Table of Contents

AMA Summit on Child Abuse

Executive Summary

This Summit was organised as part of the core work of the AMA Child and Youth Health Committee in response to the rising rate of substantiated cases of child abuse throughout Australia.

The Child and Youth Health Committee recognises that child protection is a serious public health issue which is complicated by a system that is fragmented by differing approaches and regulations across the State and Territory boundaries. There is currently no national policy and no unified national system of child protection and recovery.

The need for a multidisciplinary approach is also recognised. Representatives from medicine, nursing, social work, education, early childhood, law, family welfare, police, Government and non-Government organisations attended the Summit.

Speakers at the Summit also reflected the wide range of disciplines and approaches. A public health model was emphasised by Associate Professor Dorothy Scott. Professor Graham Vimpani brought new evidence on the serious long-term effects of adverse childhood events while Muriel Cadd described the key reforms proposed for Aboriginal and Torres Strait Islander child protection. The human rights of children held in immigration detention were raised by Dr Louise Newman. The forensic aspects of child protection from the medical perspective were also discussed.

Outcomes from the Summit included recommendations that:

- All levels of Government work in partnership with other key stakeholders to adopt an integrated national public health strategy to address the issue of child abuse and neglect.
- The Commonwealth, State and Territory Governments work in partnership with the non-Government sector to develop a national policy and service framework that promotes the status and wellbeing of all children.
- All professions, involved in work with children and their families, include pre-service and continuing education on child protection.
- A coalition of organisations be formed to get child protection onto the national agenda for child health and wellbeing.
- Children in immigration detention be given the same standard of health care and welfare services as all other children in Australia and that these services be independently monitored.

Opening Speech at the AMA Summit on Child Abuse

Working Together

Dr Bill Glasson
AMA President

Good morning everyone.

Well, thank you to the Bundah Booris, these wonderful dancers from Narrabundah Primary School, with whom the AMA has special links.

This morning I'd like to acknowledge the Ngunnawal people, the traditional owners of the land on which Canberra is built.

And I want to welcome you all to this summit today, a summit I wish we did not have to have. Australia should be a great place to bring up kids. We've got lots of space, a growing economy and a stable political system. Our education system is world class. Our health system is world class. Yet our children are suffering. Every year, the rate of substantiated child abuse cases in all States and Territories is rising. The burden, in terms of human and financial costs, cannot be overestimated.

Child abuse has an immediate and traumatic impact on the victim. But the long-term consequences are also significant. As a community, we need to work with survivors of abuse. And we need to work on preventing abuse.

I am encouraged to welcome so many experts from so many disciplines here today. It's testament to the gravity of this issue. The AMA endorses the *World Medical Association Statement on Child Abuse and Neglect*, which states that: 'the right of children to be free of abuse and neglect takes priority over any rights of adults'.

The AMA recognises that the effective prevention and management of child abuse and neglect calls for cooperation among medical practitioners in different disciplines and between medical practitioners and experts in other professions.

Working together is the theme of this summit.

The medical profession is just one of the **many** professional disciplines that must work together to help children and their families develop and enjoy healthy life. And I use the term 'healthy' very broadly. When we talk about

health we include social, cultural and emotional health – as well as physical well-being.

There has been criticism in the past that the medical profession has been too narrow in its outlook about social issues. That many doctors have only been interested in the medical model of health, focusing on the biological determinants of disease. That doctors have ignored the vital social and cultural issues that can influence our health and wellbeing.

This Summit is an example of the way the medical profession can work on an even par with other health professionals for the benefit of families, children and so for the wider community. I am very proud that the AMA is able to be part of this cooperation.

Working together also seeks a national approach to crucial issues. Child protection and recovery transcends State and Territory boundaries. It's very encouraging to welcome State, Territory and Federal representatives and so many representatives from non-Government organisations here today because of this common goal. I know many States and Territories have been reviewing their child protection policies and have instituted systems for reform.

This Summit provides a great opportunity to share our concerns, our knowledge and our experiences of this serious threat to the health of many Australians.

Thank you all for making the effort to be here today. Special thanks go to our speakers, Professor Graham Vimpani, Dr Louise Newman, Associate Professor Dorothy Scott, Muriel Cadd, Sandie de Wolf and Dr Terry Donald.

We look forward to your insight and your wisdom. I welcome this opportunity to work across professional, geographic and political boundaries as we work together towards a national policy for child protection and recovery.

I commend this Summit to you all.

AMA Summit on Child Abuse

Working Together: toward a national policy of child protection and recovery

Introduction

Over 50 representatives from families, medicine, nursing, social work, welfare, law, police, education, early childhood, State and Territory government child protection agencies and non-government organisations attended a Summit on Child Abuse at AMA House in Canberra on 19 February 2004. The Summit was organised by the Child and Youth Health Committee of the Federal AMA.

The wide range of represented disciplines reflected the concern felt about child abuse by both the community and those professionals working with children and families. It is also an indication of the multidisciplinary approach which is needed to best prevent, identify and treat current child abuse as well as caring for the survivors of past abuse.

As Dr Bill Glasson, President of the AMA, said in his opening speech: 'The medical profession is just one of the many disciplines that must work together to help children and their families develop and enjoy healthy life'

As the peak health advocacy organisation in Australia, the AMA seeks to advance the health of the community. The AMA thus has a vital role to play with other organisations in preventing child abuse.

Why the Summit was held

It would be comforting to think that cruelty to children is a thing of the past. Australia formally recognises the rights of the child as declared by the United Nations in the 1989 Convention on the Rights of the Child. Childhood in Australia is also recognised as a very important time and a National Agenda for Early Childhood is currently being developed as an intergovernmental project.

Yet the number of substantiated cases of child abuse and neglect in Australia is rising steeply. The Australian Institute of Health and Welfare Report Child Protection Australia 2002-3 shows that the number of reports of suspected child abuse and neglect has more than doubled in the past 12 years. Throughout Australia, there were 40,416 substantiated cases of child abuse or neglect in 2002-03.

The increasing number of notifications to child protection authorities has thrown State and Territory welfare systems into crisis where many notifications are not followed up due to a lack of resources.

Costs of child abuse and neglect?

The social and emotional costs of child abuse cannot be overestimated. The full cost of child abuse and neglect to the community, in monetary terms, is difficult to assess. A report commissioned by Kids First Foundation in 2003 showed that the annual cost is likely to be between $2,700m and $5000m. These costings exclude the cost of community contributions.

State rights versus children's rights

Child protection is currently a State and Territory matter with no Commonwealth involvement. There is no national policy for child protection and recovery although there is proposed National Plan for Foster Children, Young People and their Carers

Yet, as Dr Michael Rice, Chair of the AMA Child and Youth Health Committee points out child abuse is a serious public health issue. If the number of cases of a childhood physical disease (such as tuberculosis) was increasing at the rate of child abuse notifications, there would be a public outcry and the Commonwealth would be forced to become involved.

History of child abuse and neglect in contemporary society

It is now over 40 years since Henry Kempe in the US identified the "battered child syndrome" in the Journal of the American Medical Association. The use of the descriptive term "syndrome" brought child abuse right into the arena of the medical practitioner. A little later in 1968 John and Robert Birrell assessing the injuries of children in hospital, described what they called the 'child maltreatment syndrome.

Since that time there have been many social changes. Families have become smaller. They have become more mobile which can mean separation from the support of extended families. Child care outside the home has become important for the preschool age group as well as out of school hours care for older children.

The large institutions that once cared for children in need of care and protection have been closed and the foster care system has reached crisis point.

Who came to the Summit

Child protection is the concern of many disciplines and organisations who were represented at the Summit.

- State and Territory Governments
- Non-Government organisations
- child health
- welfare
- social work
- law
- education
- child care/early childhood
- police
- family organisations
- Indigenous groups
- Human rights groups

Summit program

The one day program was opened by Dr William Glasson, Federal AMA President, together with some lively dancers from Narrabundah Primary School in the ACT.

The morning session was made up of presented papers with workshop groups in the afternoon coming together with a plenary session at the end of the day.

Presented papers

- Associate Professor Dorothy Scott OAM: Child protection – a public health model
- Professor Graham Vimpani: Child abuse is not just a children's issue
- Dr Louise Newman: Child protection and children's rights
- Ms Muriel Cadd AM: Aboriginal and Torres Strait Islander child protection – key reform issues
- Ms Sandie de Wolf: Families Australia – an overview
- Dr Terry Donald: Forensic aspects of child protection – establishing the level of harm and the need for protection

What the speakers said at the Summit

Social conditions at the start of the 21st Century

Associate Professor Dorothy Scott set the scene in which many Australian children are growing up.

- There is a marked increase in the number of children who live in families where no adult is in paid employment.
- The number of single parent families has increased which, for many children, means living in poverty. It also means having a relationship with only one parent and half their extended family. It may also mean for some children being in close contact with men with whom they have no kinship ties and who may pose a greater risk of abuse.
- Many more children are growing up in families where parents are drug or alcohol dependent, or have a mental illness or a degree of intellectual disability.

Long term sequelae of child abuse

Professor Graham Vimpani brought new evidence to the Summit of the serious long-term effects throughout adult life of adverse childhood events. Child abuse is not just a children's issue. The trauma of abuse affects brain development with increased rises in the rates of lifelong adversity.

A large US study has clearly shown that:

- Adverse childhood experiences (ACEs) are very common.
- ACEs are strong predictors of health behaviours in adolescence and adult life.
- ACEs are one of the leading, if not the leading, determinant of the health and social well-being of a community. (reference)

Aboriginal and Torres Strait Islander children

Indigenous children are at an even higher risk of child abuse and neglect than other groups.

The cultural alienation of past Government policies, including that of removing Aboriginal children from their families, means that generations of children have grown up without ever having a close emotional relationship, without ever knowing their parents or extended family. These children are now the parents of the current generation.

Muriel Cadd described the key reforms proposed by the Secretariat for National Aboriginal and Islander Child Care (SNAICC).

- Making a formal apology to the Stolen Generations through the Federal Parliament.
- Establishing a National Indigenous Child Welfare and Developmental Council as a partnership between SNAICC, ATSIC, the Commonwealth and each State and Territory Government to drive child protection reforms.
- Expanding funding for Commonwealth funded children's services.
- Establishing progressive targets for reducing the current rate of Indigenous child removals by State and Territory welfare authorities.

Children's Rights and Immigration Detention

Dr Louise Newman, President of the NSW Institute of Psychiatry, presented stark observations of the conditions of children in immigration detention.

- Children are called by number, not by a name
- They have no education opportunities
- There is no safe place to play and the physical environment is monotonous
- They are exposed to violence and to physical risk
- They are exposed to suicidal and self harming adults
- They live with parents who are depressed and have lost hope
- Their environment is brutalising and dehumanising

What do we need to do to protect children...?

Strengthening Families

Ms Sandie de Wolf described how Families Australia, as the first national non-government peak body, is specifically concerned with family related issues. They aim to improve policies and programs affecting families through advocacy and representation at all levels of government.

In 2003, Families Australia undertook a project to establish a case for greater Commonwealth Government leadership and investment in child welfare.

Having a standard gauge for child protection

The different approaches to, and rules and regulation for, child protection in each State and Territory does not help Australian's children.

Professor Graham Vimpani clearly illustrated this point when he described the muddle of rail gauges that once beset Australia when each State had it's own size of rail gauge. It was both embarrassing and inefficient.

Having different gauges for child protection costs $$$$s and lives.

A public health approach to child protection

Why not approach child protection as we would a public health problem such as skin cancer asked Associate Professor Dorothy Scott ?

This model:

- Uses epidemiological research to identify prevalence and high risk groups
- Tackles the core environmental causes
- Institutes sustained population based interventions
- Improves the capacity of General Practitioners to screen for cases
- Treats diagnosed cases as early as possible.

The public health approach would use existing health, welfare an education structures. It would not need the introduction of new programs. We need to utilise

- Maternal and child health services
- Early childhood education
- Primary schools
- GPs and specialist services for adults.

Workshop groups: role of the AMA

Developing a coalition of organisations

- The profile of the AMA can be very valuable to the cause of child protection
- AMA's involvement will broaden a coalition and remind us that child abuse is a community issue – not just Government regulations.

Submissions to Government

- The AMA can lobby the Federal Government on social policy issues and advocate for the rights of children

Recommendations for training organisations

- The AMA can lobby to have prevention of child abuse and child protection made an integral part of training courses and of ongoing in-service education.

Reforms to the detention of children asylum seekers

- The AMA can advocate for children's rights – so that all children in any Australian jurisdiction receive the same level of health welfare services

Some quotes from the Summit

We are at the watershed in the history of child protection in Australia.

Associate Professor Dorothy Scott

The trauma of abuse affects brain development with increased rises in the rates of lifelong adversity.

Professor Graham Vimpani

Until Indigenous children can expect to grow up in an environment that meets their developmental needs we will continue to have Indigenous children over represented in child protection.

Ms Muriel Cadd

All I can see is the fence and us behind it

Child in immigration detention centre

The relative poverty and chronic demoralisation of families, schools and communities.....this is the sociological hole in the ozone layer.

Associate Professor Dorothy Scott

Child abuse cannot be tackled in isolation from school failure, child and adolescent mental health, parental alcohol and substance dependence, demoralised families and demoralised communities

Associate Professor Dorothy Scott

Child Protection: A Public Health Model

Associate Professor Dorothy Scott OAM
Head of Department
School of Social Work
University of Melbourne

It is almost 40 years since the paper "The Maltreatment Syndrome in Children" by the Victorian police surgeon Dr John Birrell and his paediatrician brother Dr Robert Birrell was published in the MJA (Birrell & Birrell, 1966). It documented the non-accidental injuries of children admitted to the Royal Children's Hospital in Melbourne. It followed the classic paper on "The Battered Child Syndrome" published by Henry Kempe and his colleagues in the Journal of the American Medical Association four years earlier (Kempe, Silverman, Steele, Droegmueller & Silver, 1962).

In the same issue of the MJA appeared Dr Dora Bialestock's paper on her examination of 289 babies consecutively admitted to the care of child welfare authorities which revealed significant developmental delay associated with child neglect (Bialestock, 1966). It is interesting to note that the Birrells' paper and the evocative term "the battered baby syndrome" caught the attention of press, professionals and politicians.

Child physical abuse and later child sexual abuse have commanded greater attention than neglect, despite the evidence indicating that neglect is more common and associated with more damaging long term outcomes. Is it because of the voyeurism created by acts of commission rather than acts of omission?

Is it because neglect seems less intentional and so our moral outrage is not as strong? Is it because neglect is associated with poverty and social disadvantage and we prefer a simple moral and legal model that focuses on the individual and ignores the societal context? Regardless of the reason, the suffering of children demands that we cease to neglect the problem of child neglect.

In our book Confronting Cruelty, Historical Perspectives on Child Protection in Australia (Melbourne University Press, 2002), Associate Professor Shurlee Swain and I have described the mid 1960s as the commencement of "the second wave" in the history of the child protection movement. The first wave, rising in the latter part of the nineteenth century and called the child rescue movement, led to the creation of Societies for the Prevention of Cruelty to Children in North America, the United Kingdom and in some parts of

Australia. In Melbourne the Victorian Society for the Prevention of Cruelty to Children, now the Children's Protection Society, was founded in 1896.

The faces of individual children have often been the catalyst for and the symbol of changes in child protection policy and practice. In New York it was the celebrated Mary Ellen whose case gave rise to the New York Society for the Prevention of Cruelty to Children. In Melbourne it was Leslie, born in 1889 and found scavenging for food on a Hawthorn rubbish tip with his sister. There is a photograph of Leslie, all dressed up in his rags in the photographer's studio for propaganda purposes of the Victorian Society for the Prevention of Cruelty to Children.

Next to him in the photograph is Inspector Noble in his fine uniform, the officer of the Society, commonly referred to in the slums of Melbourne as "the cruelty man", a term replaced in the twentieth century by "the welfare".

The newspaper headline cried "CHILD LIFE FRAUGHT WITH HORROR, STARVED AND FILTHY, TWO LITTLE SUFFERERS, TWO PARENTS PROSECUTED". After multiple occasions and the removal of several children, Leslie's stepmother, who was said to have a drinking problem, was sentenced to six months imprisonment and the children committed to the care of the State.

The headlines remind me of those which accompanied the publicity surrounding the conviction of the stepfather of Daniel Valerio, the child's whose bruised yet smiling photograph taken by a Police Surgeon was directly responsible fore the introduction of mandatory reporting in Victoria. It mattered not that his case was already known to the police and the child protection service but the emotion the case aroused demanded that "something be done". The press has always been a doubled edged sword in the child protection movement, increasing awareness of the plight of children and giving rise to moral outrage and policies that often have little empirical justification. Forty years on from the beginning of the second wave of the child rescue movement we can look back and say that while we still have a long way to go, a great deal has been achieved in recognizing and responding to child physical and sexual abuse. Yet despite our current knowledge on the causal pathways relating to child maltreatment and a broad range of related psycho-social problems, we are yet to fulfill the vision of over a century ago in relation to "the prevention of cruelty to children".

Forty years after the second wave of the child rescue movement began we face added challenges:

- A marked increase in the number of children living in families in which no adult is in paid employment (now once in six Australian children).

- A marked increase in the number of single parent families, which for far many children means living in poverty and having a relationship with only one parent and the support of only half their extended family. For some children it also means being exposed to unrelated men who pose a higher risk of abuse.

- A massive increase in the drug problem with many children seriously affected by parental drug dependence, now an intergenerational problem, and others exposed to the risks which parental alcohol abuse, mental illness or intellectual disability represent to children.

- An escalation in the notifications to child protection authorities per annum (for example a six fold increase in Victoria over the past 30 years), reaching 198,355 in 2002/2003, plunging the child welfare systems in some States into crisis

- After a period of marked decline in the number of children coming into the care of the State since the 1960s, in recent years this has been reversed (from 13,979 at June 30 1997 to 20,297 at June 30 2003, representing a 45% increase).

- The almost total disappearance of stable residential care in the child welfare field in Australia and the rapid demise in the number of families willing to foster children, with an alarming level of instability in this system (eg over 60% of children in or of home care in Victoria having had four or more previous placements).

Incidence of Child Abuse and Neglect

I will not explore the issue of how child abuse is defined except to say that it is an historical and cultural construct, and that many parental behaviours which would once not have been regarded as child abuse or dealt with by informal social sanctions are now seen as the responsibility of the child protection system. It is unclear whether there is evidence of an overall actual increase in child maltreatment. That is not to say that it was not and is not a serious problem. There is certainly an increase in awareness of the issue and a far greater willingness to report alleged cases but there is little evidence as to whether the latter helps or harms most children caught in the child protection net.

Because of the elasticity of the phenomenon and its stigma, we have virtually no prevalence data on child maltreatment or even sound data on the incidence of non-accidental injuries to children presenting to hospitals. The national data on the incidence of child abuse notifications collected by State child protection authorities is inherently problematic. Differences between

States and within States over time in regard to policies and methods of data collection make comparisons invalid. For example, States such as WA and Tasmania have two level systems and their data do not include the vast majority of child neglect cases. Notifications of alleged abuse do not equate to children as there is a significant rate of renotifications of the same children in most States (for example, 60% of notifications in Victoria are children who have been previously notified).

At the same time we know that some children who should be notified are not, and that only 20% of those notified are substantiated as child abuse cases. This highlights an issue which is almost always ignored – the likelihood that in our current system a very large number of families are subject to the intrusive investigation by the State for alleged child maltreatment that is not substantiated. The possible effects of this on families are unknown but in the UK, which incidentally has approximately half the notification rate of some Australian States, research suggests that even in cases where alleged abuse is not substantiated, these families are subsequently less likely to utilize services.

My clinical experience and my qualitative research with such families suggests they are left very angry, fearful and deeply humiliated. The resource implications in terms of the ever expanding but poorly qualified child protection workforce where there are chronic and severe problems of recruitment retention are enormous. It is a sad statement that the number of child protection workers in Victoria now exceeds the number of maternal and child health nurses. I expect this is also true of other States.

Given these qualifications, it is still useful to examine some key facts.

- From 1999/2000 to 2002/2003 the number of notifications to child protection authorities in Australia increased from 107,134 to 198,355.
- From 1999/2000 to 2002/2003 the number of substantiated reports rose from 24,732 to 40,416.

This dramatic increase is overwhelmingly due to the doubling of NSW notifications (and substantiations) in the wake of introducing a centralised intake system and increasing penalties for failure to report suspected child abuse. If we take this into consideration, the increase is much lower but there has still been a steady increase over the past decade.

Indigenous children are grossly over-represented in the child protection system. For example, the rate of indigenous children in substantiations was nearly ten times the rate for other children in Victoria and seven times in WA. While a decade ago it was common to dismiss this as a reflection of culturally insensitive practice and over-intervention by the State of which of course

there is a long history, in recent times there has been a greater willingness to acknowledge the reality of neglect, physical abuse, sexual abuse and exposure to domestic violence in some indigenous communities and the broader context of poor health and educational outcomes for indigenous children.

Nature of Child Maltreatment

What do we know about the nature of the abuse and the characteristics of these children and their families? Victoria has collected some of the best data on this and it is highly illuminating. I expect that it can be fairly safely extrapolated to other States.

Victorian Children First Investigated and Substantiated in 2001/2002 (n= 3839)

Emotional	43.9%
Neglect	19.7%
Physical	28.1%
Sexual	8.3%
Total	100%

The patterns vary according to age

- Children aged 0-4 had higher levels of environmental neglect, exposure to domestic violence, exposure to parental psychiatric illness and likelihood of significant physical harm than other age groups.
- Children aged 5-9 were more likely to suffer significant harm due to sexual abuse.
- Young people aged 10-14 and those over 15 were more likely to have involvement in high risk/self harm, homelessness and suicide risk

Familial and Social Characteristics

What do we now about the families of these children? There is no national data on this but the picture which emerges from Victoria which has some of the best data, is very illustrative of the broader familial and social context of child maltreatment.

Parents with "Concerning Characteristics": 6591 Cases First Investigated 2001/02, Victoria

Psychiatric Illness	14.7%
Intellectual Disability	2.2%

Physical Disability	2.9%
Alcohol Abuse	21.3%
Substance Dependence	25.2%
Domestic Violence	40.3%

(Does not add up to 100% as some parents do not have any of these characteristics and others may more than one).

The child protection data also indicate a gross over-representation of low income and single parent headed households. For example of families investigated for suspected child abuse in Victoria in 2001/2001, more than 75% were on low incomes and 45% were sole parent families (Department of Human Services, An Integrated Strategy for Child Protection and Placement Services, 2002, page 2)

Where to From Here?

Doubling child protection notifications every decade or less is unsustainable and poses great risks to children caught up in a complex bureaucracies. Intervention is not based on an individualized professional assessment of each child and their family driven by the question "How is the child and what do we need to do to assist?" but is increasingly based on processing cases along an overloaded assembly line of legalistic procedures that asks "Do we have a case that meets the threshold of evidence that justifies court action?" This is its fundamental weakness.

When the system is overwhelmed as occurred in NSW in recent times, there is an intensification of staff turnover and a decrease in referrals to family support services as the system just can't process the cases to make referrals. The child protection system thus becomes like a Casualty Department flooded by cases and with the staff in flight.

An overloaded system has only 2 choices – to have a waiting list such that the small proportion of endangered children will be harmed by the time you finally get to them, or do "quick and dirty" risk assessments, resulting in a high rate of both false positives and false negatives. It is important to recognize that child abuse does not lend itself easily to triage. All the risk assessment instruments have very high false positive rates, and of course, statutory intervention is dependent on actual evidence of significant harm, not a statistical measure of risk.

Policies such as mandatory reporting for suspected child abuse exacerbate the situation as professionals are more inclined to engage in defensive notifications. There are also an enormous number of notifications from the public. These have the lowest substantiation rate. It is like all professionals

and the public being able to make referrals to the intensive care ward of the local hospital! No wonder the system is under siege.

The UK which does not have mandatory reporting but which has inculcated in health and educational professionals a strong ethos of appropriate referral, has half the notification rate of States such as Victoria (eg 15 per 1000 children in the UK compared with 30 per 1000 children per annum).

Why do professionals notify cases to child protection authorities which are unlikely to reach the court's threshold of evidence of significant harm? We do not have good data on this but I would suggest that they do so because:

- the law or the protocol of their employing agency requires them to do so
- they are afraid not do so in case a child is subsequently harmed
- they have a sense of helplessness in how to assist the family
- they have an illusion that statutory intervention will help

With the exception of children whose plight is so severe that they need to be removed from their families, and those parents who respond, often temporarily to threats of removal, it is hard to see how such intervention is helpful. Given that the removal of a child is itself such a potentially damaging intervention, it can only be justified when it is likely that significant harm will result from not doing so and in most cases this cannot be argued with any confidence.

What evidence do we have that parental behavioural change can be achieved this way? The answer is very little. What is so surprising is that there has been so little research on the fundamental question of the efficacy of child protection intervention on parental behaviour and child outcomes. Contrast this with our approach to behaviour we classify as a "health" problem such as parental smoking.

Here the long term physical, cognitive and behavioural risks associated with exposure in utero are clear. We do not use statutory intervention to protect children from this type of parental behaviour while we use such powers when we lack evidence on the effects of other parental behaviours. Why? Because we see it as a public health problem and we know that coercive interventions are likely to fail.

We need a public health approach to child protection. Let us look at what we do with a problem such as skin cancer.

- we use epidemiological research to identify prevalence and high risk groups
- we tackle the core environmental causes
- we institute sustained population based interventions
- we improve the capacity of GP's to screen for skin cancer

- we treat diagnosed cases as early as possible

What would a public health approach to the problem of child protection look like? We could operationalise physical abuse and neglect in ways that would enable us to measure them at a population level better than through child protection notification rates. For example, we could measure the number of children admitted to hospital with non-accidental physical injuries, the number identified by universal maternal and child health services as suffering from non-organic failure to thrive, the number of child who are not ready to start school, or the level of school absenteeism in a community.

We already know that child maltreatment is associated with a range of other problems such as school failure, child behavioural problems, child and adolescent mental health problems, drug dependence, juvenile crime, teenage motherhood etc. We also know that there is a common set of risk and protective factors in relation to these problems. The quality of early parent-child attachment, peer and school connectedness, the availability of social support and poverty are all important.

A major background factor is the economic and social decline in regions undergoing economic restructuring, and the consequent relative poverty and chronic demoralisation of families, schools and communities. It is not so much a matter of absolute poverty. This was far worse in the Great Depression but there was greater extended family support and social cohesion.

This is the sociological hole in the ozone layer. We have to address the underlying causes, but they are very hard to change and even if society has the political will to do so, it will take a long time to have an impact because we already have a generational cohort that has had a high level of exposure.

Prevention programs or "the slip, slop and slap" strategies are more within our reach. A meta-analysis of prevention programs (Durlak 1998) suggests that those that are multi-facetted and address the underlying risk factors are more effective than those that are single issue focussed such as preventing teen pregnancy.

Primary prevention of child abuse can range from social attitudinal and behavioural change via mass media such as the "Don't Shake the Baby" campaign to highly focused secondary prevention based on the reforming universal health and education services so that they become vehicles for strengthening families, extending social networks and rebuilding communities.

The latter is the approach underpinning population-based initiatives such as Families First in NSW and Sure Start in the UK. These are cross-sectoral initiatives in which leadership comes from the Premier's of Treasury, thus

transcending Departmental boundaries and barriers and reforming funding models so that they are no longer based on single input services based on categorical funding, the source of such much fragmentation and duplication.

A New Vision For Child Abuse Prevention?

Maternal and Child Health Services

Through the 1:1 supportive relationship that the nurse can establish with families through performing the basic paediatric surveillance role for all children 0 to 6 years, she is well situated to perform primary, secondary and tertiary prevention roles if adequately resourced, trained and supported to do so.

For example at the primary prevention level – first time parent groups. In Victoria now two thirds of all first time mothers join 8 week groups offered by local maternal and child health nurses. In a follow study 2 years later it was found that over 80% of the groups had continued to meet in one another's homes and that a high level of significant friendships had been established between families. The maternal and child health nurse thus has the potential to play a central community development role.

At the secondary prevention level, the maternal child health nurse is ideally located to act as the base from which home visiting programs by professionals, paraprofessionals or volunteers are offered to vulnerable families. At the tertiary prevention level, the maternal and child health nurse may have the potential to undertake the roles now being performed by UK Health Visitors with mothers with a substance dependence, linking them to home-based detoxification services and child care assistance. In many case this could be done without the direct involvement of child protection services.

Early Childhood Education

One could apply the same thinking to early childhood services, as the SDN Children's Services in Sydney is doing, developing ways to reach out from an early childhood centre that also provides high quality care, stimulation and good nutrition to the child while skillfully engaging parents with problems such as substance dependence. Again this type of work is best done in the context of trusting relationships outside the child protection system but could also be provided to families under a Children's Court order.

Primary Schools

Schools are also a major vehicle for reaching families and in States such as NSW initiative such as the Schools as Community Centres have led the way. The outreach potential of school based social workers, psychologists and nurses in working with vulnerable children and families is still undeveloped. Programs such as Families and Schools Together demonstrate how it is

possible to work with families in ways which strengthens mutual support between them.

GPs and Specialist Services for Adults

GPs, paediatrician and child psychiatrists obviously have a central role in relation to their child patients but an aspect of the GP role which has received little attention is where parents have health conditions that pose a risk to children. It should be possible for GPs to work with their patients with say a serious mental illness or substance dependence so that the children are also part of the strategy?

The same applies to specialist services in the drug rehabilitation field, adult mental health services and intellectual disability, all of which have the potential to offer family centred services if given the right training and resources to do so.

In short, our current health and education services have been far too focused on notifying suspected maltreatment and are missing opportunities for primary and secondary prevention.

While the role of family support services and specialist child welfare NGOs are vital of course and there will always be a place for statutory child protection intervention for some children, the major challenge is building the capacity of the rest of the service system and strengthening the collaboration between services across the whole breadth of the human services – health, education and social welfare.

A Third Wave of the Child Protection Movement?

We are at a watershed in the history of child protection in Australia. Are we ready to embrace the third wave of the child protection movement – one based on prevention and integrated early intervention? We have little choice. Our reactive, legalistic and bureaucratic child protection systems are imploding with increased notifications, an unstable and fragile workforce, increased numbers of children coming into care and a diminishing number of foster families. The current system is completely unsustainable.

We have the knowledge to create an evidence and population-based prevention strategy which addresses child abuse and its associated psycho-social problems. Child abuse cannot be tackled in isolation from school failure, child and adolescent mental health, parental alcohol and substance dependence, demoralized families and demoralized communities.

It is in the nation's self interest that we adopt a broad public health strategy. If we are to nurture a generation of children who have the capacity to contribute to the society by virtue of being healthy, literate, law abiding, tax paying

adults, then strengthening families and rebuilding communities need to be right at the top of our national agenda. There are signs of hope that the message has been heard and that children's needs are receiving greater salience not just in the political context, but in the community at large.

In 1969, at the height of the second wave of the child rescue movement, Professor Wallace Ironside from the Department of Psychological Medicine at Monash University spoke these words.

> ... future historians will look back on this age as one in which ... children were paradoxically deprived of their birthright in spite of increasing knowledge of the developmental requirements for healthy emotional, mental and personality growth.

This does not have to be the scenario. If there is sufficient collective will, the third wave of the child rescue movement can be one based on public health and prevention.

References

Bialestock D 1966. Neglected babies: a study of 289 babies admitted consecutively to a reception centre. *Med J Aust,* Dec 10;2(24): 1129-33.

Birrell RG, Birrell JH 1966. The "maltreatment syndrome" in children. *Med J Aust,* Dec 1;2(24): 1134-8.

Durlak JA 1998. Common risk and protective factors in successful prevention programs *Am J Orthopsychiatry,* Oct;68(4): 512-20.

Kempe CH et al 1962. The battered-child syndrome. *Journal of the American Medical Association,* 22;251(24): 3288-3294.

Aboriginal and Torres Strait Islander Child Protection Key Reform Issues

Ms Muriel Cadd AM
National Chairperson
Secretariat of National Aboriginal and Islander Child Care

Introduction

I would like to begin today by recognising that we are gathered here on the traditional lands of the Ngunnawal people.

Like all Aboriginal and Torres Strait Islander peoples of Australia the history of the Ngunnawal extends beyond all other chapters of human history and is rich with culture and traditions, language, story telling, dance, arts, spiritual practices and beliefs, knowledge and wisdom.

Sadly though our more recent history has been tainted with stories of violence and dispossession, child removal and family break up, forced relocation, poverty and marginalisation. The next chapter in our shared history is being written today and it concerns the future of Ngunnawal children and of all the Indigenous children in Australia.

SNAICC appreciates the opportunity to gather here in Ngunnawal country to discuss these issues and as the dancers showed us this morning children and young people are the key to ensuring that our culture remains strong.

We would also like to acknowledge and thank the Australian Medical Association for convening this summit. Whilst child abuse and neglect are issues which have been on the national agenda in recent times we need to sustain the focus on children if we are to make progress. For over 20 years SNAICC has advocated that we need national policy on child protection. We are pleased then that the AMA has convened this summit to build partnerships to pursue that goal.

Historical context

Since the earliest days of colonisation Aboriginal and Torres Strait Islander peoples were subjected to harsh, discriminatory, racist and profoundly damaging policies of state intervention into the lives of their families.

Throughout the nineteenth and most of the twentieth century control and forcible removal of children from their families became the dominating intervention in child welfare practice, often motivated by the desire to eliminate Aboriginal and Torres Strait Islander people by preventing their children from being raised as Aboriginal or Torres Strait Islander.

This racism was based on the belief that Aboriginal and Torres Strait Islander people weren't good enough or capable of looking after their own children. That our children would be better off away from their parents, families and communities. As I will touch on later this racism is still present in our child protection systems today which in many instances still assumes our children would be better off away from their family and community.

The policies and practices of child removal gave rise to what has become known as the Stolen Generations with calls for a national apology and compensation to those affected featuring as prominent political issues in recent years.

SNAICC was in fact the first national organisation to call for an inquiry into the Stolen Generations. SNAICC has also been at the forefront in calling for a national apology to the Stolen Generations from the Federal Parliament and we again call upon our elected political leaders to support a national apology. Whilst we know what the current Prime Minister thinks about this issue the views of the Opposition leader are a little less clear. SNAICC was heartened by the strong stand the two most recent leaders of the Federal ALP took in support of a national apology and we trust the current leader, Mr Latham, will have the heart to support an apology. Being all brains and no heart is no recipe for success.

Child removal policies and the economic, social and political segregation of Aboriginal people throughout Australia, for a period of a hundred years or more, laid the foundation for the unemployment, poverty, homelessness, poor educational access and family dysfunction which Indigenous people experience today.

Arrangements for the welfare of Indigenous children today need to recognise this historical legacy – not by making excuses for perpetrators of abuse or violence – but by addressing the underlying causes of abuse and neglect.

The Current Situation

In considering these issues it is not sufficient to speak about child abuse without explicitly speaking about family violence and child neglect. Neglect and the impact of violence are issues which seem to get lost in the discussion about child abuse. They are however very significant factors amongst the

complex reasons which lead to so many of our families having contact with child protection authorities.

As participants at this summit would probably know Aboriginal and Torres Strait Islander children are over represented in the child protection system including in out-of-home care. As noted in the recent report of the Australian Institute of Health and Welfare, Child Protection Australia 2003 – 2003; our children are upto ten times more likely to be removed from home and placed in out-of-home care.

However the reasons why our children enter the child protection system differ from the reasons for other children. Child neglect – not child abuse - is the most significant cause of Indigenous children coming into contact with child protection. Another significant difference, particularly in Victoria, is the higher incidence of emotional abuse as a result of children witnessing and living with family violence. The harm children suffer when they are exposed to violence is now recognised as a form of emotional abuse and this has led to an increase in child protection notifications.

When we understand that child neglect is the major contributor to child protection notifications for our children it becomes clear that the most effective way to protect Indigenous children is to strengthen their families and develop Indigenous communities.

We cannot escape the fact that impoverished communities raise impoverished children and that poverty remains the single greatest cause of family breakdown, child neglect and child removal. Not sexual assault, not violence, not alcohol or other forms of substance abuse, not bad parenting - but child neglect where poverty prevents families from being able to care for their children.

A focus on child development

In order to start addressing the underlying causes of child abuse and neglect we need to invest in the development of children. Our children are three times less likely to access early childhood services than other Australian children but six times more likely to be in the care and protection system. This is not a coincidence.

We must improve access for Aboriginal and Torres Strait Islander children to culturally appropriate early childhood services, programs and support and provide our children with a better start in life. Whilst the Commonwealth has said a great deal about the importance of the early years we need some stronger leadership and stronger investment. A good place to start would be in relation to Commonwealth funded child care and family support services. The next Federal Budget should, if we are serious about investing in the early

years, substantially expand Commonwealth child care services and family support programs for Indigenous communities.

Until Indigenous children can expect to grow up in an environment that meets their developmental needs we will continue to have Indigenous children over represented in child protection.

Listening to the voices of Indigenous people.

So where have we gone wrong ?

As I mentioned earlier SNAICC's view is that the racism that led people to take or children away in the past century lives on. At each and every level of the child protection system decisions continue to be made about the welfare and future of our children without us at the table. Our voices are still not being heard when and where it matters.

By way of example at the national level the Commonwealth State and Territory Governments have recently established an inter-governmental working group, the Indigenous Services Working Group, to examine issues relation to Indigenous child protection. This group has no representation or input from SNAICC or any other Indigenous organisations, communities or families.

At the local practice level decisions continue to be made on a daily basis about the removal of our children from their families and placement of these children into non-Aboriginal care with no family or community input.

Currently our systems of child protection mistakenly see children as individual victims rather than as members of a family and community which may also have been victimised, neglected or abused. Too often our child welfare interventions focus exclusively on the child and fail to address the needs of the family and community to which the child belongs. Too often the response is to remove a child but leave behind a dysfunctional family and an impoverished community to bring another child into the world.

SNAICC argues that fundamental reforms are required to shift our systems of child protection from their narrow risk and resiliency focus to a broader more holistic focus based around community development and family support.

This is in fact what Aboriginal people have been advocating since the 1970's including at the First Aboriginal Child Survival Seminar convened in 1979 by the Victorian Aboriginal Child Care Agency, VACCA.

In a workshop on Aboriginal Community Involvement the seminar recommended that the development of Aboriginal Child Care Agencies be

supported with agencies to be expanded to ensure state wide coverage in all States and Territories. Significantly it recommended that these agencies be focused broadly on family support and primary prevention of family breakdown. This hasn't happened. Whilst there are over 30 such agencies operating in Australia they have typically only been funded to work in the tertiary end of the child protection system and agencies have not been established in most parts of Australia.

There was a shared concern amongst delegates, black and white, for the survival of Aboriginal children and families given the high rates of family breakdown and institutionalisation of Aboriginal and Torres Strait Islander children. The seminar heard reports of the massive over representation of Aboriginal and Torres Strait Islander children in the child welfare institutions and advocated for Indigenous home based care.

Last year SNAICC gathered people again, including some from 1979, at the National Indigenous Child Welfare and Development Seminar – Our Future Generations. Delegates noted that there had been significant progress in providing home based care to replace institutional care through the Aboriginal Child Placement Principle.

However behind the successes of the past two decades lies the ongoing failure to reduce the over representation of Indigenous children in the care and protection system of each State and Territory. Undoubtedly we have better ways of caring for Indigenous children removed from home but the rates of child removal are in reality no better than they were 23 years ago.

Reform proposals

SNAICC has outlined a number of reform proposals in a paper we have prepared for this summit. These proposals reflect much of the discussion at Our Future Generations as well as SNAICC's independent analysis of the needs of children.

We ask delegates to read the paper and support the proposals in your various workshops.

In summary the key reforms SNAICC proposes are:

1. Making a formal apology to the Stolen Generations through the Federal Parliament.

2. Establishing a National Indigenous Child Welfare and Development Council as a partnership between SNAICC, ATSIC, the Commonwealth and each State and Territory Government to drive child protection reforms

3. Expanding funding for Commonwealth funded children's services in the next Federal Budget - minimum of $15 million per annum

4. Establishing progressive targets for reducing the current rate of Indigenous child removal by State/Territory welfare authorities.

5. Establishing national benchmarks for all government services to ensure planning takes account of the high proportion of Indigenous people under the age of 30, (70%).

6. Implementing recommendations from Bringing Them Home in relation to National Standards legislation and National Framework legislation to reform child protection

7. Establishing and funding a National Indigenous Family and Children's Resource Centre to developing culturally appropriate community based child abuse prevention programs

8. Providing Aboriginal and Torres Strait Islander families with improved access to culturally appropriate family support services to combat family breakdown

9. Improve compliance with the Aboriginal Child Placement Principle through strategies including improved financial and other support to Aboriginal and Torres Strait Islander foster carers.

Conclusion

We know that significant numbers of Aboriginal and Torres Strait Islander children continue to grow up in circumstances which mean they will confront disadvantage and injustices which most children in Australia will, fortunately, never know.

That so many Aboriginal and Torres Strait Islander children overcome the prejudice and disadvantage which confronts them is a source of inspiration to SNAICC and our members who work closely with them. Let their courage inspire you to pursue the far reaching

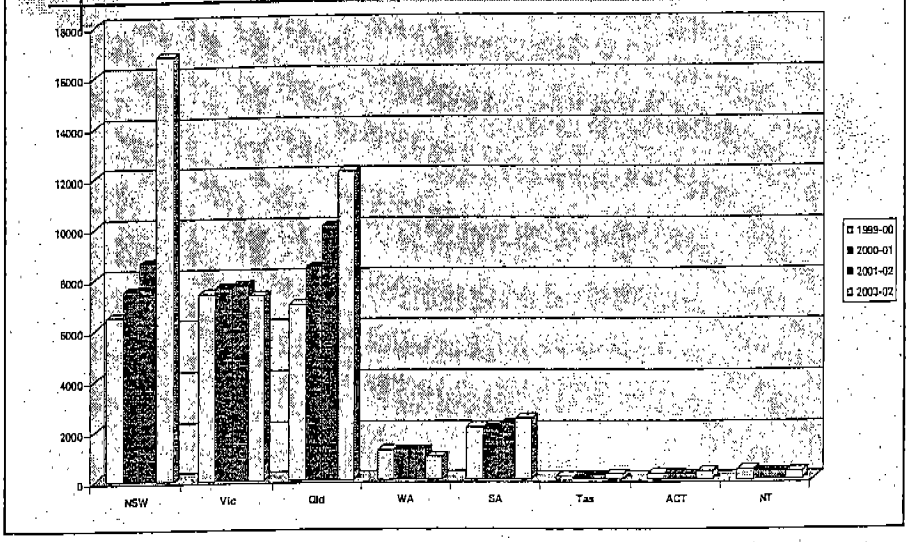
Child Abuse – it's not just a children's issue

Professor Graham Vimpani
Head of Discipline of Paediatrics and Child Health
University of Newcastle

Overview

- Child abuse is common and there is some evidence of variation in incidence over time
- The trauma of abuse affects brain development with increased rises of lifelong adversity
- Reducing the incidence of abuse and the context that contributes to it should be a national priority – effective strategies exist
- Political will to overcome the "our rail gauge is best" mentality must be fostered

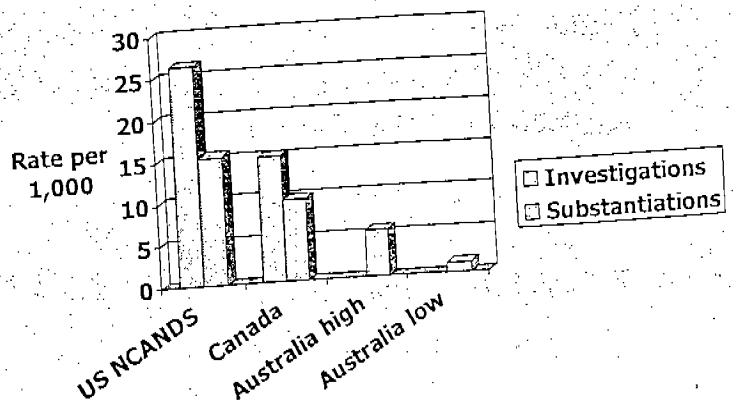
Substantiated cases of abuse (AIHW 2003)



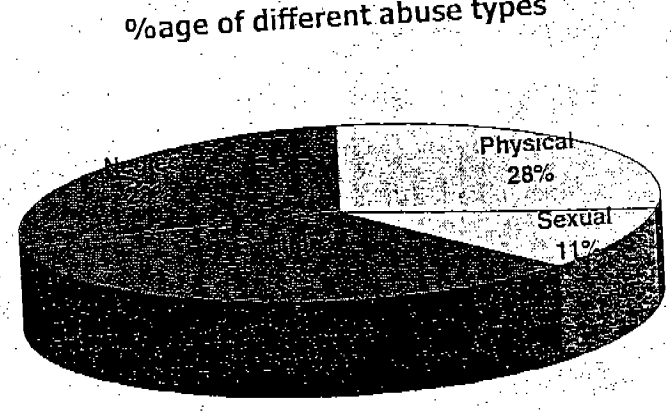
Questions about data

- Why are rates static in most places except NSW & Qld?
- Why are rates disproportionately lower in Victoria & WA?

Comparative data on Investigations and Substantiations from Australia, Canada and US



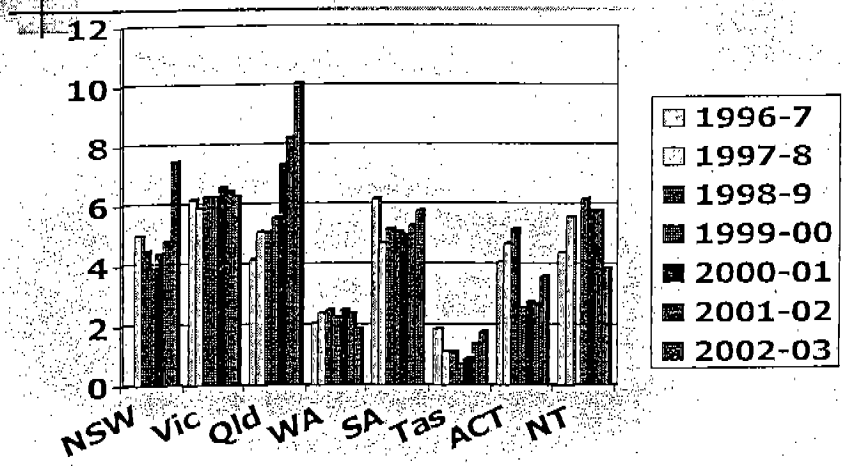
Types of Maltreatment (Australia)



More questions about available data

- Proportion of substantiated cases due to different categories of abuse vary between jurisdictions – why?
  - Physical abuse: 23% Qld – 43% NT
  - Sexual abuse: 5% Qld - 29% Tas
  - Neglect: 19% NSW – 42% SA (59% US)
  - Emotional abuse: 5% SA – 44% Vic

Rates (per 1,000) of children 0-16 yrs subject to substantiation



More questions about available data

- Why are rates lower in Tasmania and WA?
- Why are rates rising in Qld and nowhere else?

Ratio of Indigenous: Other substantiation rates

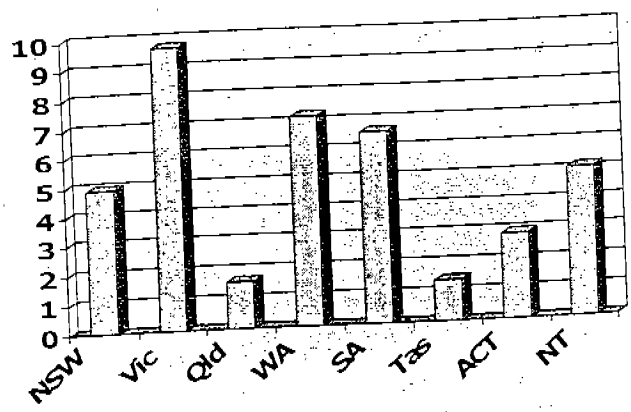
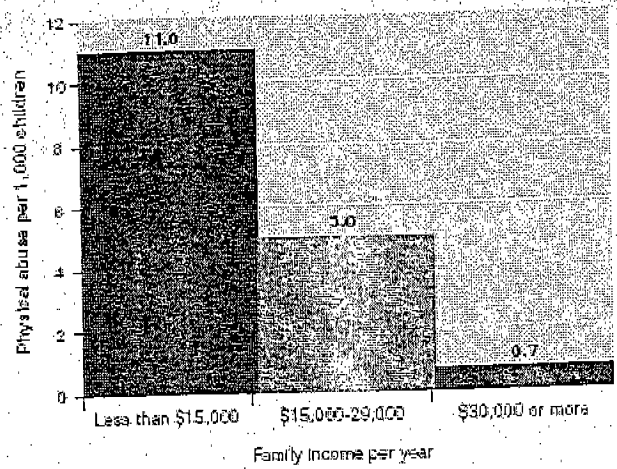
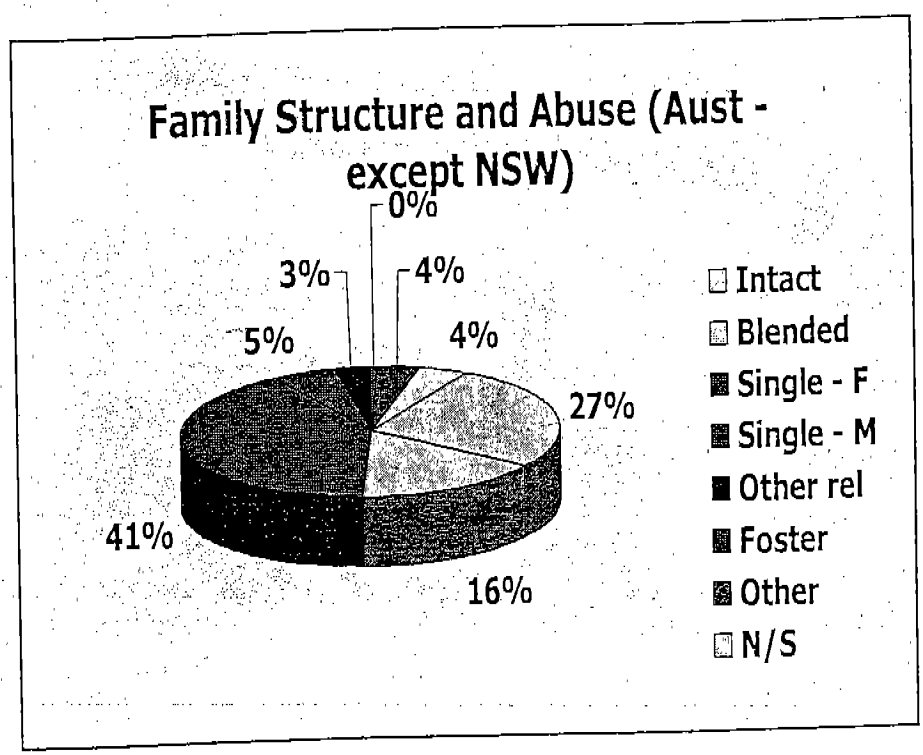


Figure 12 Family income and physical maltreatment

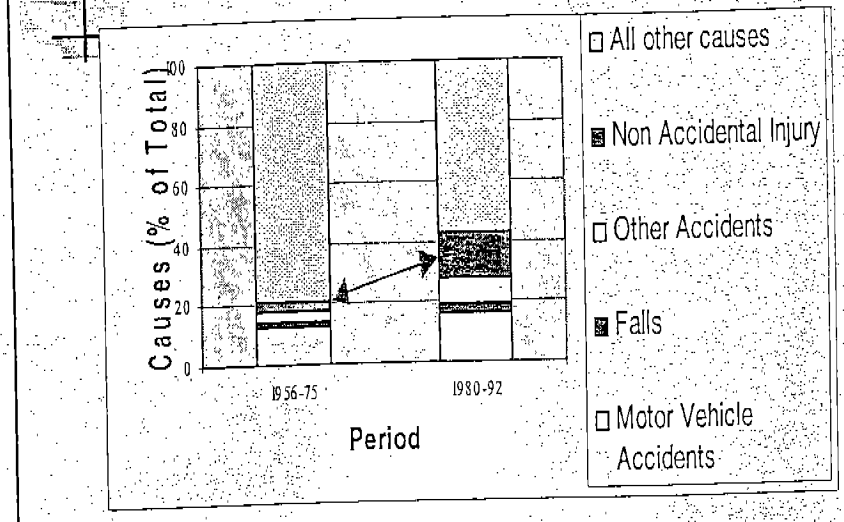
The table shows the number of children who have suffered demonstrable harm as a result of physical maltreatment by a parent or parent substitute. Data are expressed per 1,000 children living in families in each income bracket. Data are from the USA in 1993.





Increase in Child Abuse

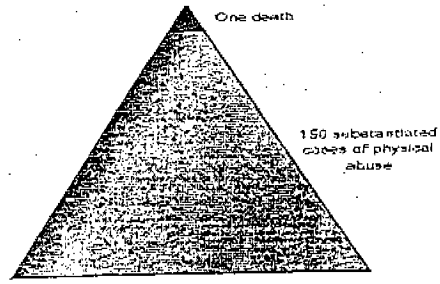
Causes of Child Cerebral Palsy in Western Australia

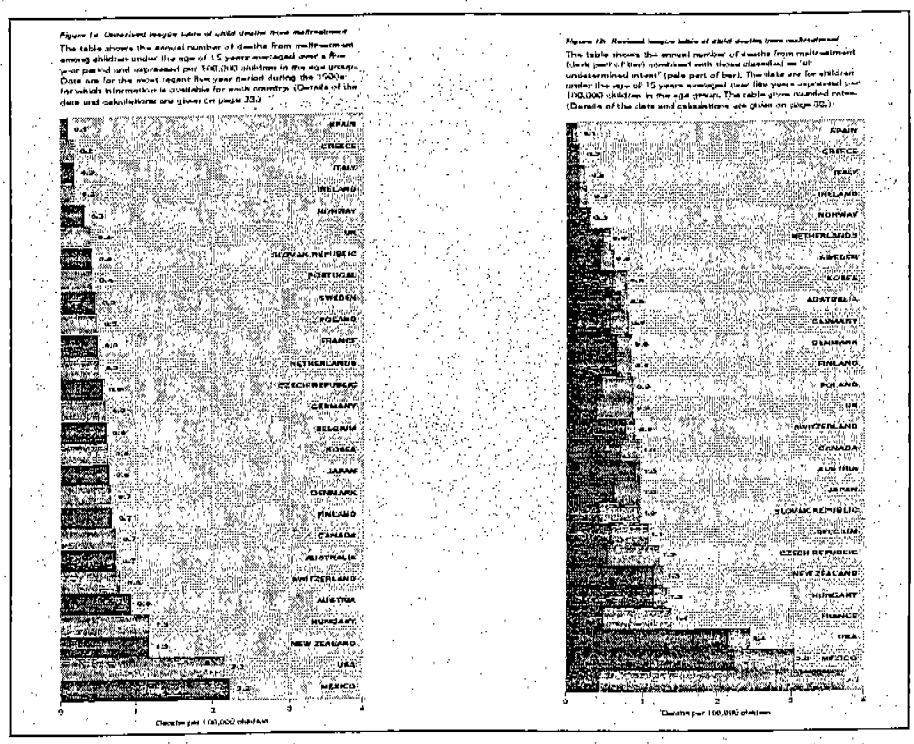


Ratio of deaths to substantiations - Australia

Figure 9
The physical maltreatment 'iceberg'

For every one death from maltreatment among children under the age of 15 years in Australia during 1999-2000 there were 150 cases of physical abuse that were substantiated following investigation.

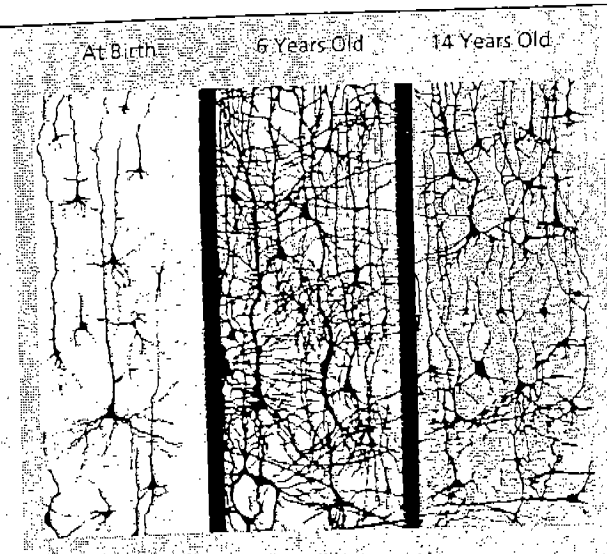




Trauma and brain development

Is the brain hard-wired?

- Brain at birth is about 1/3 adult size
- By age 6, 90% adult size
- Increase in size due to increased growth of neural networks and supporting tissue (glia) not in numbers of neurons
- Neural networks proliferate in early life and subsequently pruned – retained pathways reflect use-dependent response to experience



SYNAPTIC DENSITY: Synapses are created with astonishing speed in the first three years of life. For the rest of the first decade, children's brains have twice as many synapses as adults' brains.

Drawings supplied by H. T. Chugani.

The human brain is awesome!

- 2 million miles of neuronal fibres
- 20 billion neurons – each connected to an average of 10,000 other neurons
- Trillions of synapses
- Number of possible firing patterns (on/off profiles) – ten to the millionth
- The most complex natural or artificial thing known

Brain & Mind: Biology & Experience

- Brain responds to experience from the start of life by altering neuronal connections – these allow memory
- Brain structure → brain function → mind
- Information is stored in a *use-dependent* fashion
  - the more a neurobiological system is *activated* the more that state (and functions associated with that state) will be *built-in*
    - memorising a poem
    - practising the piano
    - staying in a state of fear

Experience and brain development

Experience expectant

- Binocular vision
- Relationships

Experience dependent

- Skill acquisition
- Trauma

Memory – *ghost from the past*

Implicit

- From birth (or earlier)
- Creation of circuits for emotion, behavioural response, encoding of bodily sensations
- Forms mental models → generalisations of repeated experiences
- Attachment experience critical
- No sense of recollection when memories recalled

Explicit

- From second year
- Sense of recollection present when recalled
- Factual and autobiographical
- Autobiographical – sense of self and time present; involves prefrontal cortex
- Prefrontal cortex development affected by interpersonal experiences
- Requires conscious attention
- Involves hippocampus

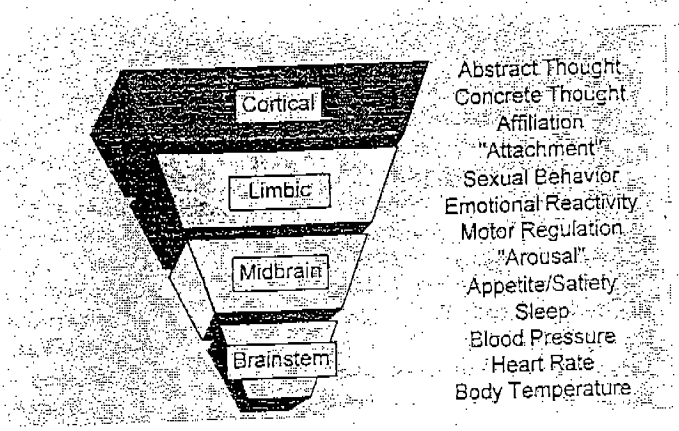
Interpersonal neurobiology

- Ways parents interact with their children influence later developmental pathways – *biological embedding of experience*
- Attachment relationships promote development of integrative capacities of brain → acquisition of emotional, cognitive and interpersonal abilities including self-regulation
- Trauma during infancy and childhood has the potential to permanently influence brain organisation
  - and hence all future functional capabilities of the child

Stress & Memory

- Stress may impact differently than non-traumatic events
  - Interfere with normal progression of memory encoding and storage
    - e.g. inhibition of hippocampal processing of an input by stress hormones or neurotransmitters – implicit but not explicit memory processed
    - *or* focus conscious attention on non-traumatising aspect of environment
  - Recall of implicit-only memories – dread, flashbacks

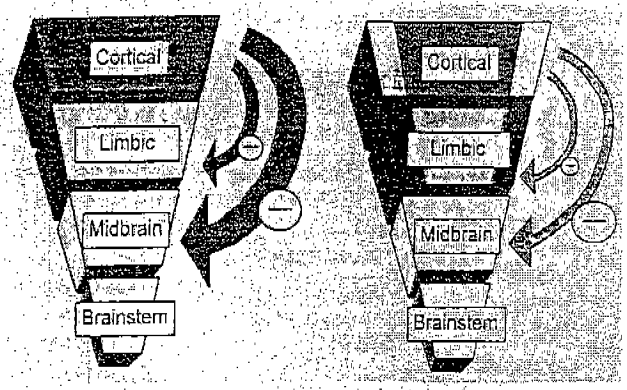
Hierarchy of Brain Function



Key points in brain development

- Optimal development of more complex systems (eg cortex) requires healthy development of less complex systems (eg midbrain and brainstem)
  - if state-regulating parts of brain (midbrain and brainstem) develop in less than optimal pattern (eg excessive traumatic experience), this will impact on development of all other brain systems

Cortical Modulation - age related



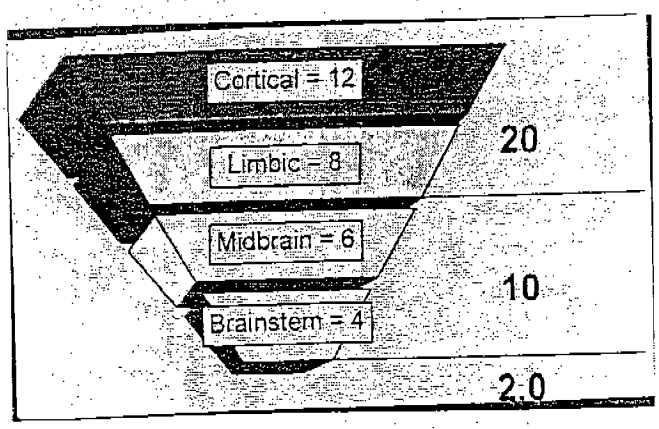
Cortical modulation

- The capacity to moderate frustration, impulsivity, aggression and violent behaviour is age-related
- With a set of sufficient motor, sensory, emotional cognitive and social experiences during early childhood, the mature brain *normally* develops an ability to tolerate frustration, control impulsivity and channel aggression

Cortical modulation

- Adverse early childhood experiences – such as trauma – impairs development of this capacity – see figure

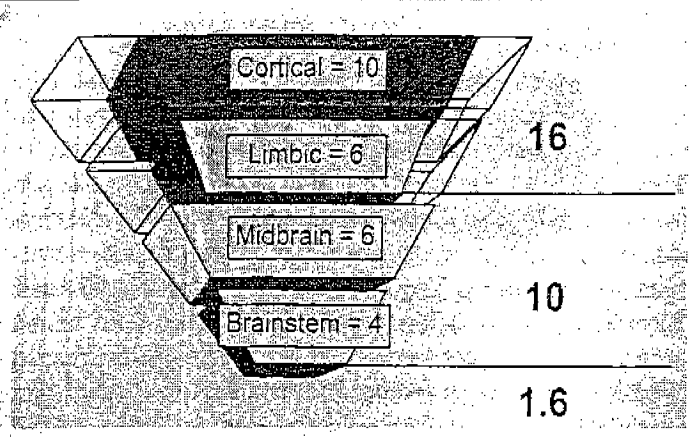
Ratio of Modulation: optimal development



Ratio of modulation in optimum development

- This indicative ratio suggests the relative "power" of the maturing and mature brain to modulate the more primitive, reactive, reflexive midbrain and brainstem
- Any disruption to normal development that "overdevelops" the midbrain or brainstem or "underdevelops" limbic and cortical areas will affect ratio and predispose to aggressive and violent behaviour

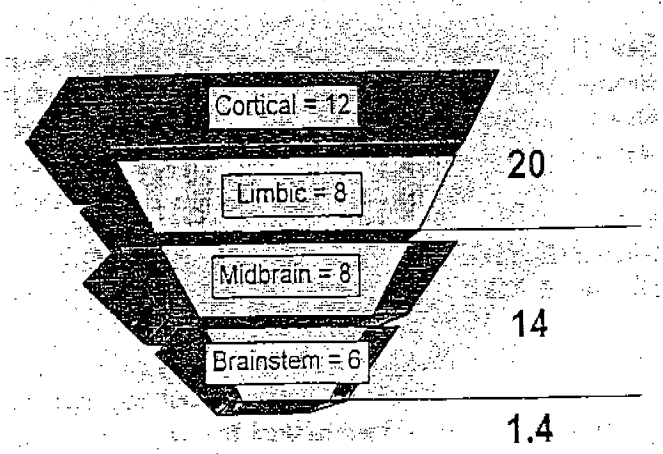
Developmental neglect



Developmental neglect

- Absence or reduction of key experiences results in poor modulation of impulsivity, immature emotional and behavioural functioning and a predisposition to violence
- Ability of maturing brain to modify impulsive and reactive responses in face of stress or frustration is diminished

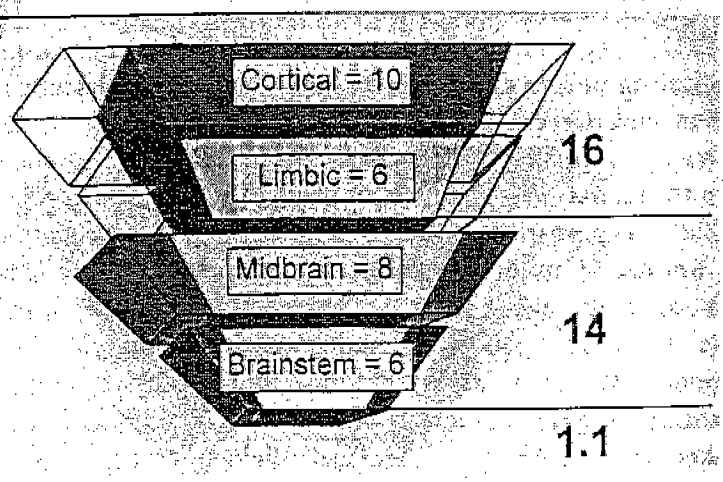
Persisting fear response: developmental trauma



Persisting fear response

- Children raised in violent environments likely to develop extremely active and reactive stress-response apparatus
- Most stress-response systems lie in midbrain or brainstem
- Relative overdevelopment of these areas predisposes to aggressive, impulsive and reactive behaviour

Neglect *and* Trauma



Key points in brain development

- The brain remains sensitive to experience throughout life
  - more plastic (and later developing) parts more sensitive than earlier developing and less plastic parts
    - cortex compared to brainstem
- Reflection as occurs in psychotherapy may lead to remoulding of brain pathways
- Risk is not destiny

Key points in brain development

- Experience can change the mature brain *but* experience during the critical periods of early childhood organises brain systems
- Trauma during infancy and childhood has the potential to permanently influence brain organisation
  - and hence all future functional capabilities of the child

Epidemiology & Interpersonal Neurobiology

- Is there evidence to support the existence of poorer outcomes in people who have been exposed to adverse early childhood experiences?

The Adverse Childhood Experiences (ACE) Study

The largest study of its kind ever done to examine the health and social effects of these childhood experiences throughout the lifespan (17,421 HMO participants resident in San Diego)

What do we mean by Adverse Childhood Experiences?

Experiences that represent health or social problems of national importance.

-childhood abuse and neglect

-growing up with domestic violence, substance abuse or mental illness in the home, parental discord, crime

The Adverse Childhood Experiences (ACE) Study

Summary of Findings:

-Adverse Childhood Experiences (ACEs) are very common

-ACEs are strong predictors of health behaviors in adolescence and adult life

-This combination of findings makes ACEs one of the leading, if not the leading determinant of the health and social well-being of our nation

Adverse Childhood Experiences Are Very Common

Percent reporting types of ACEs:

Household exposures:	
Alcohol abuse	23.5%
Mental illness	18.8%
Battered mother	12.5%
Drug abuse	4.9%
Criminal behavior	3.4%
Childhood Abuse:	
Psychological	11.0%
Physical	30.1%
Sexual	19.9%

Adverse Childhood Experiences Rarely Occur in Isolation...

They come in groups.

Adverse Childhood Experiences Score

Number of individual adverse childhood experiences were summed...

ACE score	Prevalence
0	47.9%
1	24.9%
2	13.1%
3	7.3%
4 or more	6.8%

-More than half had at least one ACE
-More than one in four had 2 or more ACEs

Estimates of the Population Attributable Risk* (PAR) of ACEs for Selected Outcomes in Women

	PAR
Mental Health:	
Current depression	54%
Depressed affect	41%
Suicide attempt	58%
Drug Abuse:	
Alcoholism	65%
Drug abuse	50%
IV drug abuse	78%
Promiscuity	48%
Crime Victim:	
Sexual assault	62%
Domestic violence	52%

*Based upon the prevalence of one or more ACEs (62%) and the adjusted odds ratio ≥1 ACE.

It's About Our Children

The major public health and social problems CDC and other agencies address have a common wellspring:

The routine exposure of our Nation's children to trauma/stressors during critical physical and developmental stages.

Bridging The Chasm

Child health as it stands today

Breakthroughs in molecular genetics and biology:
- Mental illness
- Substance abuse
- Violence

Improved recognition and treatment of:
- Mental illness
- Substance abuse
- Domestic violence
- Child abuse

Mass education about child development & parenting:
- Media
- Schools

Documenting the societal burden of child health as it stands today

↓

New directions in prevention

Child health as it could be

Bridging The Chasm

Child health as it stands today

Involving those who don't yet realize that they are working on issues that represent the "downstream" wreckage of child abuse and neglect--and other adverse childhood experiences--in the effort to bridge the chasm.

Child health as it could be

Effective strategies for reducing abuse

Universal: minimise risk – strengthen resilience

- Increase emotional literacy and sensitivity to children's needs
  - Public education, school-based programs
- Reduce acceptability of violence to deal with frustration and conflict
- Reduce poverty and socioeconomic inequality and increase support to vulnerable families

Effective strategies for reducing abuse

Universal and targeted

- Home visiting
  - Strengths-based, respectful, constructivist
  - Based on a genuine partnership
  - Parent and child focused elements

Targeted

- Parent-child Interaction therapy
- Deal with intergenerational trauma
- Increase support to vulnerable families

"Our rail gauge is best"

Lessons from rail and road transport

- Costs of maintaining the status quo
  - $$s and lives
  - Embarrassment & Inefficiency
    - Albury-Wodonga,
    - Canberra-Queanbeyan,
    - Tweed Heads-Coolangatta

    are the modern parallel to Pt Pirie (SA)

"Our rail gauge is best"

Lessons from rail and road transport

- States & Territories fiercely guard their independence unless change is financially rewarding
  - "black spot" roads program tied to uniform legislation

"Our rail gauge is best"

Lessons from rail and road transport

- Public intolerance and cross-professional leadership
  - Victims' stories
  - Doctors and Engineers collaborated in getting better data
    - Road accident research unit, Adelaide University 1961
  - Alcohol, road & vehicle design major issues

Strategic national leadership to improve child protection

- Vision is critical
  - What do we want and how are we going to get there?
    - What and where are the barriers?
    - How can they be overcome?
  - Uniform national legislation as with road laws?
    - Collaborative development of model legislation
    - Appeal to the legacy gene – how do you want to be remembered?

Strategic national leadership to improve child protection

- Role of doctors is crucial
  - Awareness of long-term outcomes
  - Costs of failed child protection felt in health, crime, social security & workplace outcomes
    - Broadcast the ACE story
    - Australian data - ?Growing up in Australia
  - Holders and potential gatherers of data
    - cf blood alcohol in road trauma victims
    - sentinel event recording
      - ?Neglect or assault resulting in injury in <2ys @ EDs

Strategic national leadership to improve child protection

- Role of doctors and other health professionals is crucial
  - Promotion of evidence-based approaches to prevention, investigation and treatment
    - Uniform definition of "the problem" – current situation akin to the "rail gauge" problem
    - Biomechanics – collaborative investigation of injury sites
    - Parents with a substance abuse disorder – what works?
    - Home visiting in Australian context
    - Foster & kinship care outcomes
    - Working with the legal and courts systems to better inform decision making

Strategic national leadership to improve child protection

- Independent *multidisciplinary* research
  - Counting the same things
  - Controlled from outside the system
  - Importance of critical mass
  - Something that The Alliance could foster?
- Champions
  - Respected and influential
  - Tell the story
  - Provide some strategies for early wins

Strategic national leadership to improve child protection

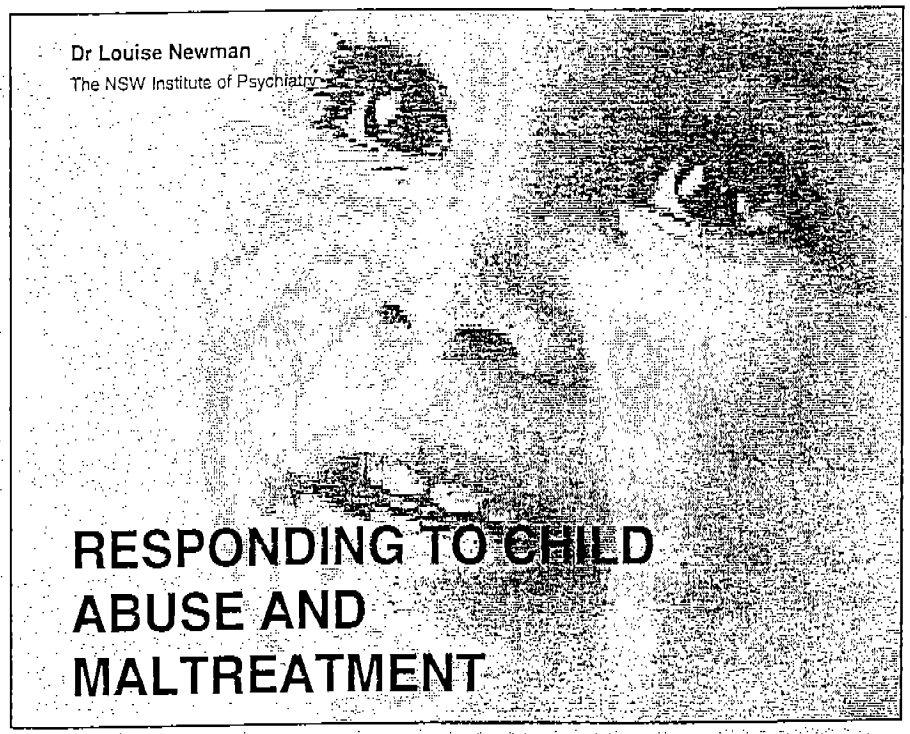
- Children as champions
  - Tell the story
  - "Child abuse will only stop when children like me become important to everyone"
    - words of a 9 year old boy receiving counselling at the Australian Children's Foundation following rejection by parent at age 4

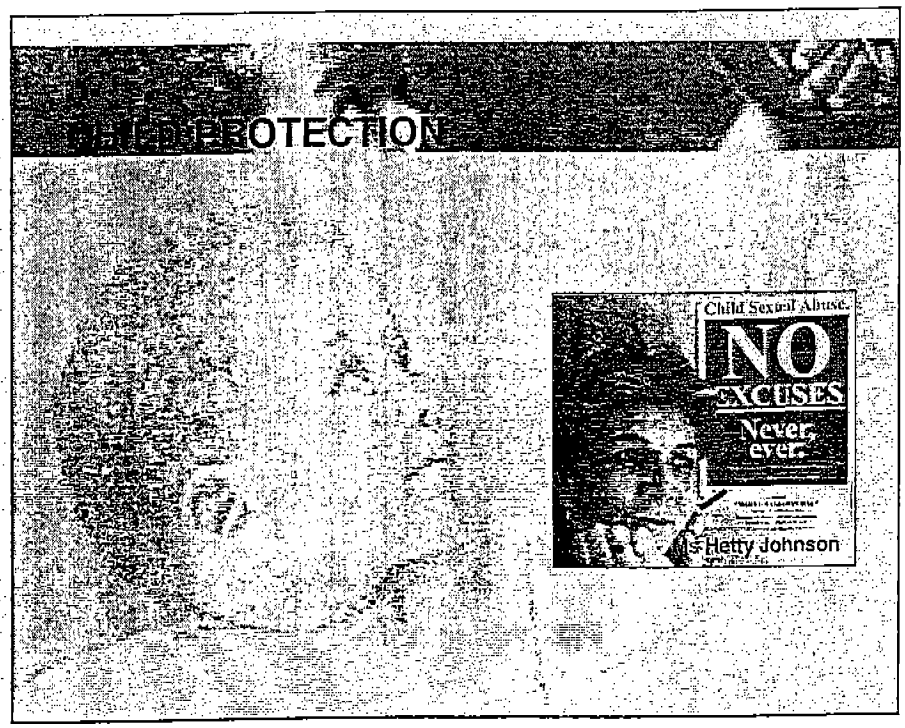
Strategic national leadership to improve child protection

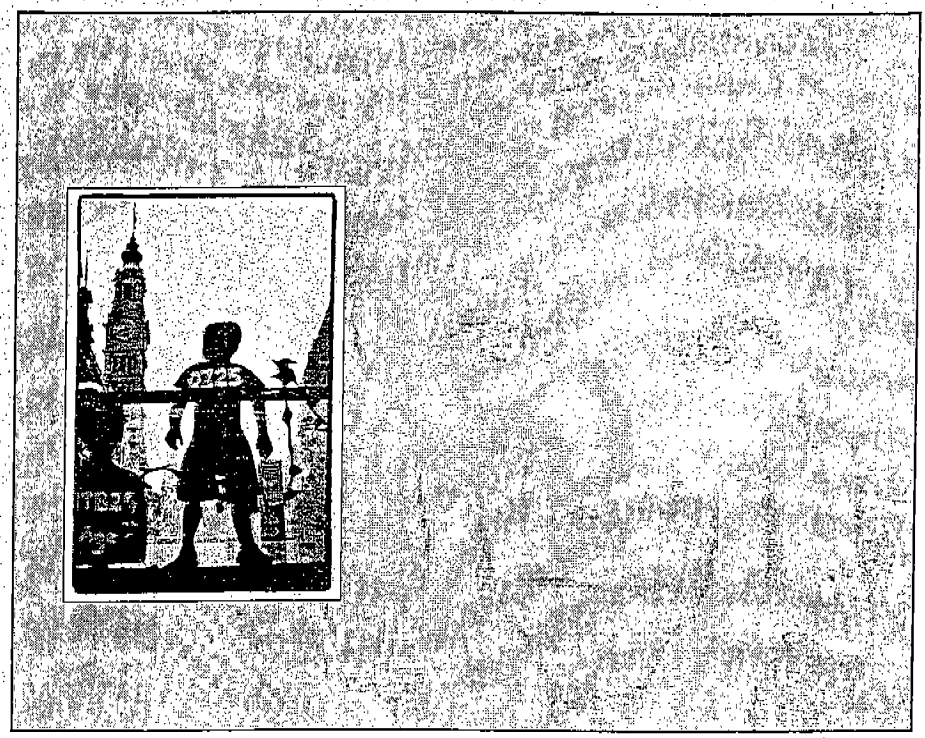
- It won't be easy
  - If it was, it would have already been done
  - Political minefield
    - Community critical of a State that does not protect ***its*** children
  - Long-distance relay – not a sprint
    - Respect and acknowledgement of others' role in the team

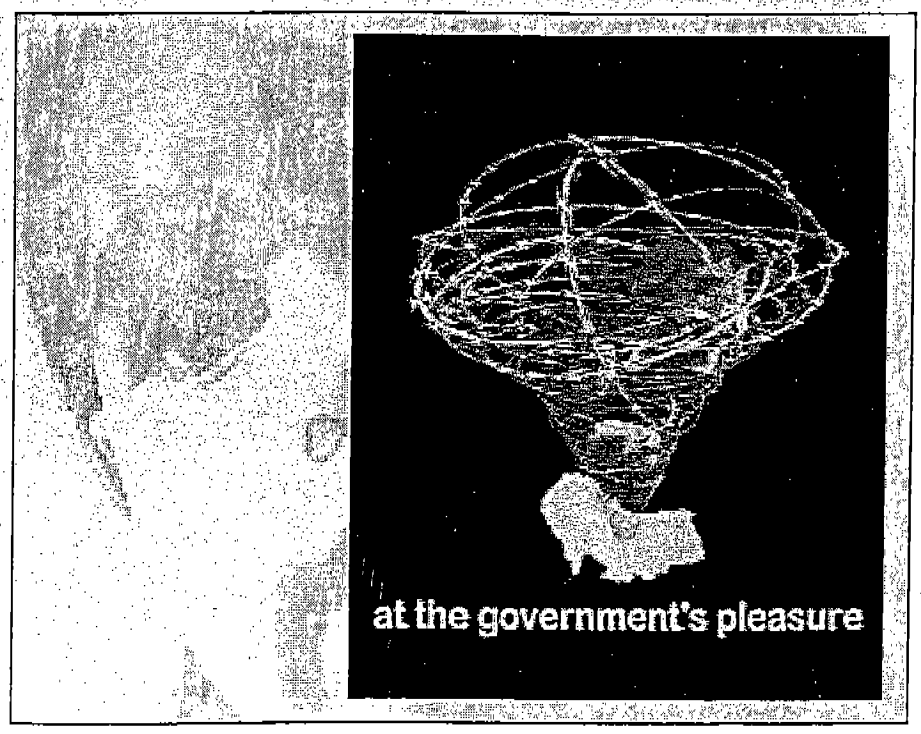
Key references

1. Siegel D & Hartzell M. Parenting from the inside out. Tarcher Putnam, New York, 2003
2. Perry B. Incubated in terror. In Osofsky J, Children & Violence, Guilford, New York 1996
3. Felitti V, Anda R, & Nordenburg D et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. Amer J Prev Med 1998; **14:**245-258.


Dr Louise Newman
The NSW Institute of Psychiatry
RESPONDING TO CHILD ABUSE AND MALTREATMENT


CHILD PROTECTION
Child Sexual Abuse
NO
EXCUSES
Never, ever.
Hetty Johnson




at the government's pleasure

WORLD HEALTH ORGANISATION 1999

⌘Child abuse or maltreatment constitutes all forms of physical and/or emotional maltreatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the childs' health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

WHO FATALITIES FROM CHILD ABUSE

⌘2000 57000 DEATHS OF CHILDREN

⌘LOW INCOME COUNTRIES - children under 5 years, 5-6/100,000

⌘HIGH INCOME COUNTRIES - children under 5 years, 1-2/100,000

CHILD ABUSE - VULNERABILITY FACTORS

- ⌘AGE - most fatalities in infancy
- ⌘SEX- girls higher risk of infanticide, sexual abuse, educational and nutritional neglect, forced prostitution
- ⌘SPECIFIC - prematurity, illness, disability

CHILD ABUSE - FAMILY CHARACTERISITICS

- ⌘PHYSICALLY ABUSIVE - young, single,poor, less educated
- ⌘Unstable family environments- neglect
- ⌘Social isolation
- ⌘Multiple social stressors

MALTREATING PARENTS

- Low self-esteem, poor impulse control,poor relationship history, depression, social isolation
- Unrealistic expectations of the child
- History of childhood abuse and neglect
- Associated domestic violence

CHILD ABUSE COMMUNITY FACTORS

- POVERTY - transience, overcrowding
- LOW SOCIAL COHESION - limited community investment, networks
- BROADER SOCIAL FACTORS - policies and systems that support children and families

CHILD ABUSE _ SOCIETAL FACTORS

- Child and family policies - parental leave,maternal employment, child care systems
- Strength of the social welfare system and supports
- Nature and extent of preventive heath care for infants and children and capacity to identify abuse

CHILD ABUSE _ SOCIETAL FACTORS

- Nature and extent of social protection and the responsiveness of the criminal justice system and child protection jurisdictions
- Cultural norms surrounding gender roles, parent-child relationships,family privacy
- Presence of larger social conflicts, war, displacement, persecution.

MENTAL HEALTH RISKS

⌘Mental health risks of child abuse:
2-4x increase, correlated with:

⌘Severity/duration
⌘Coercion/violence
⌘Incest (betrayal & severity)

PSYCHOBIOLOGICAL IMPACT OF ABUSE

"chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information"
(van der Kolk et al, 2000)

CHILDHOOD SYMPTOMS

- Wide range of emotional and behavioural problems
- anxiety, regression, clinging, hyperactivity, poor concentration and attention
- Sexualised and aggressive behaviour
- Disturbed peer relationships and academic failure

DISTURBANCE IN ADOLESCENCE

- Suicidality 27x
- Depressions 7x
- D&A 19x
- Conduct Disorder 9x
- Premature, poorly judged sex r'ships
- Running away
- Revictimization and exploitation

ADULTHOOD

Entire range of disorders:

- Depression (most common)
- Suicidality and self harm
- Anxiety
- Antisocial
- D&A
- Eating disorders
- Personality and relationship disorders
- PTSD
- Sexual difficulties
- Somatoform disorders, eg pelvic: 64%

STRESS AND TRAUMA IN INFANCY

- Infants do not have adult stress adaptation mechanisms
- Infants are more vulnerable to extremes of arousal and to trauma
- Infants cannot escape stressful interactions
- Paradox of infant abuse -approach-avoidance conflict

TRAUMA AND THE BRAIN

- Stress hormones and cortisol are neurotoxic
- Sensitised pathways develop in R orbito-frontal brain regions - PTSD
- Long lasting impairment in brain regions involved in regulation of the intensity of feelings
- Persistent dissociation

MECHANISM OF TRAUMA

- The two fundamental effects of trauma are:
  - 1. Affect dysregulation
  - 2. Disturbances in attachment relations and self-representation
  - These result from effects of trauma on brain function and development and have long-term consequences

RECOGNITION OF CHILD ABUSE

- 1860 TARDIEU - multiple fractures
- 1946 COFFEY - fractures and subdural haemaotoma
- 1962 KEMPE - battered child syndrome
- 1970-1980 - child abuse as public health problem
- 1989 - UN Convention on the Rights of the Child

UN CONVENTION ON THE RIGHTS OF THE CHILD

- PROVISION - services, supports and systems
- PROTECION - abuse, maltreatment, torture, arbitrary detention, exploitation
- PARTICIPATION - decision making and social process

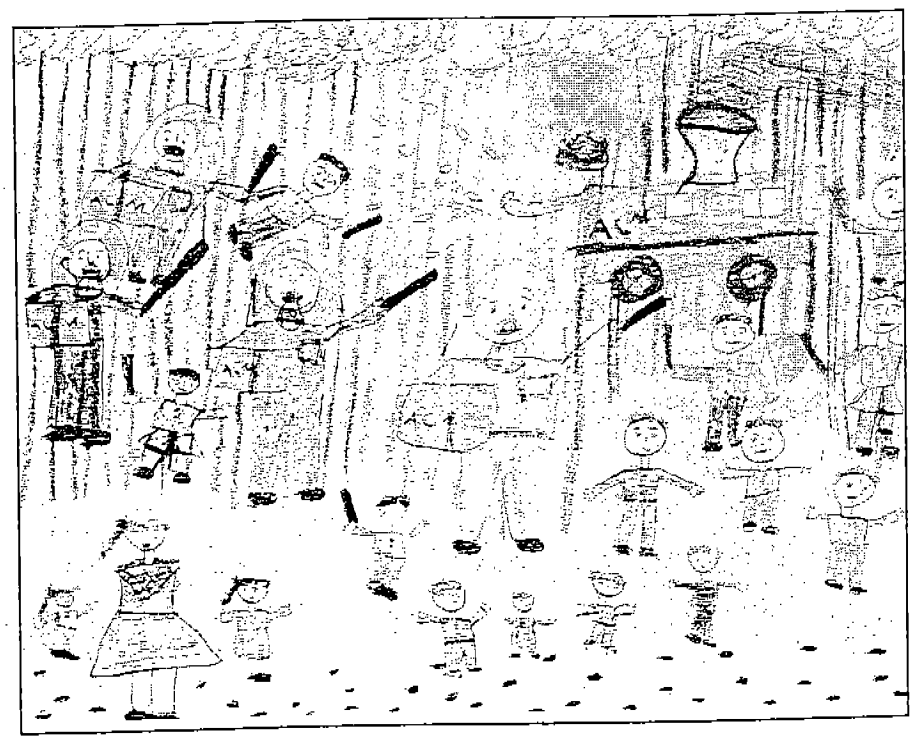
CHILDRENS RIGHTS - HISTORY

- 1875 Society for the Prevention of cruelty to children
- 1919 Child Protection Committee of the League of Nations
- 1924 Declaration of the Rights of the Child
- 1948 Universal Declaration of Human rights Article 25.2
- 1990 UN CROC

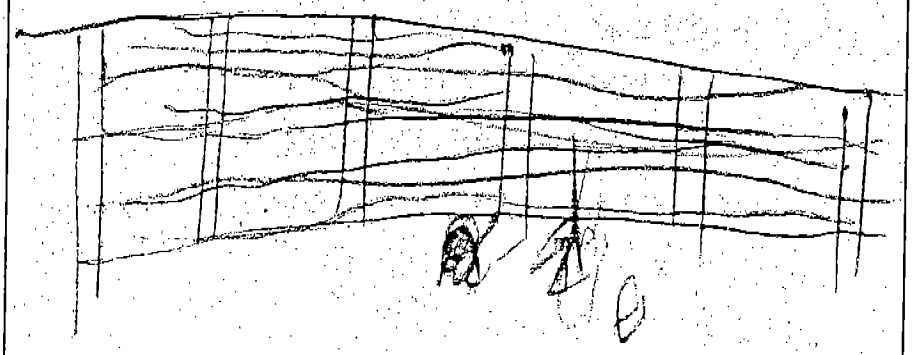
CHILDREN AND PARENTS IN IMMIGRATION DETENTION

MANDATORY DETENTION

- Policy introduced in 1992 for all unauthorised arrivals
- Highly traumatised populations
- Violates several UN Conventions
- 13475 arrivals 2002
- 1871 minors 2001-2002



"All I can see is the fence and us behind it"



MENTAL DISORDERS AND DETENTION

- PTSD and Depression 60-85%
- Physical symptoms common
- Conversion disorder and stress related disorders
- Progressive deterioration related to length of detention
- Paranoia and psychotic symptoms
- Interpersonal conflict and family breakdown

EFFECTS OF DETENTION

- Non Symptomatic Stage
  - **SHOCK**
- Primary Depressive Stage
  - **DEPRESSION**
  - **PTSD**
- Secondary depressive stage
- Tertiary Depressive Stage

EXCESS RATES OF SUICIDE AND SELF-HARM

- Suicide in IDC x 10 general community
- Self-harm and suicidal behaviour endemic
- Pre-Pubertal suicide attempts
- Protest, despair and imitation

SELF HARM IN IDC

- Outbreaks of mass self-harm in Jan 2002
- Hunger-strikes and lip sewing in multiple centres
- Poisoning
- Involves children and adolescents
- Endemic, rates x10-17

CONCLUSION:
DETENTION AND TRAUMA

- Suicidality and mass self-harm in IDCs represents a convergence of health, advocacy and human rights concerns
- These problems are directly related to the extremity of the detention environment and to the politics of detention

Steel, Silove, Newman et al

- Study of 11 families of single ethnic group in remote centre – 22 children
- SCID-IV, K-SADS-PL
- 21 children major depression, 50% PTSD, 50% separation anxiety
- All symptoms related to traumatic exposure

REMOTE CENTRE STUDY

- All adults and children met diagnostic criteria for at least one mental disorder
- Children showed a 10 fold increase in the rate of disorder subsequent to detention
- All detainees had trauma symptoms related to the experience of detention

CHILD DETAINEES

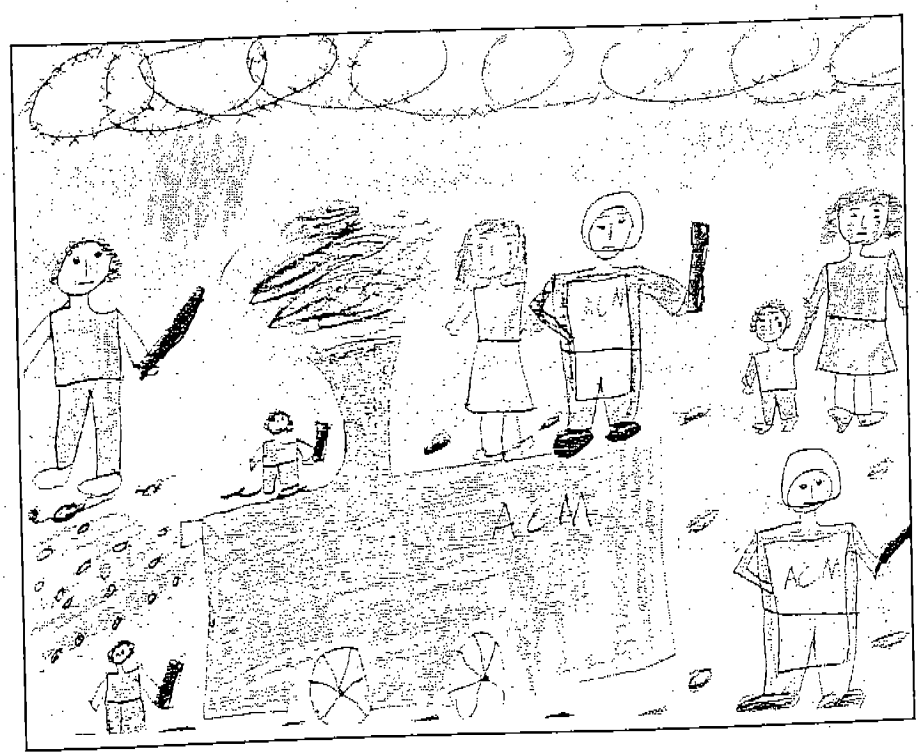
- High rates of depression, anxiety, PTSD
- Attachment disorders, withdrawal and developmental delay in young children
- Effects of traumatic exposure- riots, self-harm, suicidal behaviour
- Unmediated experiences of trauma
- Constant threat of abandonment

LONG TERM IMPACT OF DETENTION CENTRES

- Neurodevelopmental effects of Trauma and Neglect
- Attachment disorder and relationship disturbance
- Risk of chronic depression
- Ongoing anger and alienation

OBSERVATIONS

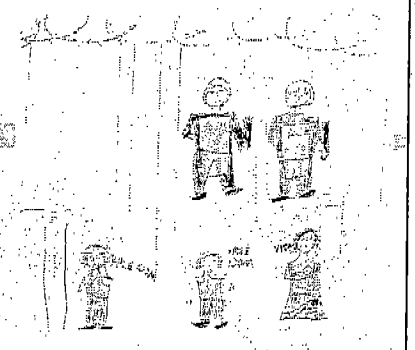
- Called by number not name
- No education
- No safe place to play, monotonous environment
- Exposed to violence – physical risk
- Exposed to suicidal and self harming adults
- With parents who are depressed and have lost hope
- Brutalising/ dehumanising environment



FAMILY Z

- 2 year old boy, in detention with parents since 12 months old, 5/12 old girl
- In detention 12 months
- Mo admitted to hospital 4 weeks before next child
- Mo returned traumatised & depressed after caesarian
- Not eating food or sleeping, defiant,spitting, eating objects, running away
- Trauma:-separation, parental hopelessness, exposure to violence, risk of physical abuse

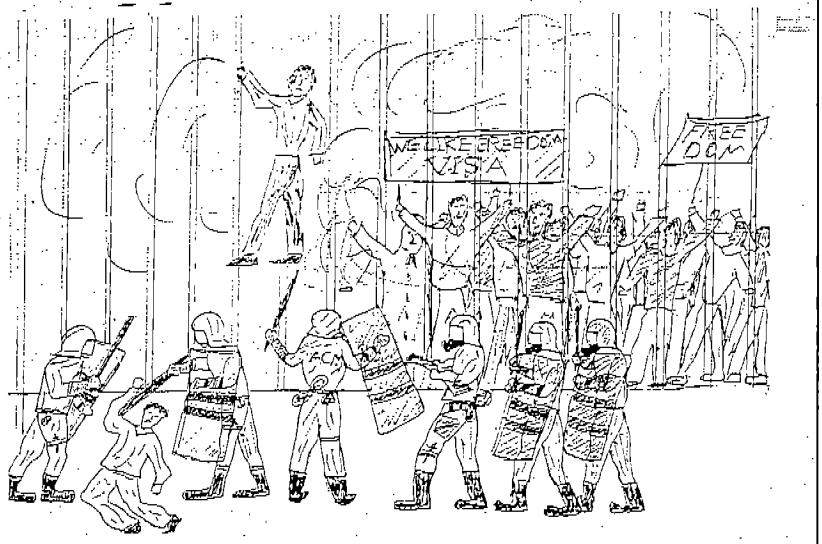
FAMILY Z .....



Infant, now 5/12
- *Sad, withdrawn, mute*
- *Cared for in a mechanical way*

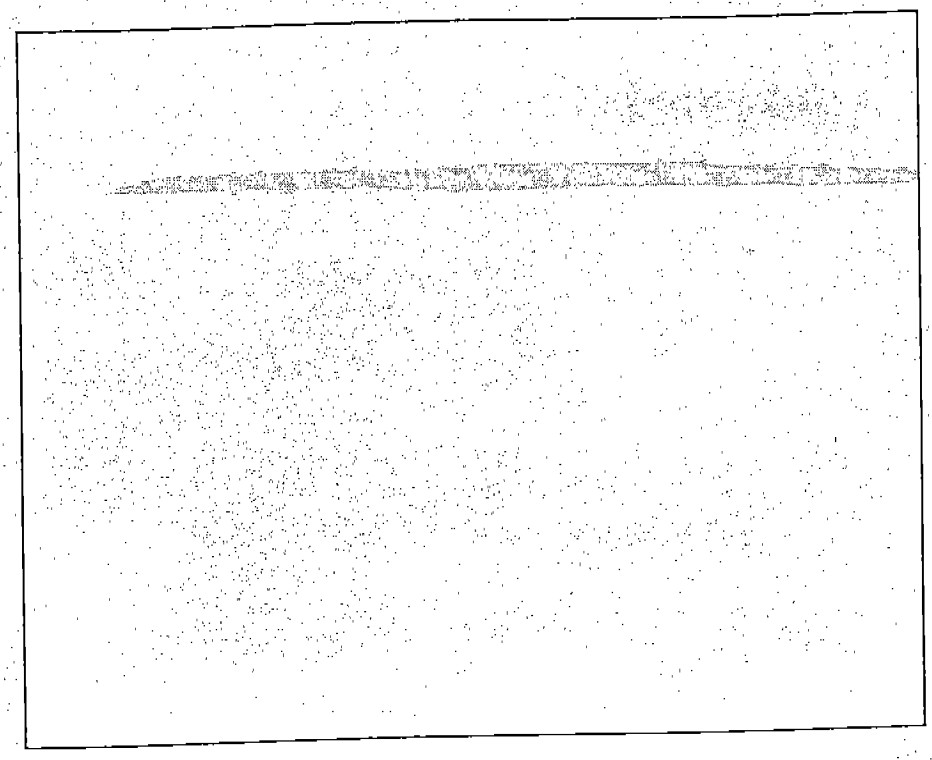
Trauma :
- *impact of parental depression, emotional neglect*

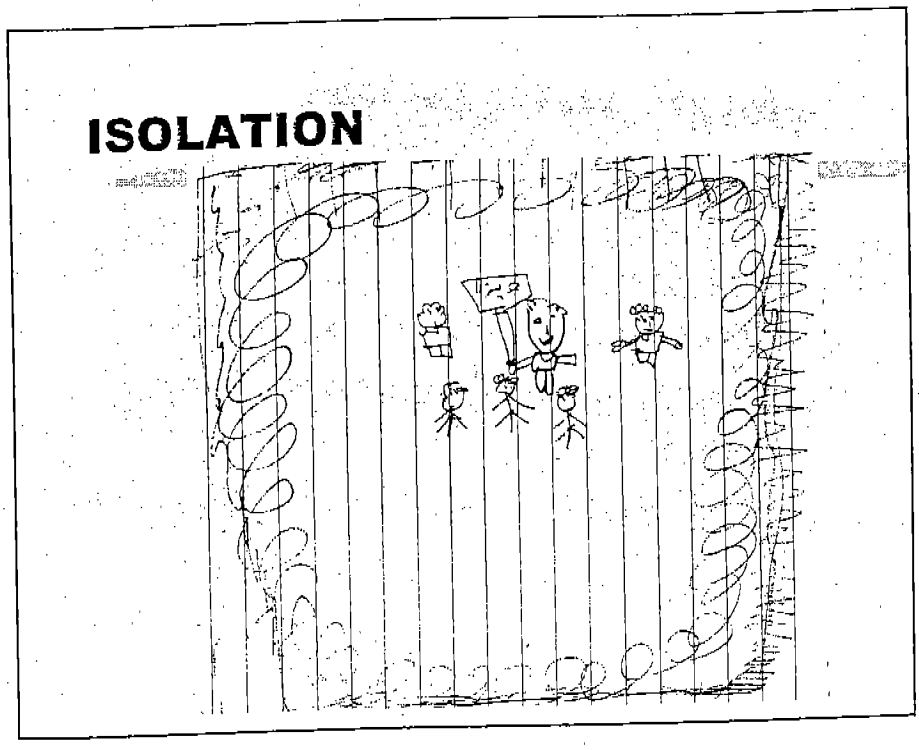
VIOLENCE



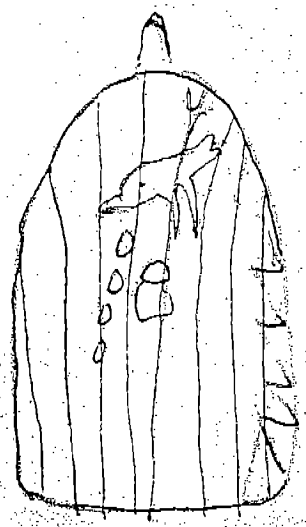
JULIE AND NADIA

- Traumatic pregnancy and delivery in detention
- Severe depression and suicidality
- Infectious complications and physical collapse
- Management in detention environment

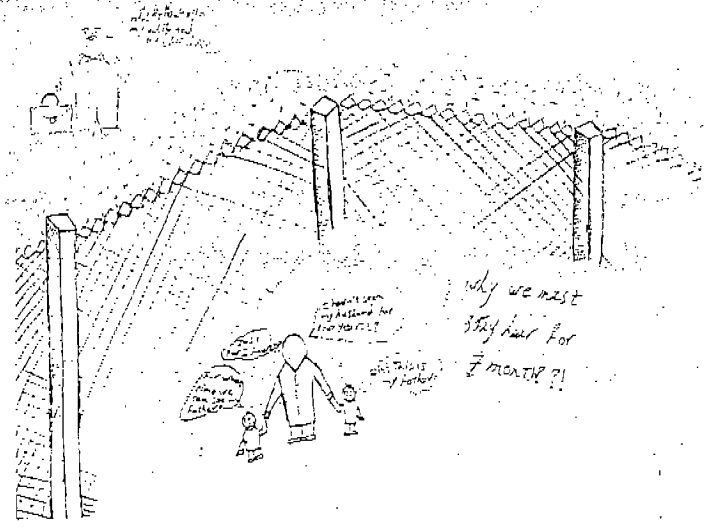


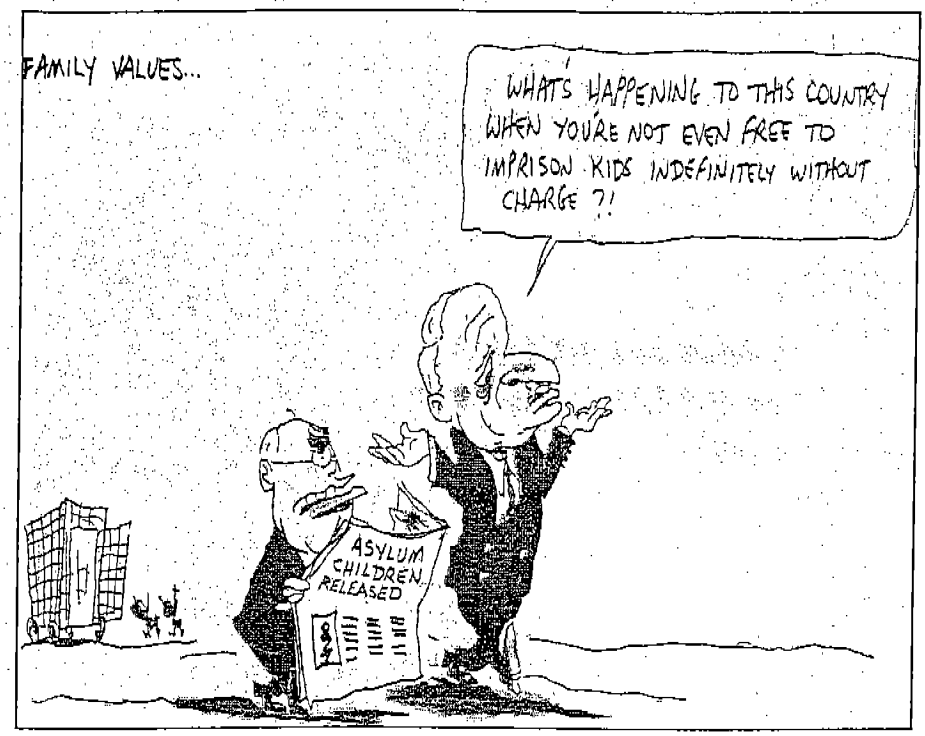

ISOLATION

"*This is not how I feel this is how I am*"



SEPARATION AND LOSS





FAMILY SUPPORT APPROACHES

- ⌘Training for parenting
- ⌘home visitation and family support
- ⌘Intensive family preservation services
- ⌘Respite and alternate care and attachments
- ⌘School based approaches

HEALTH SERVICE APPROACHES

- Screening by health care professionals and training for health professionals
- Therapeutic approaches and services for children
- Services for children who witness violence
- Services for adults abused as children

LEGAL REPONSES

- Mandatory and voluntary reporting and capacity to respond
- Child protection services - role clarification
- Child fatality review teams
- Arrest and prosecution policies
- Mandatory treatment for offenders - efficacy

SOCIETAL APPROACHES

- ⌘Prevention and educational campaigns
- ⌘Interventions to change community attitudes and behaviour
- ⌘National policies and programmes - poverty, child services, family support
- ⌘International treaties - integrating stipulations into domestic law

NATIONAL AGENDA FOR CHILD PROTECTION

- ⌘Based on the human rights of children
- ⌘Integration into domestic law
- ⌘National coordination of child protection system with independent review
- ⌘Creation of Children's Rights Commission
- ⌘Adequately resourced response system
- ⌘Research support for primary prevention and high risk intervention

STATE SPONSORED CHILD ABUSE AND MALTREATMENT

- Professional responsibility to oppose any policy which is traumatising, harmful and renders clinicians powerless in terms of healing role
- Lessons form history that medicine/psychiatry can be misused or coopted by political agendas in an unethical manner; collaboration may become collusion

RECOMMENDATION

- Release of children and unaccompanied minors and preservation of attachment relationships
- Independent clinical review and advisory structures
- State Child Protection involvement and monitoring

RECOMMENDATIONS

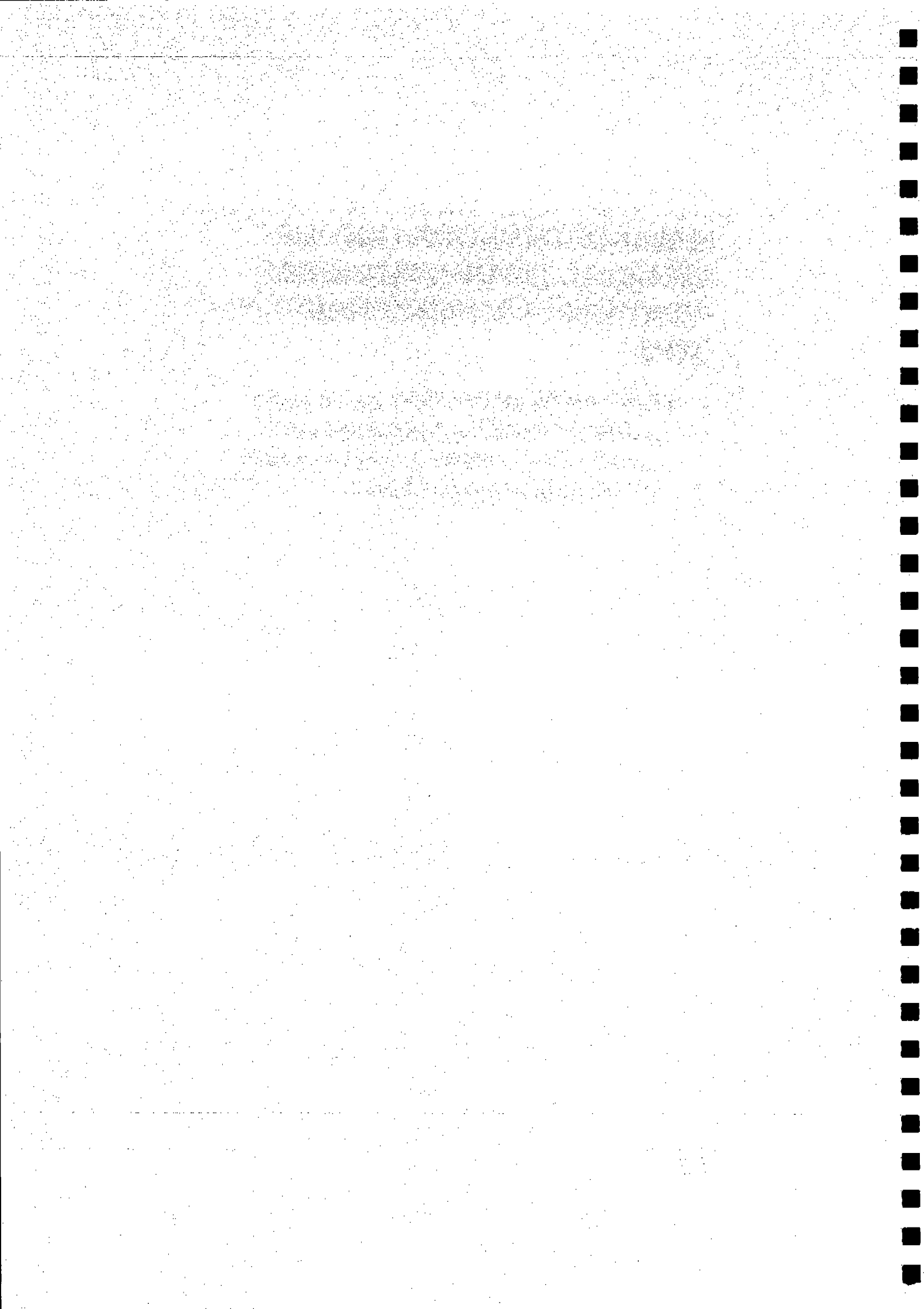
The Australian Government revoke the policy of indefinite detention without trial as international experience and Australian research has shown it to be unnecessary for processing refugee status and because it produces psychological damage that is unacceptable on ethical and humanitarian grounds.

ISSUES FOR CLINICIANS

- Compromise of clinical standards
- Interference with clinical decision making
- Disregard of recommendations
- Ethical compromise and employment by detention providers
- Limited efficacy of treatment
- Intersection of clinical care, advocacy and political action

MADRID DECLARATION OF ETHICAL STANDARDS FOR PSYCHIATRIC PRACTICE WPA

- Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts



The Forensic Aspects of Child Protection: establishing the level of harm and the need for protection (from the medical perspective)

Terence G Donald
Head, Child Protection Services
Women's & Children's Hospital
Adelaide

1

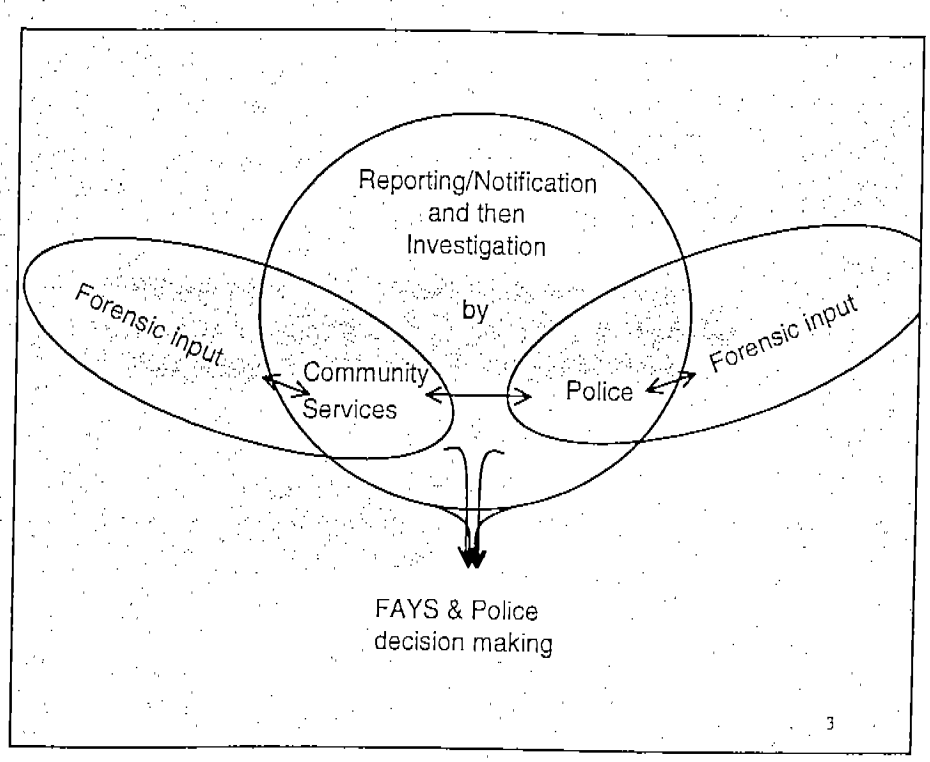
The context of this presentation

WCH Child Protection Services

Assessment & Treatment facility
Accepts referrals from FAYS & police
Serves 2/3 of South Australia (geographic)
Receives of the order of 1800 referrals annually
Clinical service provided to 850-950 clients

Training in forensic paediatric medicine to tertiary level doctors (150 over 5 years)

2



Examples of factors which may influence child protection in Australia

- The effect that early intervention services may have on the rate of notification & particularly the prevalence of serious harm that may require state intervention.
- The manner in which notifications are assessed
  - experience of screening staff
  - what happens to notifications not screened 'in'
  - the 'value' of centralised intake systems
- The emphasis placed on the identification & investigation of narrowly defined ***incidents*** of child abuse & neglect compared with a broader assessment of whether a child has ***suffered harm***.

  (The assessment involved in the broader approach helps ascertain the **child's need for protection** & may assist in better managing the high **rate of renotification & resubstantiation**).

4

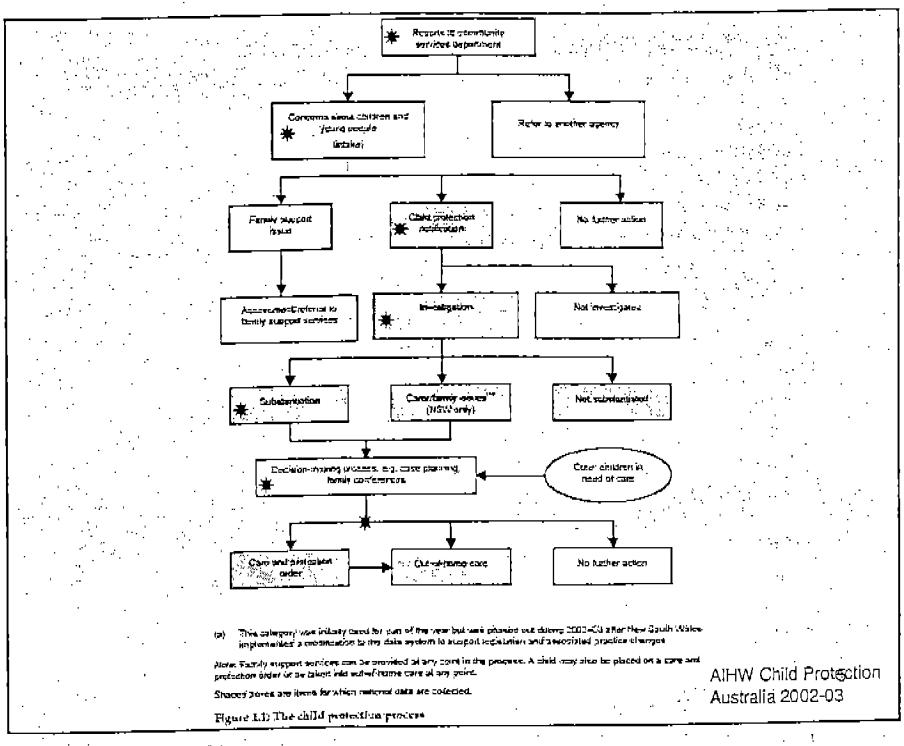


Figure 1.1: The child protection process

AIHW Child Protection Australia 2002-03

Over the last 4 years the number of child protection notifications in Australia increased from **107,134** in 1999–00 to **198,355** in 2002–03.

Table 2.1: Notifications, by type of action and state and territory, 2002–03

Type of action	NSW[a]	Vic	Qld	WA	SA	Tas	ACT	NT[b]
				Number				
Investigations finalised[c]	26,463	12,403	17,542	1,835	6,128	540	795	745
Investigations not finalised[d]	18,802	368	8,645	373	47	93	452	145
Total investigations	*45,265*	*12,759*	*26,187*	*2,208*	*6,175*	*641*	*1,247*	*890*
Dealt with by other means[e]	64,230	24,366	3,850	—	7,267	24	49	—
No investigation possible/no action[f]	—	—	1,031	85	—	76	828	664
Total notifications	109,498	37,535	31,068	2,293	13,442	741	2,124	1,554

6

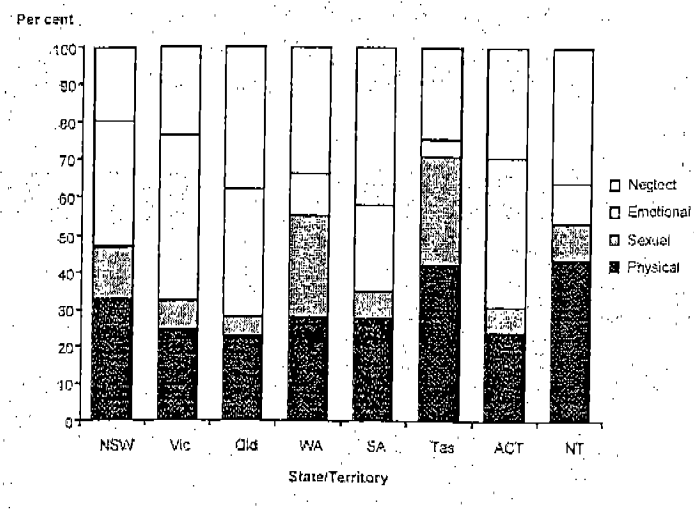
Table 2.2: Outcomes of finalised investigations, by state and territory, 2002–03

Outcome	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
				Number				
Substantiation	16,765	7,287	12,203	888	2,423	213	310	327
Carer/family issues[a]	628	..	..	..	..	..	..	..
Not substantiated	9,070	5,113	5,339	947	3,705	335	485	418
Total finalised investigations	26,463	12,400	17,542	1,835	6,128	548	795	745

Table 2.3: Substantiations, by main type of abuse or neglect and state and territory, 2002–03

Type of abuse or neglect substantiated	NSW[a]	Vic	Qld	WA	SA	Tas	ACT	NT
				Number				
Physical	5,435	1,787	2,809	247	667	90	74	141
Sexual	2,427	562	610	243	180	61	21	33
Emotional	5,562	3,202	4,135	98	553	10	125	35
Neglect	3,363	1,736	4,652	300	1,023	52	92	118
Other[a]	58	..	..	..	..	..	..	..
Total substantiations	16,765	7,287	12,203	888	2,423	213	310	327
				Per cent				
Physical	32	25	23	28	28	42	24	43
Sexual	14	8	5	27	7	29	7	10
Emotional	33	44	34	11	23	5	40	11
Neglect	19	24	38	34	42	24	30	36
Other[a]	—	..	..	..	..	..	..	..
Total substantiations	100	100	100	100	100	100	100	100

(a) The category 'other' used for New South Wales comprises children identified as being at high risk but with no identifiable injury or harm.



Note: For New South Wales the 'Other' category of type of abuse or neglect has been excluded from this Figure due to the low proportion of substantiations recorded under the category. Refer to Table 2.5 for further information.

Figure 2.1: Substantiations, by type of abuse or neglect, by state and territory, 2002–03

An integrated, functional child protection system?

Doesn't start and stop with "Incidents of Abuse"

- Specific prevention services available to all families focussed on achieving adequate parenting
- Early recognition of inadequate and potentially harmful parenting (equivalent to harm and risk of harm)
- Recognition of children in whom there is a suspicion of harm (usually incident based)
- Investigation of incidents of harm -- The forensic component
- Therapeutic Services

9

An integrated, functional child protection system?

- Optimal interagency management of children in whom an incident of harm – physical, sexual, psychological - is established – ***THE FORENSIC COMPONENT***
  - *Assessment* – specialist medical & psychosocial forensic services
  - *Prosecution* – specialist police
  - *Protection* – statutory agency intervention
  - *Current and future care* – based on level of intervention, need for on-going protection, therapeutic needs

10

An integrated, functional child protection system?

- Provision of therapeutic services
  - To address the harm suffered by the child (including the psychological trauma suffered by infants, affecting their primary relationship and attachment patterns)
  - To assist abusive parents to achieve adequate parenting in the future (when children are reunified)

Principles of therapy provision to abused children
- Safe from further harm or threats of harm
- Integration of therapy into the child's daily activities

11

Medical/Nursing roles & responsibilities	Medical/Nursing needs to meet responsibilities
• Specific prevention services available to all families focussed on achieving adequate parenting	Education of health professionals regarding availability & advisability of services
• Early recognition of inadequate and potentially harmful parenting (equivalent to harm and risk of harm)	Training of medical/nursing staff at General Practice & General Paediatric level
• Recognition of children in whom there is a suspicion of harm (usually incident based)	Training in reporting requirements, processes, interagency responsibilities

12

The Forensic Component

- Optimal interagency management of children in whom an incident of harm – physical, sexual, psychological - is established
  - *Assessment* – specialist medical & psychosocial forensic services
  - *Prosecution* – specialist police
  - *Protection* – statutory agency intervention
  - *Current and future care* – based on level of intervention, need for on-going protection, therapeutic needs

What's necessary to achieve optimal forensic outcomes

Specialist forensically trained doctors & psychosocial clinicians

Located in or related to tertiary level service

1^0 responsibility to conduct forensic assessments for community services & police

2^0 responsibility to provide consultation, support & training at an interagency level

13

What do we mean by the term "forensic"

forensic, a. and n.

adj. Pertaining to, connected with, or used in courts of law; suitable or analogous to pleadings in court.

forensic medicine: medicine in its relations to law; medical jurisprudence (knowledge of or skill in law; the science which treats of human laws (written or unwritten) in general; the philosophy of law; a system or body of law; a legal system).

14

What do we mean by the term "forensic"

Forensic Assessments must follow specific principals because of the potential for court involvement.

The legal jurisdictions that may become involved include:

- Children's/Youth Court
- Family Court
- Magistrates/Supreme Court

Forensic Assessments must always be adequate for the criminal jurisdiction

15

Forensic Principles – 'Chain of Evidence'

Optimal documentation of clinical information/material

- Note taking, audio/visual recording
- photographic documentation

The requirements of the legal system

- thoroughness,
- objectivity,
- clarity and logicality

.....must be addressed in the opinion formulation

16

The Forensic Medical Role.

The **goal of a standard paediatric medical assessment** is to formulate a diagnosis optimal for medical management & health.

The **goal of a forensic paediatric medical assessment** is to formulate a diagnosis optimal for legal purposes.

To achieve this the forensic approach incorporates routine procedures not normally followed in standard paediatric assessments.

17

Forensic 'load' in 2002-2003

Table 2.5: Substantiations, by main type of abuse or neglect and state and territory, 2002–03

Type of abuse or neglect substantiated	NSW[a]	Vic	Qld	WA	SA	Tas	ACT	NT
				Number				
Physical	5,435	1,787	2,806	247	667	90	74	141
Sexual	2,427	552	610	243	180	61	21	33
Emotional	5,582	3,202	4,135	98	553	10	123	35
Neglect	3,253	1,736	4,552	300	1,023	52	92	118
Other[a]	58	..	..	..	..	..	..	..
Total substantiations	16,755	7,287	12,203	888	2,423	213	310	327
				Per cent				
Physical	32	25	23	28	28	42	24	43
Sexual	14	8	5	27	7	29	7	10
Emotional	33	44	34	11	23	5	40	11
Neglect	19	24	38	34	42	24	30	36
Other[a]	—	..	..	..	..	..	..	..
Total substantiations	100	100	100	100	100	100	100	100

(a) The category 'other' used for New South Wales comprises children identified as being at high risk but with no identifiable injury or harm.

18

Table 2.2: Outcomes of finalised investigations, by state and territory, 2002–03

Outcome	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
				Number				
Substantiation	16,765	7,287	12,203	868	2,423	213	310	327
Carer/family issues[a]	628	..	..	..	..	..	..	..
Not substantiated	9,070	5,113	5,339	947	3,705	335	485	414
Total finalised investigations	26,463	12,400	17,542	1,835	6,128	548	795	745

What was the level of expertise of the medical professionals assessing the suspected harm due to physical, sexual abuse or neglect in these cases?

If these assessments were overseen by doctors with forensic training would the level of substantiation vary?

19

Provision of therapeutic services

- To address the harm suffered by the child (including the psychological trauma suffered by infants, affecting their primary relationship and attachment patterns)
- To assist abusive parents to achieve adequate parenting in the future (whether or not children are reunified)

Principles of therapy provision to abused children

- Safe from further harm or threats of harm
- Integration of therapy into the child's daily activities

Therapy aims include

The amelioration of the effects of abuse

The enhancement of the child's sense of self

The re-socialisation of the child

If appropriate the therapeutic issues related to re-unification of the child & family

Therapy provision

Trained, experienced & supervised clinicians

Any child who has experienced significant physical and/or psychological trauma from abuse

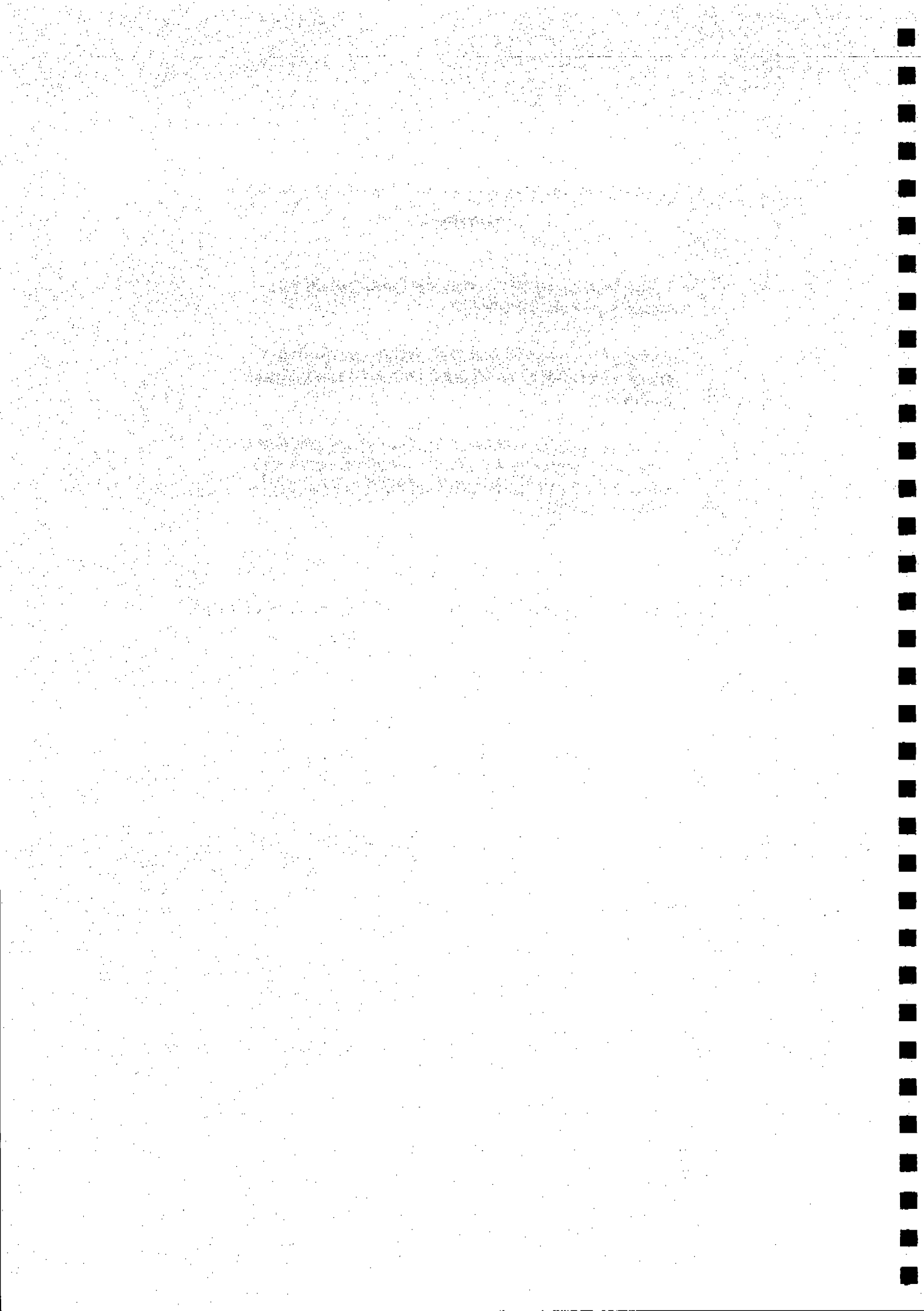
Treatment modalities must reflect child's individual needs in a developmental context eg treating infants, primary school children, adolescents

20

Summary

- Establishing universal and targeted home visiting will improve parenting practises
- Shifting the emphasis from incident of abuse to harm suffered or likely to be suffered will be more acceptable to families
- There must be developed and maintained a high level of forensic assessment skills to ensure that children who experience serious harm are able to be protected & allowed to recover.

21



Families Australia

Ms Sandie de Wolf
Chair
Families Australia

Families Australia

- Is a non-profit national peak organisation dedicated to promoting the needs and interests of families.
- Is funded through the Commonwealth Department of Family and Community Services (FaCS), and is the first national non-government peak body specifically concerned with family-related issues.

Families Australia's mission is to improve policies and programs affecting families through advocacy and representation at all levels of government.

We plan to achieve this by working from a network of services, organisations, carers, consumers and communities, and developing policy and research that is informed by the rich diversity of families and communities.

The objectives of Families Australia are to:

- Be a leading organisation I the field of family policy by working in collaboration with other stakeholders;
- Work towards the recognition of, and support for, the needs of families, young people and children;
- Provide a strong national voice and advice to government on issues that impact on families when they speak about family policy;
- Improve policy, programs and service delivery with a particular focus on the interface between Commonwealth and State/Territory responsibilities;
- Advocate for adequate resources for and ensure that family policy reflects the diversity of family forms, addresses disadvantaged circumstances experienced by many families, and has a primary emphasis on the best interests of children and young people; and
- Initiate or undertake research that contributes to improved knowledge, policy, programs and service delivery practice.

Our Children: Our Concern: Our Responsibility

Early in 2003, Families Australia undertook a project to establish a case for greater Commonwealth Government leadership and investment in child welfare. The campaign document can be found on:
www.familiesaustralia.org.au

Workshop groups

- Developing formal submissions to Government
- Recommendations for training organisations
- Developing a coalition of organisations
- Children in immigration: child abuse and detention behind the razor wire

Workshop 1

Developing formal submissions to Government

- Child abuse is a major pandemic in Australia and violence in the community compounds this problem. All levels of government must work in partnership with other key stakeholders to adopt an integrated national public health approach/strategy to address the issue of child abuse and neglect.
- For the AMA to advocate to federal government on issues of social policy such as structural issues that compromise good health outcomes for children
- That the commonwealth and state governments work in partnership with the non government sector to develop a national policy and service framework that promotes the status and wellbeing of all children. As part of this framework we would want to see:
  - improved targetting of programs for vulnerable and disenfranchised children, young people and their families, and communities
  - Looking at what children need for the achievement of their full potential
  - Establishing standards that ensure equity and access in service delivery
- The AMA takes its responsibility on this issue seriously and will champion the development of the educations and capacity building within its own membership to more effectively address then needs of children at risk
- The AMA calls on all levels of government to provide the injection of new funds across all levels of government and community for services development/reconfiguration and enhancement that is sustainable

Healthy communities result in healthy children

Workshop 2

Recommendations for training organisations

Some questions

- What do we mean by training organisations?
- What sort of training are we talking about?
- Who is the training for?
- Who needs training?

- People who work with children & families (?how wide should this be)
- Professionals require adequate training in their initial educational program in child protection to meet the needs of their profession
- Continuing education/on the job training is essential

Whose responsibility?

- Responsibility of practitioner
- Also employer to increase competency (national competency standards for child protection)
- Includes health and allied service, law enforcement and education, non govt organisations who have contact with children

What training?

- Core set of competencies/knowledge eg pre-indicators of abuse
- Exposure to theory and practical issues around parenting
- Indicators of child abuse, risk and protective factors
- Specialist training in interviewing or communicating with children
- Parenting training/awareness introduced at school level to enhance their ability to form meaningful relationships and enhance parenting ability
- Need for better level of understanding across human services area in human relationships and parenting
- Move into work then competencies trained at postgraduate level
- AMA to make recommendations to specialty groups

Role of Federal government

- Funding to raise awareness in community organisations eg scouts (by information kits)
- Review national competency standards on child protection to establish their usefulness for professionals – make them broader
- Extend competency framework

National professional associations

- Act as conduit between recommendations for federal funding and training and the states
- Centrally managed and distributed through state branches
- Work towards credentials that are reasonable for practitioners at various levels

Workshop 3

Developing a coalition of organisations

Profile of the AMA is incredibly valuable to the cause of child protection

Coalitions can build enormous power

Part of the agenda is to ensure that the solutions developed in an election year are strategic and effective (not "add water & stir")

Question: what is the AMA's objective in raising this issue in this way?

Observation: Federal Government clear in its view that child protection is and should remain a State constitutional responsibility

Observation: many coalitions already exist but operate in small circles – we need to broaden the sphere

Recommendations: the AMA should document all the stakeholders & collaborations already in existence re: child protection

A need: to build the capacity of existing organizations via greater collaboration

A coalition of groups is highly desirable – more difficult for Governments to ignore

Existing collaborations:

- Australian Research Alliance for Children and Youth
- Families Australia
- Secretariat National Aboriginal and Islander Child Care

Emphasis required on primary prevention (in association with secondary & tertiary services)

AMA's role:

- Play a part but not be dominant partner eg. AMA-sponsored in partnership with other coalition partners
- Be committed long term to this issue long term – or is it a passing phase/issue
- Recognise that the AMA can assist – but that child protection groups eg. Families Australia, ARACY continue to play a leadership/coordination role

- AMA's involvement broadens the coalition and reminds us that child abuse is a community issue (not just the province of Government)

How would greater cooperation look?:

- Draw on existing expertise (AMA has good track record in this regard)
- AMA using its media clout to make the public aware of the extent of child abuse & neglect
- Identify common ground between coalition members – make these issues of consensus the focus

Begin with the end in mind – what OUTCOMES are we seeking from the following actions: developing a coalition, advocating etc

ARACY's agenda will be clearer by the middle of the year – strong emphasis on working collaboratively

AMA should provide resources to maximize communication between coalition partners – such a role is resource intensive

OUTCOMES:

- Strategic investment in the entirety of the continuum (primary, secondary, tertiary)
- Changing community attitudes re: children (recognizing the economic benefits of investing in kids) - this includes changing the mindsets of politicians
- Focus on the child – not just on statistics
- Making community building initiatives sustainable
- The "national rail gauge" for child protection issues (practice standards, collection of statistics, reporting etc)
- Note: some concern that uniformity may not always produce the best outcomes eg. it may stifle initiative, flexibility etc
- Seek Commonwealth action in support/ancilliary areas – recognizing that the Commonwealth is not likely to immerse itself in a State responsibility
- Indigenous children – goal that the incidence of abuse in indigenous families not exceed the incidence in the wider community
- Broader representation (eg. indigenous, CALD communities) on Federal consultative committees
- Involve business in the issue eg. Telstra sponsorship of the Kids First Foundation

Structure: a coalition of organizations (and an opportunity to re-convene to keep the ball rolling)

Request: could AMA please prepare a strategy for how these ideas can be taken forward (and how its resources will be used to assist in this)

Recommend: Working group needs to meet soon to maintain momentum

Recommend: National Child Protection Clearinghouse could assist AMA with contact details for CEOs/Executive Directors of organizations

Workshop 4

Children in immigration detention: child abuse and protection behind the razor wire

Reforms to the detention of children asylum seekers

Duration of initial processing

- 4 weeks maximum detention for children and families on the basis of evidence of the harm caused by prolonged detention in depriving and traumatising environments.
- Sufficient time for processing and administration and health assessments
- If the period is to be extended, the onus is on the government to apply not the individual

Model

- Health and welfare model not punitive system
- These children need the same level of health and welfare services as all other children in Australia (why are we scared of babies and infants)

Services

- Not only preventative services but services for those already traumatised
- Universal access to health, mental health and community support services irrespective of visa status and including off shore facilities
- Medical, psychiatric and counselling services should be adequately resourced
- Access to social services: English classes, migrant resettlement
- Qualified and experienced staff rather than unqualified prison guards
- Adequate resources for asylum seekers after detention including funding for community taking in refugees

Monitoring

- Independent monitoring of services by health and child protection authorities
- Establishment of a standing independent monitoring body with external review e.g.Commonwealth Government Chief Medical Officer.

Appendices

- Media conference transcript
- List of participants
- Summit Program
- Communique No 1

Media Conference Transcript

19 February 2004

Transcript - Media Conference - AMA Summit on Child Abuse

RICE: An interesting morning. Perhaps I could start by saying I was asked the question yesterday, why would the AMA become involved child abuse? And I responded by saying that it's very clear that this is a major public health issue in this country.

We were given data this morning that showed that there'd been in excess of 40,000 substantiated cases of child abuse in the 12 months ending 2003. And it's gone up by about 20% a year.

Now, if we had an increase in the incidence of tuberculosis in this country of the same number and the same rate, there'd be a national outcry. If we had - you can pick any number of diseases where, if the incidence went up 20% a year the public would be up in arms, demanding that something be done about it.

Yet somehow we seem to ignore the fact that there are this number of children in our community being exposed to abuse. And it's not just physical, sexual abuse, it's neglect, it's emotional abuse. And we were told this morning that maybe you'd like to ask Graham Vimpani about the effects of this sort of abuse on the subsequent health and wellbeing of the abused individual. Graham's talk is entitled 'Child Abuse is not just a Children's Issue.'

So we really do have to look at it from a public health issue. We were given data this morning, and it's all well known, well known in the community, it should be well known to government, it's certainly known to government agencies, the predisposing factors to child abuse. Family breakdown, substance abuse, alcohol, etcetera, poor social circumstances, the data is all in. It does not need any more studies to tell us, what we do need is action.

And what this meeting today is trying to put together is an action plan. Louise Newman talked to us this morning about children's rights, and illustrated that by some issues that are very real to this country and that is how we treat children in detention, and what may happen to them in the future.

We all know that unhappily the incidence of abuse is a problem in our Indigenous families. As Muriel Cadd talked to us this morning and made a series of reform proposals of what needs to be done to address the problem of child abuse in the Indigenous community. And so you might like to address your questions to her on this regard.

Terry Donald, this afternoon will be talking about how we really need to determine the level of harm. And finally the other speaker from this morning - and I missed much of what she said unfortunately, I had to rush up with the white face to appear before the cameras up on the hill. But Sandy de Wolf, from Families Australia, was talking about the important role of families, and what we need to do to help them.

So it's been a wide-ranging set of discussions this morning, and this afternoon we hope this will lead on to formulating a set of approaches that we would not ...[inaudible]... go forward to government on a national basis, to alleviate what is - someone has described as a pandemic problem at the moment.

I described it on radio yesterday, because I work in this field, as a cancer in child abuse.

So, ladies and gentlemen, we'll open this up to you for questions and I suggest that - Bill, do you want to?

QUESTION: Can I just ask you what's in the action plan that you want done?

VIMPANI: Well that's one of the things we're going to be addressing this afternoon.

RICE: Well, let me tell you one of the problems that's happened. We've been able to engage state governments to come along, we've had trouble engaging the Federal Government.

QUESTION: Why is it [inaudible]?

RICE: It's hard to know, you'd have to ask them, but I think its' symptomatic of the problems that beset this country in Federal/State relationships. This is a Federal issue, this needs Federal and States actually working together. But, you know, what it's like getting that ...[inaudible].... It's too convenient to be able to blame one another for inaction.

QUESTION: [inaudible] Labor Government in an election year. Mark Latham seems to be quite keen on this issue of [inaudible].

RICE: Money where the mouth is.

QUESTION: How much funding do you think you'll need for a program?

NEWMAN: Can I just say, before we answer that, that one of the issues that we have been addressing in several states [inaudible] is that we currently lack a national agenda, a national committee for child protection. And when we say that we're talking about a coordinated system that can actually look at prevention of child abuse and maltreatment in all forms, that can actually address some of the underlying causal factors that are implicated in this escalation of child abuse.

We're both concerned about the current [inaudible] history of approach - and fragmented approach - across the country to child protection where we have state legislation - different states have different policies and procedures, even at the level of data collection. Different states collect the figures about [inaudible] child abuse differently, for example.

What we're calling for is a Commonwealth commitment to a national agenda, and a national body and ...[inaudible]... in their ...[inaudible]... protection which is currently ...[inaudible]....

DE WOLF: Could I just add that one of the things that seems to be a bit different about timing now is that there is a real interest from most of the states about ...[inaudible]... and a real willingness to work with the Commonwealth on this really ...[inaudible]... issue.

VIMPANI: I also think that there's a failure in the community generally to recognise the long-term consequences of child abuse. It's not just a children's issue, and I presented some data this morning and Louise added to that, data from an American study that looked at 17,000 members of a health maintenance organisation. So they would be well enough off to be able to afford private health insurance.

And it asked this population of 17,000 in their childhood whether they'd been exposed to abuse, domestic violence, parents with mental illness or parents who had a substance abuse problem, or parents who had been in jail.

And they looked at, over the course of these people's lives, the impact of that experience in early childhood on their subsequent development and health experience. And in many instances, not only in mental health

problems but physical health problems, over 50% of the morbidity could be tracked back to people who had had this kind of adverse experience in childhood, and child abuse, physical abuse, sexual abuse, emotional abuse and neglect was one of the key adverse experiences that these kids encountered - these people encountered - when they were children.

And when you start to ask the question as to why this might be the case I think what we're actually starting to now understand about early brain development is that it's the impact of that adversity on the way in which our brains are sculptured as young children, and the consequence that has for our subsequent functioning, our functioning in terms of relationships with our parents, with our peers at school and also our capacity to learn at school.

And I think people's earliest relationships - children's earliest relationships - with their parents and carers set a template with them that creates a mental model of what relationship's going to be like in the future. So if you don't have a good early relationship, one that's fraught with trauma, that is going to set up in your mind a picture that all kinds of relationships in the future are like that.

That clearly affects the way that kids learn in a school situation, so it's not just - literacy doesn't come out of a vacuum, literacy comes out of a strong and solid relationship that has been established between kids and their parents.

And I think we've got to get this message across to the community about the importance of those early relationships between children and their parents for future health and wellbeing and life success.

QUESTION: Why are the rates of child abuse [inaudible]?

RICE: [inaudible] the community is prepared to tolerate things happening to children that they would not tolerate happening to themselves. I mean the data is all available and if experiences are bad in childhood their outcome is terrible. I mean, the date ...[inaudible]... you may be aware of a document called Pathways to Prevention ...[inaudible]... under here, demonstrates the relationship between adverse early childhood experiences in the criminal justice system.

Graham's talked about early death rate. All very clear. I don't know why we tolerate it - this sort of abuse and - and incidence of maltreatment in our community. But we ...[inaudible]...

NEWMAN: Just to add to that, I spoke this morning about what I believe to be a tremendous difficulty we have as a culture in talking about child abuse, as do many other cultures. Child abuse is nasty, and people would prefer it not to exist. Quite understandably, they also prefer to keep it hidden. That leads to a culture of secrecy, obfuscation, and silence, which many survivors of child abuse describe as a very damaging experience.

Reluctance to speak out, failure sometimes to ...[inaudible]... to believe and to acknowledge the legality of their experiences.

Now at a national level I think we suffer from much the same thing. We certainly do some things about child abuse. What we're saying is that it's fragmented and over all it's not addressing the problems adequately, but we still don't like to have a national discussion about child abuse. Some very courageous people do speak out about child abuse - survivors and other ...[inaudible].... But you can see that on a cultural level there is reluctance around that. I think that until we as a community make some step towards acknowledging the reality of some people's lives - both adult lives and children, and that needs to be shown by Federal leadership and initiative, we will be doomed to repeating some of the terrible sins that have been done to those people who have experienced abuse, which is to not acknowledge their reality and to actually deny them adequate support.

QUESTION: ...[inaudible]... the economic cost of this?

DONALD: I can't quote figures. There has been economic research done in Australia on the economic cost of child abuse, and it's mainly talked about the costs to the health system of children who've been significantly physically harmed. And that's quite high, but that's only a very small section of the sort of ...[inaudible]... we're talking about.

QUESTION: It's not true that the Government's ignoring this though, because they have ...[inaudible]...

RICE: The last time they put something about child health on the COAG agenda ...

QUESTION: Can you talk into the mike please?

RICE: Yes, they produced a national policy in 1995 for child and youth health. What happened to it? Disappeared without trace. Sunk.

DONALD: Can I comment on that twenty per cent you raised earlier on? Another important point to realise is that we're talking about disadvantaged communities on the whole. It doesn't mean that children in

advantaged communities aren't harmed, but the population of children that mainly are represented in statistics come from disadvantaged Aboriginal children, single parent families, and it's extremely difficult if you belong to that group of the community to get your plight recognised, and it's easy for governments to push it away, because there's not an outcry as there would be if suddenly, as Michael said, there was an outbreak of tuberculosis in your community.

You know, the well-to-do would be worried that they'd catch tuberculosis. The well-to-do aren't worried that they're going to catch child abuse so they just push it away.

NEWMAN: Can I just comment on the cost - someone asked before about the costs of child abuse. It's a very difficult and complex calculation, given that there are immediate costs in terms of treating children and services and so on, but there are also the projected costs in terms of mental health problems, effects on people's capacity to work and contribute - so loss of productivity. The latest figures I have are U.S. figures that calculated in 1996 that in the USA it estimated that child abuse cost $US12.4 billion, and that's including those projections for adult mental health treatment for children who'd been abused and loss of productivity.

I think though - so when you asked the question about how much money is it going to - to fix the problem, I think the preceding calculation and work needs to be done, where we can actually calculate how much money this is already costing us, including these projections, and whether we can afford not to anything about the problem.

QUESTION: [inaudible] talk about what your recommendations have been about? ...[inaudible]...

CADD: Well, obviously my story this morning and the statistics that I was putting - Aboriginal children are ten times more likely to be in out of home care. Six times more likely to be removed. It's a significant issue. Most of the over-representation has a basis in neglect rather than child abuse. Aboriginal communities, we're struggling with the fact that there's a lack of adequate funding for family support to keep children in the families. Less than three per cent of our children are enrolled in childcare. Maternal and child health is a significant issue, so all of these issues we certainly think that an integrated approach is needed, not just from, you know, a health perspective, that we need across Government.

I think to have child protection on the agenda, I know that you talked about the COAG, and I know that COAG was specifically focusing on

Indigenous child abuse, and my understanding is that there was Indigenous family violence, and child abuse. Family violence got a lot of publicity and a lot of mention. Indigenous child abuse seems to be pushed to the back.

What it needs is a serious commitment by Government. There's been the initial proposal put by this - by the Prime Minister to COAG, and unfortunately it was when the health was also on the agenda, and all of the premiers walked out on the discussion when the Prime Minister was upset about the fact that he didn't get it on.

But the longer term is that the states have set up advisory committees with no Aboriginal people on those committees, so there is, you know, things happening all the time where Aboriginal people aren't at the centre of the planning and aren't being involved in early intervention and prevention and stopping the cycle of abuse that's happening in ...[inaudible]... communities.

QUESTION: Is there a need for stronger ...[inaudible]... reporting requirements of child abuse or suspected child abuse? Is that part of the ...[inaudible]...?

DONALD: No, I don't think there is. There's a lot of debate about mandatory reporting everywhere in the world, and nobody who's introduced it has ever got rid of it, but a lot of places that have thought about it haven't incorporated it into their practise.

The advantage of it is it makes a statement about the community's concern for this problem, and that is an advantage, there's no question of that. But we're trying to move away, I think, from the concept of incident-based harm for children, more towards children are in an environment where parenting is inadequate, and sometimes a problem for them.

Occasionally with those children there will be violence, sexual abuse, neglect, psychological abuse. There's a spectrum of difficulties in this area that mandatory reporting doesn't really address. You can contact the statutory agency and say I think this parent isn't looking after this child properly. But if we had a way of that person being able to allow that family some assistance, rather than just providing it with a notification and then no intervention, I think we'd be much better off in the long run, and I think that's part of what we're talking about today. Getting away from incidents and looking more at the issue of harm to children.

QUESTION: Particularly here in the ACT in recent months we've had cases of serious department failures. Not reporting, not putting

investigators into places. Is this issue to be put seriously on the agenda - do we need our Federal Government to take responsibility and ...[inaudible]... when there are serious failings within departments?

GLASSON: I mean, very much so. I mean the idea of having ...[inaudible]... is to - a group of experts from all levels of government and all aspects of the profession is to really look at whose responsibility is it and make sure that those appropriate agencies act. The important thing really, as has been said, is that you need structural reform of the whole system. I mean, you've got to address the problem and top down and bottom up necessarily - don't ...[inaudible]... necessarily. And I think that from the point of view of this group, and you've asked the question why don't we - or why haven't we made some huge, catastrophic announcement about this issue in the community - why aren't we jumping up and down. Well, I suppose part of this committee's role is to make sure that we do speak out - that we speak out on behalf of these - of this group, who often feel they want to - prefer to hide the issue under the carpet, and working together in a cohesive way so we can actually go back to the Commonwealth, or go the Commonwealth in the first place, and say this is your responsibility, these are the reforms we need, this is the funding that we need, and obviously you may deliver that through a state system, but essentially what we do at the moment, the approach has been very fragmented, the programs that have been attached to this have been very fragmented, and so it really is trying to get an overall national strategy of both implementation and some way, I suppose, of measuring an outcome so we - and beginning here today ...[inaudible]....

QUESTION: ...[inaudible]... wrong, and children are put at risk, should our heads of Government be accountable?

GLASSON: Yep. You go ahead, Sandy.

DE WOLF: I'll just say, I think what's very clear from this morning is that more of the same will not solve the problem. There are about - last year there were 200,000 notifications across Australia, and 40,000 substantiations. Now, we're not even investigating all of those 200,000, so the system, as, you know, several people - Professor Dorothy Scott spoke this morning, she said the system is at crisis point.

We cannot just keep notifying more and more and more children, because there aren't the resources to deal with it. We have to do something different, and that's why we're asking for a national strategy, which will do a whole range of different things as well as some of the same.

QUESTION: But just picking up on that point about ...[inaudible]... the Government to take responsibility, is that an issue that COAG should

take up? Is that something that you'd like to see ...[inaudible]...?

RICE: I think that if they would take it up that would be fine. But it needs a commitment, not just to talk about it, it needs to be to do something. And that's what has let us down in the past. I mean, I've been in paediatrics for forty years now, and one's lost track of the number of recommendations that have been made.

Twelve years ago we commissioned a study that was called National Goals and Targets for Australian Children and Youth. What's happened? Twelve years later here we are saying we need national action.

We've had strategies, we've had reports, we've had ...[inaudible].... We need action. In South Australia you had a report handed down into child abuse a year ago. To my knowledge not one action has yet occurred. Terry may be able to ...

DONALD: That's correct.

RICE: So you know, where's the action? The ...[inaudible].... We know the returns that can be made, as U.S. data - spend one dollar, save seven. In the ...[inaudible]... project. There was another one. The El Mira [phonetic] - spend one save six. And Frank ...[inaudible]... in summing up this morning talked about the need to spend money on infrastructure, and he said we're willing to spend big money on railway lines, dams. What about spending it on children and on families?

QUESTION: Apart from the Government, isn't it something that everyone in the community will need to take some degree of responsibility for - if everyone sort of turns the other cheek or turns a blind eye to the situation - I mean isn't it more of residents' community awareness and not just blame governments?

GLASSON: Very much. Obviously this is a community issue and responsibility. And again, what the idea of getting all these groups together is that we come out with a single voice, and make sure that obviously not only the Governments sit up and listen and act - as Michael said we seem to put one proposal behind another, and nothing seems to happen. But a sense of community must rise. It must come from the grass roots. It must come from the ground up.

Because it's the only way of getting up really ...[inaudible]... government bureaucrats and a call for Parliament to actually do something about it. But it's not seen as sexy, that's the trouble. It's seen as something they don't want - they want to bury it. And in reality what they want to make sure out of this, is that with an election coming up

this year, we'll put it on the front page. And we're going to keep it on the front page - we have to - until we get a commitment out of these guys that not only are they going to commit to it, they're going to deliver on it.

So the whole idea of this strategy is to actually get them on their ...[inaudible]... to actually deliver it in the long-term.

QUESTION: [inaudible] how much money needs to be poured in the national well?

DE WOLF: That work hasn't been done yet. It needs to - one of the other points that was made this morning, there are a lot of - all the initiatives happening in different areas, but they're not integrated, so that they don't build on each other. And that's why we need a different approach.

QUESTION: When do you propose actually - well, when do you expect to have an actual proposal to take to the Government and say this is what we have, and this is how much we want for it?

RICE: I'm not sure that it's easy to answer that, because much of the thrust of this morning is that what we need is a preventative strategy. And you know, this is the nasty stuff. How do you fix domestic violence? How do you fix alcoholism, substance abuse, poverty? Because these are all the factors that are associated with child abuse.

So when you say can you put a figure on how much money it would cost, I think the answer's no. We might be able to put a figure on the cost of treating child abuse after the event. That is, you've missed the boat. So we've missed it.

So if you want to say how much will it cost, well how much will it cost to fix the social ills of Australia?

NEWMAN: In fact on that point I think there are some immediate gaps in terms of being able to provide even an acute response to children where ...[inaudible]... adult survivors, and one of the major difficulties is of course the lack of funding overall for mental health services, ...[inaudible]... problems well known to be quite significant in children and adults who have suffered abuse.

But certainly we can look at an immediate injection into mental health services. If you look at the overall amount of health funding spent on mental health in this country, it's still lagging behind all comparable countries. We still have major infrastructure problems.

I think we're aware we've got workforce problems - child and adolescent mental health still only receives twenty per cent of the overall mental health budget. So it's grossly inadequate. So even in the acute ...[inaudible]....

QUESTION: Do you think that ... sorry.

VIMPANI: I was going to add that at the primary care level, too, there needs to be a greater level of investment, and I'm talking about child and family health nursing, for example, where the level of resourcing varies from state to state. It has to be - to start working in that service, to be able to provide the kind of resource that really benefits some of these families with high needs through programs like sustained home visiting for example.

The capacity needs ...[inaudible]... can be quite considerable because it - it's interesting, one of the nurses who's involved in what I'd regard as a kind of premier home visiting program, [inaudible], when I spent some time with her a year or so ago she said to me "For our nurses advice is a dirty word."

And what she was really getting at, the way in which we work with families really has to be turned on its head from what traditionally health professionals have done, which is come in and offer advice and information, to actually engage and work constructively with people in a relationship that brings about a change in the way in which they think about themselves and the way in which they change in relation to their children. There's a real challenge there in creating that ...[inaudible].... The capacity in the workforce to do that. So, even with the existing workforce there are considerable costs.

We've estimated in New South Wales, for example, that to introduce sustained home visiting - that's long-term home visiting of the ...[inaudible]... type - over a - pre-natally through to the age of about two - to introduce that to a group of people in New South Wales who we think could benefit from it, could be somewhere in the order of $30 million over and above the current level of resourcing. That assumes that you've got the staff, as well, with the capacity to provide that.

So it's not a simple fix, but we need to get on the path to actually bring about the changes in the system, and the capacity to start to actually deal with the problem at the primary care level.

QUESTION: How much money is that ...[inaudible]...?

VIMPANI: Well, on the basis of the old stuff you could argue that the $30 million invested you would save in terms of adverse outcomes around crime, poor job prospects, increased welfare payments - around $150 million.

GLASSON: Okay, we're going to close. Any final comments, or ...

CADD: Can I just make one point - I just want to make a comment, obviously the media in the last few days has been highlighting Redfern, but Redfern's not an isolated community. There are communities that are in crisis right across Australia.

In Palm Island, on the ...[inaudible]... they lock our children up. ...[inaudible]... violence. Family violence is destroying communities. Violence against children, emotional abuse, the statistics that were presented this morning about the children in care because of family violence - all of these things, all of these systemic things are happening increasingly in Aboriginal communities.

Children are in crisis and we need to do something about it, and I think that if - when children come to our services, Aboriginal services have been told, you know, if they're looking for help they're told to go away and wait til child protection's involved, they're not going to do that. It's too late, but that's the way the system is geared. Children have to be at risk of being taken before you can ...[inaudible].... It's a crisis response. We have ...[inaudible].... And we have to build a future.

Our children don't have a future. They see themselves as ending up in the juvenile justice system, as ending up in prison. And the pathways are well documented about how many children in care end up in the prison justice system.

GLASSON: [inaudible] Well, this is all about social and economic poverty. If we can solve that problem ...[inaudible]... goes a long way to solving this one, but as Muriel points out circumstances under which certain members of the community have to live is just [inaudible.]

Look, thanks very much indeed. Thanks for your time.

Participants attending

AMA Summit on

Child Abuse

Name	Organisation and address	Email
Ambikapathy Patmalar	Commissioner for Children Child and Family Services Level 5 99 Bathurst Street Hobart Tas 7000	Tasmanianchildrenscommissioner @dhhs.tas.gov.au
Anastassiadis Kay	Child Protection Review Implementation Unit C/- Department of Human Services PO Box 287 Rundle Mall SA 5000	kay.anastassiadis@dhs.sa.gov.au
Bahen Vicki	Community Care Division Department of Human Services 20/555 Collins Street Melbourne Vic 3000	vicki.bahen@dhs.vic.gov.au
Barry Fran	ACT Health GPO Box 825 Canberra City ACT 2601	fran.barry@act.gov.au
Briggs Carolyn	Australian Association of Maternal, Child and Family Nurses C/- Faculty of Nursing, Midwifery and Health University of Technology, Sydney PO Box 222 Lindfield NSW 2070	carolyn.briggs@uts.edu.au

Buxton Sally	Australian Medical Students Association PO Box 1223 Unley DC SA 5061	treasurer@amsa.org.au
Cadd Muriel	Secretariat National Aboriginal and Islander Child Care Ground Floor 48 High Street Northcote Vic 3070	mcadd@vacca.org
Cahir Pam	Early Childhood Australia PO Box 105 Watson ACT 2602	eca@earlychildhood.org.au
Carrington Dr Kerry	Australian Institute of Health and Welfare GPO Box 570 Canberra ACT 2601	kerry.carrington@aihw.gov.au
Cavanagh Jo	Family Services Australia PO Box 326 Deakin West ACT 2606	jcavanagh@sfl.org.au
Connolly Trish	Aboriginal and Torres Strait Islander Service PO Box 17 Woden ACT 2606	trish.Connolly@atsis.gov.au
Cripps-Clark John	Faculty of Education Deakin University 221 Burwood Highway Burwood Vic 3125	crippscl@deakin.edu.au

de Wolf Sandie	Families Australia PO Box 83 Campbell ACT 2612	sdewolf@berrystreet.org.au
Donald Dr Terry	Child Protection Women's and Children's Hospital 72 King William Road Adelaide SA 5006	donaldt@wch.sa.gov.au
Engelhardt Dr David	CEO Child and Youth Health 295 South Terrace Adelaide SA 5000	engelhardt.david@cyh.sa.gov.au
Foster Adam	NAPCAN PO Box K241 Haymarket NSW 1240	adamdfoster@aol.com
Gilmore Victoria	Australian Nursing Federation Unit 3/ 28 Eyre Street Kingston ACT 2604	professional@anf.org.au
Glasson Dr William	President Federal AMA PO Box 6090 Kingston ACT 2604	

Goddard A/Professor Chris	Department of Social Work Monash University PO Box 197 Caulfield East Vic 3145	chris.goddard@med.monash.edu.au
Goldsworthy Jenni	Commonwealth Department of Family and Community Services GPO Box 7788 Canberra ACT 2610	jenni.goldsworthy@facs.gov.au
Green Sue	Office for Aboriginal and Torres Strait Islander Health Department of Health and Ageing GPO Box 9484 Canberra ACT 2610	sue.green@health.gov.au
Hart Dr Diana	Vale Medical Clinic 509 Pittwater Roada Brookvale NSW 2100	hartdl@acay.com.au

Herman Anton	Australian Council for Children and Youth Organisations 196 Williams Road Toorak Vic 3142	anton@accyo.org.au
Holt Joanna	Children's Hospitals Australasia PO Box 4 Braddon ACT 2612	jholt@wha.asn.au
Hordern Sarah	Australian Association of Social Workers PO Box 4956 Kingston ACT 2604	Sarah.Hordern@act.gov.au
Keller Trish	Narrabundah Primary School Kootara Crescent Narrabundah ACT 2604	trish.keller@mnarrabundahps.act.edu.au
Kelly Barbara	Family and Children's Services Department of Health and Community Services PO Box 40596 Casuarina NT 0811	barbara.kelly@nt.gov.au
Kovacs Katie	National Child Protection Clearinghouse Australian Institute of Family Studies 300 Queen Street Melbourne Vic 3000	katiek@aifs.gov.au
Lawrence Andrew	AMA (student)	alawrence@ama.com.au

Lyndon Pam	Farrar Gesini and Dunn 17-21 University Ave Canberra City ACT 2601	p.lyndon@fgd.com.au
Margaret Roots	Catholic Welfare Australia PO Box 326 Curtin ACT 2605	margaret@catholicwelfare.com.au
Meuronen Anne	Families Australia PO Box 83 Campbell ACT 2612	policy@familiesaustralia.org.au
Mitchell Janise	Australian Childhood Foundation PO Box 525 Ringwood Vic 3134	jmitchell@childhood.org.au
Newman Dr Louise	NSW Institute of Psychiatry Locked Bag 7118 Parramatta BC NSW 2150	Louise@nswiop.nsw.edu.au
O'Connor Chris	Victoria Police Victorian Police Centre 637 Flinders Street Melbourne Vic 3005	christopher.o'connor@police.vic.gov.au

Oberklaid Prof Frank	Centre for Community Child Health C/- Royal Children's Hospital Flemington Road Parkville Vic 3052	frank.oberklaid@rch.org.au
Orr Bev	Australian Foster Care Association 2 Malindi Place Giralang ACT 2617	afca@bigpond.com
Packer Dr Sue	RACP Paediatric Division 145 Macquarie Street Sydney NSW 2000	sue.packer@act.gov.au
Pratt Jan	Australian Association of Paediatric and Child Health Nurses 184 St Paul Street Spring Hill Queensland 4000	jan_pratt@health.qld.gov.au
Priest Kathryn	Commonwealth Department of Family and Community Services – SA GPO Box 9820 Adelaide SA 5001	kathryn.priest@facs.gov.au
Read Lyndall	ACT Children's Services Department of Education, Youth and Family Services POP Box 1584 Tuggeranong ACT 2901	lyndall.read@act.gov.au

Robertson Stephen	NSW Commissioner for Children and Young People 2/407 Elizabeth Street Surrey Hills NSW 2010	stephen.robertson@kids.nsw.gov.au
Scott A/Professor Dorothy	School of Social Work Faculty of Arts University of Melbourne Parkville Vic 3010	dascott@unimelb.edu.au
Stuart Lois	Narrabundah Primary School Kootara Crescent Narrabundah ACT 2604	lois.stuart@narrabundahps.act.edu.au
Sue Tregeagle	Barnados Australia GPO Box 9996 Sydney NSW 2001	suetreg@barbados.org.au
Sullivan Dr Robin	Commisioner for Children and Young People Department of Families GPO Box 806 Brisbane Qld 4001	rsullivan@childcom.qld.gov.au
Susie Kelly	Australian Institute of Health and Welfare GPO Box 570 Canberra ACT 2601	susan.kelly@aihw.gov.au

Tait Dr Paul	Children's Hospital at Westmead Locked Bag 4001 Westmead NSW 2145	pault2@chw.edu.au
van Soelen Sandie	Department for Community Development 189 Royal Street East Perth WA 6004	sandiev@dcd.wa.gov.au
Vimpani Professor Graham	Paediatrics and Child Health John Hunter Hospital Lookout Road New Lambton NSW 2305	graham.vimpani@hunter.health.nsw.gov.au
Yong Dr Choong-Siew	PO Box W84 Wareemba NSW 2046	csyong@ausdoctors.net

AMA

AMA Summit on Child Abuse

Working together: toward a national policy for child protection and recovery

Thursday 19 February
9.30am – 4.30pm

AMA Conference Centre
AMA House
3rd Floor
42 Macquarie Street
Barton ACT 2600

For further information:

Coralie Mathews
AMA Child and Youth Health Advocate
Phone: 02 6270 5447
Email: cmathews@ama.com.au

Josie Hill
Administrative Coordinator
AMA Public Health and Ethics Department
Phone: 02 6270 5446
Email: jhill@ama.com.au

For queries/messages on day of Summit
02 6270 5400

Program

Chairperson:	Dr Michael Rice *Chair* *Child and Youth Health Committee* *Australian Medical Association*
9.30am	Opening and recognition of Traditional owners *Dr Bill Glasson* *President* *Australian Medical Association* Welcome dance by Bundah Booris from Narrabundah Primary School
9.45am	Child protection: a public health model *Associate Professor Dorothy Scott* *Head of Department* *School of Social Work* *University of Melbourne*
10.15am	Child abuse is not just a children's issue *Professor Graham Vimpani* *Chair* *National Investment for the Early Years (NIFYeY)*
10.45am	Morning tea
11.00am	Child protection and children's rights *Dr Louise Newman* *President* *NSW Institute of Psychiatry*
11.30am	Aboriginal and Torres Strait Islander child protection: Key reform issues *Ms Muriel Cadd AM* *National Chairperson* *Secretariat of National Aboriginal and Islander Child Care*
12md	Families Australia: an overview *Ms Sandie de Wolf* *Chair* *Families Australia*
12.15pm	Roundup of morning session

12.30 – 1.15pm Lunch

Afternoon Program

1.15pm **Forensic aspects of child protection: establishing the level of harm and the need for protection**
Dr Terry Donald
Head of Child Protection
Women's and Children's Hospital
Adelaide

1.30- 3.30pm **Workshop Groups**

1. Developing formal submissions to Government
2. Recommendations for Training Organisations
3. Developing a Coalition of organisations

(All these workshops are requested to consider issues related to Aboriginal and Torres Strait Islander child protection.)
Please indicate your Workshop preference by email (Josie or Coralie) by Monday 16 February)

4. Children in immigration detention: child abuse and protection behind the razor wire

(Workshop 4 is subject to adequate numbers indicating interest. Could participants who wish to join this Workshop 4, please contact Josie or Coralie (preferably by email) by Monday 16 February)

Tea and coffee will be available during the afternoon session

3.30 – 4.30pm Final Plenary Session

Bringing it all together
Chair
Professor Graham Vimpani

4.30pm Close

AMA

Australian Medical Association

Communique No 1

Summit on Child Abuse
19 February 2004

Working together: toward a national policy for child protection and recovery

Background to the Summit

There is huge concern about child abuse in the community and among those professionals working with children and families. The number of reports of suspected child abuse and neglect have more than doubled in the past 12 years with more than 40,000 substantiated cases of child abuse in a year.

Professionals from many disciplines work in child protection. Different juridictions have different approaches and different regulations. There is currently no clear national agenda and no unified national system of child protection and recovery.

Aim

Working together: toward a national policy for child protection and recovery.

Themes of Summit

- Child protection as a public health issue
- The long term effects of child abuse
- Special needs groups within Australia
  - Aboriginal and Torres Strait Islander children
  - Children in immigration detention
- Forensic aspects of child protection
- Role of Families Australia

Summary of recommendations from Summit

- That all levels of Government work in partnership with other key stakeholders to adopt an integrated national public health strategy to address the issue of child abuse and neglect.
- That the Commonwealth and State Governments work in partnership with the non-Government sector to develop a national policy and service framework that promotes the status and wellbeing of all children.
- That all professions, involved in work with children and their families, include pre-service and continuing education on child protection.

- That a coalition of organisations be formed to get child protection onto the national agenda for child health and wellbeing.
- That children in immigration detention be given the same standard of health and welfare services as all other children in Australia and that these services be independently monitored.