

# Towards a public health model of child protection in Australia

## Abstract

Most current child protection systems in Australia are unsustainable and potentially harmful. It is time to reconsider the direction in which child protection policy is heading in this country. To this end we need to understand the historical processes that have led to the current situation, explore the potential of a public health approach to child protection, enhance the capacity to translate research into policy and practice, and transplant effective and sustainable innovations on a system-wide basis.

## Key words

*Child protection; public health; policy; innovation; reform*

## Introduction

Most of the statutory child protection services in Australia are unsustainable. Notifications of suspected child abuse and neglect across Australia have increased from 107,134 in 1999-2000 to 252,831 in 2004-2005, with approximately one in five notifications being “substantiated” and one in four substantiations resulting in a court order (AIHW, 2006)<sup>1</sup>. In some parts of the United States the situation has reached an extreme point. For example in Cleveland, Ohio, 49.1% of all Afro-American children and 20.7% of all white children will at some stage in their childhood be the subject

of a child protection notification (Sabol, Coulton & Polovsky, 2004 cited by Korbin, 2005). In the face of escalating demand, statutory child protection services have become demoralised, investigation-driven bureaucracies which trawl through large numbers of low income families to identify the small minority of cases which reach the criteria for statutory intervention.

In this paper the author presents a critical analysis of current social policy. Existing research, policy and practice and their historical antecedents are critically reviewed and a public health model is put forward as the “third wave” of child protection.

## Historical drivers of child protection policies

How did such a situation come into being? The first wave of the child protection movement, or what was originally called the child rescue or child saving movement, began in the second half of the nineteenth century. Prior to this there had been organised government and charitable responses to orphaned and destitute children, but not specifically to children subject to ill-treatment by their parents and guardians. The child rescue movement led to legislation to protect children from “cruelty” (severe physical abuse) and gave rise to statutory intervention in the lives of families by government and quasi-government organisations such as the Societies for the Prevention of Cruelty to Children (Scott & Swain, 2002).

The press was a powerful player in the first wave of the child protection movement, as superbly portrayed in Larry Woolf’s book *Child Abuse in*

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<sup>1</sup> *The number of notifications does not equal the number of children as in some jurisdictions repeated notifications of the same child are included. Whether a notification is ‘substantiated’ depends on the child protection worker’s judgement of the case and is only tested in a legal sense in a very small minority of cases. This can lead to both ‘false positives’ (cases inappropriately classified as abuse) and ‘false negatives’ (cases inappropriately classified as non-abuse). Data on substantiations thus need to be used with caution.*

Freud's Vienna (Woolf, 1998). The media was also powerful in the second wave of the child protection movement in the 1960s – the discovery of the "battered baby syndrome" (Kempe, Silverman, Steele, Droegmueller and Silver, 1962).

It is four decades since the Medical Journal of Australia published "The Maltreatment Syndrome in Children" by the Victorian police surgeon Dr John Birrell and his paediatrician brother, Dr Robert Birrell, (Birrell & Birrell, 1968). Similar to that of Kempe, this study documented undiagnosed fractures and non-accidental injuries among some children admitted to the Royal Children's Hospital in Melbourne. In the same issue of the Medical Journal of Australia Dr Dora Bialestock published the results of her examination of 289 babies consecutively admitted to State care, revealing significant developmental delay associated with child neglect (Bialestock, 1966).

The Birrells' paper received far greater attention than Bialestock's paper and for over forty years child neglect has been virtually ignored, despite being the single largest reason for children coming into State care and the cause of at least half of child maltreatment fatalities (Smith & Fong, 2004).

The second wave of the child protection movement gave rise to laws and policies specifically designed to identify cases of serious physical abuse and bring these to the notice of statutory authorities without delay. In North America and most of Australia, this has taken the form of making it a criminal offence for some professional groups not to report suspected maltreatment. In Europe, including Ireland and the United Kingdom, and in New Zealand, it has taken the form of policies based on a strong voluntary professional duty of care to report child abuse. In the 1980s and the 1990s, the discovery of child sexual abuse led to a strengthening of these laws and policies.

While designed to address serious physical and sexual abuse, such laws and policies have become increasingly applied to situations where children are seen as 'at risk'. This dramatic net widening in child protection systems has been fuelled by the two inspiring historical drivers of child protection: the notion of the child as a holder of human rights; and the notion of the child as a psychological being. Within English-speaking countries, however, their application has had a narrower focus than

elsewhere.

## **The notion of the child as a holder of human rights**

As the view of the child as the property of parents has diminished over the past century, and the view of the child as a holder of human rights has grown, the pressure on the State to use its coercive powers to uphold the rights of the child vis a vis their family has increased.

In western Europe, the State's responsibility has focussed less on the use of its coercive powers than on its responsibility to provide health, education and income support for all citizens, including children. In the United States, in the absence of universal health services and income support for poor families, there has been a very strong reliance on the State's coercive powers.

While international comparative policy analysis in child protection is problematic due to significant differences in child abuse data and broader social and economic factors, it is worth noting that in the 1990s the US had three times the rate of reports, four times the rate of child abuse deaths and twice the rate of children in state care as the UK (Department of Health, 1995, p. 95).

## **The notion of the child as a psychological being**

The nineteenth century understanding of child physical abuse was that of extreme cruelty resulting in serious bodily harm, and the understanding of child neglect was the serious failure of parents to provide for the most essential needs of shelter and sustenance (Scott & Swain, 2002). In a pre-Freudian era these were not seen in terms of psychological harm and the concept of emotional abuse did not exist. In contrast, an increasing range of parental behaviours is now seen as psychologically harmful to children and emotional abuse has become the single largest category of substantiated cases in several Australian States.

Some acts now regarded as child abuse and neglect, such as physical discipline with an implement or leaving young children in the care of older children, were normative childrearing practices a generation or two ago. Moreover, child sexual abuse, while always seen as deviant, is no

longer understood in terms of moral danger but in terms of psychological harm.

The greater use of the State's coercive powers to uphold what are seen as the child's rights vis a vis their family, and the ever-widening definition of child abuse based on possible psychological harm have resulted in an epidemic of child protection notifications. However there is no evidence of an actual increase in the prevalence of child abuse and neglect in Australia. This is not to suggest that the population of children involved in the child protection system has remained unchanged – for example, the very large sibling groups admitted for reasons of neglect in the 1960s have diminished while the proportion of children in care with a substance dependent parent has increased markedly.

### **Dangers of overloaded child protection services**

Like an overloaded Casualty Department in a hospital, an overloaded statutory child protection service is potentially dangerous.

- Children who are in serious jeopardy can be missed as an overloaded child protection service struggles to avoid collapsing under the weight of escalating notifications by doing superficial assessments and/or prematurely closing cases, both of which are very evident in recent child death inquiries in some Australian States.
- Children who are at risk of abuse or neglect but below the threshold for statutory intervention are also disadvantaged. For example, in NSW, when the number of notifications doubled in twelve months from 55, 208 in 2001-2002 to 109,498 in 2002-2003 (coinciding with the introduction of a centralised intake system and increases in penalties for failure to fulfil mandatory reporting requirements), the number of referrals to family support services actually decreased due to the incapacity of the child protection service to make referrals (Fitzgerald, 2002). Thus families that fall below the threshold are denied the assistance that may prevent abuse and neglect.
- Children who have been referred inappropriately to an overloaded child protection service can also suffer. The alienation, humiliation and fear felt by many parents in the wake of an unsubstantiated investigation is rarely considered. Parents left

suspicious and uncertain about who in their family, neighbourhood or local services may have notified them to the authorities are likely to become anxious and withdrawn. Given that parental stress and social isolation are strong correlates of child abuse and neglect, and given the scale on which child protection surveillance is now occurring in Australia, it is possible that child protection services are contributing to child abuse and neglect by reducing protective factors. Research in this area is difficult due to privacy issues.

- Children and young people already in State care are also adversely affected when resources are redirected to deal with more investigations. The intensive work required to reunite children with their families is left undone, thus adding to the burgeoning numbers of children and young people in out of home care. Their health and educational needs are neglected, foster and kinship care placement breakdowns which may have been prevented occur, and children eligible for permanent care or adoptive placements suffer multiple placements and damaging delays or are deprived of a family entirely.
- Relationships between the statutory child protection service and services making notifications are strained by the necessary “gatekeeping” resulting from the large gap between the threshold for making a notification and that for statutory intervention.
- Finally, overloaded child protection services can hurt those who work in them, leading to high levels of stress and staff turnover which further weaken the service. An increasingly stigmatised and deprofessionalised workforce is the outcome, with acute staff shortages now widespread.

### **A public health model of child protection**

So what can be done to reform systems which are unsustainable and which can inflict such harm? While a legal model of child protection is necessary to protect a small number of abused and neglected children, a public health model has much greater potential to reduce the level of child abuse in the community. Baum (1998) identifies the key principles of a public health or population health approach as

follows:

- a focus on populations as entities
- an emphasis on health promotion and disease prevention strategies at a population level
- an understanding and development of health systems in terms of new contributions to population health outcomes; and
- an emphasis on the underlying social, economic, biological, genetic, environmental and cultural determinants of health as they affect whole populations.

While it is beyond the scope of this paper to provide a detailed picture of what a public health approach to child protection would look like, a few ideas are outlined below in relation to these principles.

### **A focus on populations**

A public health approach is based on primary, secondary and tertiary prevention strategies with outcomes being measured according to the prevalence of a condition. Thus, in relation to a problem such as skin cancer, primary prevention strategies are population wide measures which include tackling the hole in the ozone layer, creating shaded areas in playgrounds and educating the public through health promotion such as the 'slip, slop and slap' campaign. Secondary prevention involves efforts directed at those groups in the population at greater risk - for example, regular screening by GPs of those with a family history of skin cancer. Tertiary prevention is focussed on reducing the harm of conditions already established such as early identification and treatment of melanomas.

Epidemiology is critical to population or public health strategies as it analyses data on the prevalence of a condition and identifies the factors which are associated with differences in prevalence between geographical areas, social classes, ethnic groups and age cohorts etc. Such data can also be used to monitor progress, direct resources to areas of greater need and identify promising pockets of success despite adverse conditions (thus increasing knowledge about possible protective factors). To measure the effectiveness of strategies to reduce child abuse and neglect one therefore needs sound prevalence data. This is different from incidence data, such as the number of child protection notifications

or substantiations. The latter are highly unreliable indicators as they are primarily measures of reporting behaviour, not the amount of child maltreatment or the well-being of children in a community.

Given the difficulties of collecting data on hard-to-define and socially undesirable phenomena such as child abuse and neglect, population based indicators which are known to be strongly associated with child abuse and neglect and which are fairly easily obtained on an ongoing basis can be used to complement data on injuries etc.

Thus a combination of indicators can be used to give a picture of the well-being of children at a whole of community level. For example:

- the prevalence of women who smoke, or drink alcohol during pregnancy
- the proportion of babies born with foetal alcohol spectrum disorder, drug withdrawal symptoms and/or low birth weight
- the rate of non-organic failure to thrive in infants and young children
- the number of hospital admissions for non-accidental physical injuries
- the number of fatalities attributable to child abuse and neglect
- the number of children scoring low on school readiness criteria; and
- the rate of absenteeism in primary schools.

Child sexual abuse at a population level would need to be separately measured as there are no ongoing prevalence data or correlates available. Child sexual abuse prevalence could be collected by using a baseline measure derived from a representative community sample surveying adults on their childhood experiences.

In addition to population based measures, the well-being of children who are admitted to State care could be monitored to identify changes between cohorts of these children. This would provide data on the effectiveness of secondary prevention strategies aimed at this group of children. A comprehensive paediatric assessment of all children coming into care would identify physical health status, developmental delay, failure to thrive, mental health disorders etc. This would be of enormous benefit to individual children as well as provide baselines by which different jurisdictions could be compared or changes within a jurisdiction could be identified.

## Health promotion and prevention strategies at a population level

There have been very few health promotion style interventions in relation to child abuse and neglect in Australia and those that have been tried have been short-lived (eg 'Don't Shake the Baby' campaigns) and not well evaluated. Experience in relation to smoking, drink driving and skin cancer prevention suggests that extensive and sustained programs are required to change social attitudes and behaviour. This is expensive and in relation to child abuse there is the risk that it could increase the number of inappropriate child protection notifications. Nevertheless, this is a promising area for exploration.

Some primary prevention strategies focus on direct environmental modification. For example, from the 1960s onwards the child morbidity and mortality related to burns, drowning in swimming pools, accidental poisoning, choking on small objects, and injuries from being unrestrained in motor accidents have all been dramatically reduced by legislation and regulation. These include requiring children's nightwear to be made from low flammable materials, swimming pools to be fenced, poisons to be labelled, medication containers to be child-proof, warnings on toys with small parts, and compulsory seat belt legislation. Such measures reduce dependence on parental vigilance and have particular benefit for children at risk of supervisory neglect.

## Development of systems

There is significant potential to "re-engineer" children's universal health and education services so that they reduce the risk factors associated with child maltreatment by working more effectively with vulnerable families and communities. Broadening the role of primary service providers requires a multi-stranded approach to overcome a number of organisational and professional obstacles (Scott, 1992a). Below are a few examples of what is possible.

- The British Health Visitor service and some Australian universal maternal and child health services have successfully extended their traditional role of paediatric surveillance (monitoring the growth and development of

children) to encompass the emotional and social well-being of families. Over several decades, maternal and child health services in Victoria have undergone a major transformation, and 'enhancing family functioning' is now one of the core objectives of this service. Initially this focussed on the emotional and social well-being of mothers through increased responsiveness to problems such as maternal depression (Scott, 1992b). More recently a community development orientation has been incorporated by funding first time parent groups to generate social support at the neighbourhood level, and such groups have a take up rate of approximately two thirds of all first time parents (Scott, Brady & Glynn, 2001).

From the platform of its universal maternal and child health service, South Australia has recently introduced a sustained nurse home visiting program (the Family Home Visiting Program) to certain groups identified on a population basis (for example all indigenous mothers and all mothers under 20 years). The very high take-up rate of this program is most encouraging and one of the central foci is enhancing parent-infant attachment, a key protective factor in relation to child abuse and neglect. Close links with housing services to prevent eviction and with Centrelink to ensure families receive payments for which they are eligible, also help reduce situational stressors associated with child abuse and neglect.

- Early childhood education and care services can reduce the effects of child neglect through high quality day care (Shonkoff & Phillips, 2000). Such services can also act as platforms to reach out to vulnerable parents and thus potentially enhance the quality of parenting received by children. SDN Children's Services in New South Wales have pioneered ways of enhancing the skills in family centred practice among early childhood education and care workers (SDN Children's Services, 2004).
- Primary schools play a significant role in educating children about protective behaviours, and there are many ways in which schools can also strengthen families and community support. Watts and Laskey (2002) have written about the untapped potential of teachers to be 'real partners' in child protection, and this can be

supplemented by school nurses/social workers/counselors. An adaptation of such strategies can operate at secondary school level.

Similar strategies can be used with specialist adult services in fields such as domestic violence, mental health and drug treatment services to enhance their sensitivity to children's needs. While there are complex issues which need to be addressed in order to develop family centred practice from within adult-focussed services, there are promising signs of progress. For example, the COPMI initiative (Children of Parents with a Mental Illness) is aimed at enhancing the capacity of adult mental services to respond to the needs of children.

### **Emphasis on the underlying determinants**

Perhaps the greatest benefit of a public health approach to child protection is that it lends itself to tackling the underlying causal and contributory factors related to child abuse and neglect from a whole of government perspective which transcends health, education and child welfare service and draws in sectors such as housing and employment services.

The rationale for this is that child abuse and neglect are strongly correlated with other problems such as low birth weight, child behavioural disorders, low literacy, non-completion of school, juvenile crime, drug use, and teenage pregnancy. These share a common set of risk and protective factors (quality of early parent-child attachment, peer and school connectedness, the availability of social support for families, and parental poverty (Durlak, 1998). A meta analysis of prevention programs for these problems suggests that multi-faceted strategies which address the underlying risk and protective factors are more effective than those that are single issue focused (Durlak, 1998).

### **The "primary care" network**

If adequately resourced, maternal and child health nurses for children under school age, and school nurses/counsellors/social workers for school aged children, have the capacity to assess and respond to many cases now referred to statutory child protection services which do not result in statutory intervention. Such an assessment could include

standardised risk criteria to assist decision-making in relation to statutory intervention.

Processes would need to be developed to make it 'safe' for such services to work with vulnerable families. For example, case consultation with statutory child protection services could help determine the threshold for statutory intervention and satisfy mandatory reporting requirements.

Under such a system, statutory child protection services could focus on those children who need statutory protection and those who are already in care. The experience of Western Australia in operating a two tier system for the past decade would be worth evaluating as this could prove valuable to other States and Territories considering such options. The 'community intake' process possible under the new Victorian legislation (*The Children, Youth and Families Act 2005* and the *Child Wellbeing and Safety Act 2005*) may also provide a model which can be assessed for its outcomes and possible applicability to other jurisdictions.

### **Translate research into policy and practice**

Historically, child protection policy and practice have not been well informed by research. This has left the field of child protection very vulnerable to politically driven and media influenced policy shifts. Strong population-based measures of child abuse and neglect may help prevent the shift toward more centralised and legalistic approaches which can occur as a result of narrowly-focussed child death inquiries.

The development of computerised data bases in statutory child protection services has provided opportunities for evidence-informed policy changes to be introduced. Increased attention is also now being paid to research utilisation in health, education and social services (for example, see Shonkoff, 2000; Haines and Donald, 2002; and Greenhalgh, Robert, Macfarlane, Bate and Kyriakidou, 2004). Successful reform of child protection services will require strong strategies to enhance the capacity of practitioners and organisations to make greater use of research findings which are sufficiently robust to make them worthy of being used.

The UK has shown strong leadership in providing sustained funding for child protection related research and for disseminating the research

in ways that are accessible to policy makers, managers and practitioners. For example, “What Works for Children” is an impressive initiative which uses “knowledge brokers” to work alongside practitioners in order to help them utilise research ([www.whatworksforchildren.org.uk](http://www.whatworksforchildren.org.uk)). It is the result of a consortium of Barnardos, University of York, City University and the Economic and Social Research Council. Such models are worthy of replication in Australia.

A recent audit of Australian child protection research found that relatively few resources have been invested in research in this country, and that the studies done have been largely limited to small qualitative studies with poor generalisability (Higgins, Adams, Bromfield, Richardson and Aldana, 2005). The way forward is through collaboratively working across different jurisdictions to identify common research priorities and developing large, multi-site studies.

### **Transplant successful innovations in policy and practice in a sustainable way**

There has also been little attention in the child protection field to the systematic diffusion of innovation (Salveron, Arney and Scott, 2006). ‘Naturally occurring’ innovations in professional practice, programs and policy development occur all of the time in the human services, including child protection. These can provide solution-focussed strategies which may be useful in other contexts.

Innovations from other countries have sometimes been introduced to Australia (for example, family group conferencing from New Zealand) but usually with little attention being paid to sustainability and embedding them into Australian service systems. Rigorously evaluating innovative policies and programs in regard to their effectiveness, efficiency, transferability and sustainability is essential. Unless these conditions are met, investment in wide scale transfer of innovation is probably unjustified. The insatiable political appetite for launching new but unsustainable initiatives is a major problem in Australian child and family services and has the potential to harm organisations and the communities they serve.

Sowing the seeds of innovation is a source of hope in the history of child protection. Valerie Braithwaite

from the Australian National University has recently written about “Institutions of hope [which] refer to sets of rules, norms, and practices that ensure that we have some room not only to dream of the extraordinary but also to do the extraordinary” (Braithwaite, 2004). Even in demoralised child protection services one can find inspiring oases of hope, in both leadership and at the level of service delivery. We would do well to explore how hope is sustained under such difficult conditions as resources and research are not enough. We need to nurture hope in our organisations and in one another if we are to build the momentum for the third wave of the child protection movement – a public health approach.

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