# Child protection service system reform A way forward


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To go forward we need a map that not only shows us our destination but where we are now and where we have come from.

The history of the child welfare system in Australia and New Zealand now spans three centuries. It is a history in which there have been times when we have led the world. At the end of the nineteenth century in South Australia, a State controlled boarding-out scheme, what we now call foster care, was heralded internationally as the most progressive in the world. In the early twentieth century, New Zealand's Plunkett nurses were among the first universal maternal and child health services in the world, and were followed shortly by similar services in Australia. The emergence of Legacy in the wake of the First World War, was a unique form of home visiting and family support which also provided for the educational future of children left fatherless by war. The best in our system has thus historically not come from overseas but emerged from our own ingenuity.

In this short address today I do not have time to talk about three centuries but will talk briefly about the last three decades which witnessed the most radical transformation in the history of child welfare. I shall then weigh up the credits and debits in the ledger book of our current system, and offer a blueprint for the way forward.

The shift from the use of the term 'child welfare' to that of 'child protection' symbolises the radical transformation. Thirty years ago the child welfare system had as its core role the provision of substitute care to wards of the State and to children placed privately in institutions by their parents. What was then called 'child protection' – the investigation of alleged abuse and neglect, was a very minor part of that system. The last thirty years has seen the identification and assessment of alleged abuse become the core role of the system.

The proportion of children in the care of the State has decreased since the 1960s while the proportion of children in the community investigated for alleged abuse has risen markedly. To use Victoria as an example, my research indicates that children under statutory orders fell from 7 per 1000 children in the 1960s to 2.3 per 1000 in the 1990s. While there is no clear historical baseline on child protection investigation, my estimate is that there were fewer than 5 notifications per 1000 children per annum in the 1960s and that this had risen to 25 notifications per 1000 children per annum in the 1990s. It is very likely that this does not reflect an increase in the prevalence of child abuse but reflects broadened definitions of child maltreatment, greater public and professional awareness of the problem, and a greater willingness to report suspected maltreatment.

In response to overwhelming numbers, child protection systems are forced to develop gatekeeping mechanisms and, as a result, are at great risk of becoming deprofessionalised and proceduralised in their practice. This can exacerbate poor morale and high staff turnover. The question 'How is the child?' comes to be replaced by the question 'Do we have a case?' in a legal sense – that is, does the threshold of evidence reach a level such that we are required to take statutory intervention? If the answer is no, then a common response is to close the case. This speeds up the revolving door on the child protection assembly line, as reflected in increasing rates of renotification.

Other fundamental changes include the characteristics of the client population. For example, the growing number of children in the system whose parents have an intellectual disability or a serious mental illness is the result of deinstitutionalisation, normalisation and reproductive rights in those fields. This is a social experiment in progress – it remains to be seen what proportion of parents with such disabilities can adequately care for their children.

The most significant change in the nature of the client population, however, is the number of children whose parents have a drug dependence, as thirty years ago this social problem was numerically insignificant. Equally, it remains to be seen what proportion of parents with a serious drug dependence can adequately care for their children.

Those in the child welfare field today thus face challenges which their predecessors did not have to confront. At the same time, we have a welfare safety net which prevents children coming into care which they could not have dreamed of, and above that, we have much stronger research on which to base our policies and practice.

With knowledge comes the responsibility to act. We know so much more about the risk factors in relation to child abuse, and about the damaging effects of child sexual abuse and domestic violence on children. This knowledge, in combination with values derived from second wave feminism, have made us far more willing to intervene on

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behalf of such children than was the case in the past. However, despite increasing research on the serious long-term effects of child abuse and neglect in the first three years of a child's life, we seem unwilling to intervene on behalf of some children, especially those subject to chronic neglect.

We also know a lot more about the causal pathways of a range of closely interrelated child and adolescent problems – school failure, behavioural problems, adolescent pregnancy, certain psychiatric disorders, and drug use. The same set of protective factors, including the quality of early parent-child attachment, peer and school connectedness and the availability of social support, is strongly associated with lower rates of these problems.

What we now know about attachment in early childhood should make us very concerned about the impact of multiple placements, which are probably more damaging than much of the institutional care of a previous era.

So what does our ledger look like compared with that of 30 years ago?

### ON THE CREDIT SIDE:

- We have reformed a child welfare system which brought into institutional care large numbers of children.
- We have shifted the emphasis from residential care to foster care which, if stable, provides most children with better quality care.
- We have assisted families so that more children in care return home.
- We have done much to prevent children coming into care through family support and family preservation services.
- We recognize problems such as child sexual abuse and domestic violence that once were unacknowledged.
- We have implemented in some places methods such as family group conferences that enable children, young people, parents and other relatives to participate in a meaningful way in decision-making.
- We are beginning to develop ways of working across child and adult focussed services in order to deliver a family-centred service.
- We are beginning, at long last, to think about how we engage fathers.

### ON THE DEBIT SIDE:

- We are far worse than a previous generation in providing children in need of out-of-home care with stability and security, and this is a damning indictment of our current system, given that this is a primary responsibility of any child welfare system.
- We have allowed good quality residential care to be almost eliminated from the system when for some children and adolescents this is the most appropriate form of care.
- We have allowed the foster care systems across this country to reach a crisis point – unless urgent action is taken they are likely to collapse within a decade.
- We have become desensitized to the seriousness of chronic neglect and the damage this inflicts upon children.

## THE WAY FORWARD?

Here is my blueprint for the way forward. There are already some encouraging signs in a number of States in relation to these strategies.

1. An overarching policy framework is required which balances primary, secondary and tertiary prevention. The relative resource distribution between these levels of intervention needs to be based less on ideology and more on research.
2. Primary, secondary and tertiary prevention strategies must be cross-sectoral.
   - For example, at the primary prevention level, we must restructure universal maternal and child health services so that they are as much focused on the psycho-social well-being of families and building supportive social networks at the neighbourhood level as they are on child health surveillance.
   - For example, at the secondary prevention level, we must use the school as the vehicle to reach out to vulnerable families. A program such as FAST (Families and Schools Together) provides one model of how this can be done.
   - For example, at the tertiary level, child welfare case management must address the health and educational needs of children as well as providing placements. The UK Looking After Children program provides one model of how this can be done.
3. Secondary and tertiary prevention must be cross-sectoral in relation to key adult-focused sectors which impact on child protection. For example, we must urgently search for better ways of assisting drug and alcohol, adult mental health and intellectual disability services to become more child and family centred.
4. While doing the best we can to keep children with, and return them to, their families, where this is not achievable within the child's developmental timetable (for children under 5 years, this probably means 12 months), we need to move with resolve and without delay to secure a stable substitute family before they are irreversibly damaged. Adoption needs to be considered as the best option for some children. Families providing kinship care, long term foster care, permanent care and adoption should all be able to access high quality post-placement support services.
5. A major rescue strategy is required in relation to foster care systems. While some of the factors are beyond the child welfare system, there is much that can still be done to improve recruitment and retention. Foster families are one of the most precious resources we have. Let us not discover this too late.

6. We must provide high quality, stable, therapeutic residential care for the children and adolescents who need this form of care. This requires major rethinking in our models of residential care so that staff turnover is minimised.
7. Legislation and policy must be reformed so that it makes the above possible. That is, we need a legislative and policy framework which facilitates primary and secondary prevention AND which also strengthens the capacity of the system to respond to the needs of those children who fall through these safety nets. These objectives are not mutually exclusive. In some States (for example, Victoria) the pendulum swing against the removal policies of the1960s has gone to such an extreme that 'the least restrictive option' approach is inflicting serious harm. It is possible to have a system that implements diversionary strategies for most children who come within its reach while actively intervening with the minority of children who need a high level of statutory protection.

## CONCLUSION

It is easy in the child welfare field to become demoralized and end up feeling a level of despair which mirrors that of the families with whom we work. This is of no help to them or to us. Nor is despair justified. If we adopt an historical perspective we are able to see just how far we have come. Understanding the past should therefore give us the courage to address new challenges and overcome the shortcomings of our current policies and practices. Unless we do so we will stand condemned by those who follow us as having failed this generation of children. ♦


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