote discussion of social work practice in CYPFS;
- to encourage reflective and innovative social work practice;
- to extend practice knowledge in any aspect of adoption, care and protection, residential care and youth justice practice;
- to extend knowledge in any child, family or related service, on any aspect of administration, supervision, casework, group work, community organisation, teaching, research, interpretation, inter-disciplinary work, or social policy theory, as it relates to professional practice relevant to CYPFS.

Social Work Now

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