HISTORIES OF THE 'RESI-KID': POLICIES AND POLICING OF CHILD ABUSE

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ABSTRACT

Child abuse, and deaths of the clients of child protection services, continues to plague welfare and justice systems in many parts of Australia. Legislative changes to child protection in Victoria have introduced new procedures for managing the state's child protection services. Among its objectives, the legislation seeks to promote stable long-term care for children through timely and more efficient family interventions. This paper places these events in the historical context of recurring shifts in how the problem of child abuse is conceived and acted upon. It draws particular attention to new forms of power in relation to the policing of children and families, which promote individual responsibility for the underlying social arrangements affecting child maltreatment.

1 INTRODUCTION

1.1 A BOUNDED POPULATION

'Crisis kids exposed to low-lifes', screams the headline in another Sunday newspaper's expose of Victoria's child welfare system (*Sunday Age*, Melbourne, 11 February, 2007, p.1). The newspaper article followed the well-publicised death of a four-month-old boy apparently assessed by protection workers as not-at-risk even though both his parents were addicted to 'ice', or crystal methamphetamine. Past and present workers in the Department of Human Services (DHS) and welfare agencies are speaking on condition of anonymity about children in care being exposed to drugs, crime and sex in the State's residential units. 'Resi-kids' are those taken into care by the welfare system to protect them from abuse and other forms of risk, not because they have been charged or convicted of an offence. Children are placed in residential care because they have not been satisfactorily placed in out-of-home or foster care, or they have 'special needs'. But according to DHS workers, these children are themselves risky. They are often housed with older children - 'experienced criminals by the time they left the system'- while a child may be the sole resident of a unit because of behaviour or mental health problems. Children can be exposed to long-term residents with severe mental-health problems who self-harm, including body-slashing and attempted suicide. They are also exposed to 'drug-taking, absconding, chroming and skipping school ... police are regularly called to the units, staffed by shift workers earning $15 an hour (non-penalty rate), who can be threatened, intimidated and attacked by the DHS "clients"' (op. cit, p.2). The workers accuse DHS of 'interfering too heavily in children's lives, of ignoring the experts who work most closely with them, and promoting a bureaucratic and defensive culture paralysed by a fear of damaging publicity' (ibid). In defence of the system, Victoria's Child Safety Commissioner argues that working in residential care was 'one of most difficult types of work one can be involved in'.

> People working in these situations can be extraordinarily skilled and heroic. They put themselves in a position of being in a house with an

angry, sometimes violent 16-year-old. You can't physically restrain them, because that is against the law, or lock them in their room, because that is against the law. So they go. It is a no-win situation (*Sunday Age*, p.1).

2   DISCUSSION

One response to all this might be to criticise the sensationalising and 'moral panic' elements in a Sunday newspaper's treatment of 'resi-kids'. After all, child protection is a highly charged and emotive issue. Its newsworthiness lies not in the intensive day-to-day case work with children and families, but rather with images of scarred children in the hands of a system barely able to cope with a constantly escalating workload. Another response might be to recognise that the children described above are indeed victims, not just of the system but many also of the crime of child abuse. As Ian Hacking (1991) reminded us, child abuse is the worst of private evils. We must protect as many children as we can. We want to discover and help those who have been hurt. There is a certain familiarity with this shaping of a social problem and with our responses to it.

But we also know that this distinct population of children and these institutional sites have been constructed over time, often egging each other on. The field of child welfare has been significantly shaped by changing definitions in the field of childhood itself and in particular the category of child abuse (Hacking, 1991). The naming of persons is observable in the shifting systems of knowledge surrounding children. Hacking argues that people are affected by what we call them and by the classifications within which they can describe their own actions and make their own constrained choices: '(p)eople act and decide under descriptions, and as new possibilities for description emerge, so do new kinds of action' (Hacking, 1991: 254-5). These processes apply to both the abused and the abusers. A category of person and a particular population of children come into being as a consequence of managing problems in child and family welfare. In addition, the classification of children needing protection has interacted historically with the classification of offending children; remember that well into the last century children were charged with an offence of being 'in need of care and protection' and were brought before the children's court for their disposition. For well over a century, offending and neglected children shared a common knowledge base and institutional apparatus:

> While recent reforms have attempted to separate welfare cases from criminal cases the nexus between the two still exists because the mundane daily management of the abused child and the abusive child relies on similar forms of knowledge and power (Carrington, 1993: 3).

So perhaps we should not be surprised that the present description of our category of resi-kids contains descriptors sometimes associated with offending children. But the present might appear less familiar and taken-for-granted when we take account of the historical contingencies that have come to make up this present and the categories of person who occupy it. The aim of this paper is to provide a broad analysis of changes in definitions of child abuse various parts of Australia and to link these shifts to changes in the way in which the abused child has become known.

2.1   COUNTING CHILD ABUSE
Policy analysts in Australia and elsewhere have noted the changing ways in which child protection is conceived and organised, largely in response to changing definitions of child abuse. Cashmore (2001) observed the move from the discovery of 'battered babies' in the 1960s, to the exposure of child sexual assault in the 1990s. She argues that ever increasing numbers of children are being reported to State authorities because of increased community awareness of child maltreatment, the introduction of mandatory reporting, and an actual increased incidence of family violence, substance abuse, poverty and social disadvantage (Cashmore, 2001: 1). From the 1960s onwards, the definition of

abuse broadened from discovery of 'battered babies' in 1962 to the physical abuse of children of all ages, and now including neglect, emotional abuse and sexual abuse, and more recently the effects on children's social and emotional development of exposure to domestic violence (Cashmore, 2001: 1). So in this view, increased numbers of cases of abuse appearing in published statistics reflect a gradual uncovering of the incidence of abuse, on the one hand, and an increase in the kinds of behaviours or circumstances that are defined as abusive on the other.

It is pertinent to record here what the statistics tell us, in broad terms, about levels of out-of-home care (or foster-care). For many of the reasons already outlined, published statistics on out-of-home care in Australia require careful analysis. There are also difficulties in comparing rates of care between the states -- each state and territory has its own legislation, policies and practices in relation to child protection. But some broad trends in the provision of out-of-home care have been identified. Aggregate numbers of children in care throughout Australia rose from 18,880 children in 2002 to 25,454 in 2006, an increase of 35 percent (Australian Institute of Health and Welfare, 2007: xi). The rate of Aboriginal and Torres Strait Islander children in out-of-home care was over 7 times the rate of non-Indigenous children (ibid). When analysing rates of residential care (the 'resi-kids'), the numbers are still relatively small, with just over 1000 children in this kind of care across Australia.

Curiously, while Victoria is recording the highest rate of children placed in residential care, the rate of detention in juvenile justice facilities is the lowest of all states. In 2005, Victoria recorded a rate of 11.8 per 100,000 of the 10-17 population in juvenile detention, compared with 29.7 per 100,000 in New South Wales and an Australia-wide rate of 27.2 per 100,000 (Australian Institute of Criminology, 2005: 5). While NSW has nearly 3 times the rate of juveniles in detention, Victoria has 3 times the rate of juveniles in residential care (7.2 percent of all children in out-of home care) compared with NSW (2.6 percent) (AIHW, 2007: 52; AIC, 2006:11). There are hazards in interpreting any kind of inverse relationship between the populations in residential care and juvenile detention, although the figures may help to explain why care workers face challenges of the kind described in newspaper reports: workers in residential services in one state may be caring for a population that in another state might well be housed in juvenile detention. Furthermore, the overall numbers in either system are relatively small. In 2005, NSW had 217 persons aged 10-17 in juvenile detention, down from 611 in 1981, while Victoria had 63 persons, down from 334. 'Resi-kids' in NSW numbered 258 in 2006, compared with 347 in Victoria, even though NSW had twice the number in care overall (9896), compared to Victoria (4794).

Further issues of interpretation relate to the increased rates of out-of-home care in all the Australian states, and the significant contribution of particular states and territories to this overall increase. NSW, Queensland, Australian Capital Territory and the Northern Territory all record significant increases, a doubling over 10 years to 2006, and in the case of NT a four-fold increase. Victoria experienced lower growth rates in out-of-home care over this period, compared to most other states. However, between 2003-4 and 2005-6, protective orders in the Children's Court of Victoria rose from 26,077 to 32, 526, an increase of 25 percent in just three years (*Age*, 2/06/07). The spike in the number of cases, according to the president of the court Judge Grant, was caused by DHS auditing of its cases in one large region, and also because new child protection legislation had prompted DHS to bring more cases to court. In the headline-grabbing piece in the Melbourne *Age* newspaper - 'Children lost in court squeeze' - the judge reported that the children's court complex was 'bursting at the seams' with the family division taking over court space from the criminal division to try to handle the load. Waiting times for final child protection hearings had almost doubled since 2003. One experienced lawyer said that the court was unique in that parents turned up not knowing the material against them: 'A box is ticked - the child has suffered "physical harm" or "emotional harm"' (*Age* 3/06/07).

2.2   CHANGING DEFINITIONS OF CHILDE ABUSE

In Australian historical accounts, it is the 'landmark paper' by a group of Colorado paediatricians (Kempe, 1962) that began 'a period of awareness of child abuse', making it distinguishable from the earlier child cruelty and infanticide (Oats, 1985: 44).   In the 1940s and 50s, children's X-rays showing unexplained fractures led the American team in Colorado to use the deliberately emotive term 'baby-battering' to draw wider attention to a problem that paediatricians considered was far more widespread that their hospital experience led them to believe. According to Picton and Boss (1981: 116), this gave way to the more general term 'child abuse' because it was able to include older children, and a broader range of situations in which 'children are cruelly treated, sexually injured, or neglected, or exploited to their detriment', not only by their parents but by others who have responsibility for them. In Australia, Wurfel and Maxwell (1965) wrote a study of the 'battered child syndrome' in South Australian, while in Victoria the Birrell brothers (1966) referred to the curiously-named 'maltreatment syndrome in children' (Picton and Boss, 1981: 116).   Bob Birrell, a paediatrician, and brother John Birrell, the police surgeon, are credited with publishing the first academic paper on child abuse in Victoria. But their contention that child maltreatment was a widespread problem in Victoria received little support from within the Children's Hospital, and their suggestion to set up a child protection unit in the hospital was treated as a joke (Yule, 1999: 446). Early in the century the hospital had confronted the problem of gonorrhoea in children, often put down to infected linen and one doctor describing it as 'mysterious in its origin', while there were ongoing observations about deliberate burning of children (Yule, 1999: 139, 146-7).   But by the early 198os there were no reliable studies that could give even approximate estimates of the extent of child abuse in Australia. The counting of child abuse cases began in Australia and New Zealand in 1972 (Fergusson, et.al, 1972), but the count became higher every time there was a change in the law or definition of abuse (Picton and Boss, 1981: 120).

Child abuse as a medical problem also emerged from the long-standing problem of 'nonorganic failure to thrive' amongst very young children. The pathologising of growth failure in infancy had been recognised from early 20th century studies in the US, Europe and Australia. Chapin in 1915, for example, cited 'deficient and inefficient fathers and mothers' while Spitz in 1945 suggested 'lack of emotional stimulation' and 'maternal deprivation'). Widowson cited emotional deprivation as a key factor after comparing the growth of children in two orphanages in post-War Germany in 1948, one of which had a more caring house-mother than the other. But Oates (1985: 5- 15) pointed out that in neither of these studies was there a count of the actual amount of food consumed by the children, and of the 123 infants separated from these mothers at age 6-8 months, only 19 experienced 'severe reactions and growth disturbance following the separation' (p.15).   A Melbourne study in 1959 gave 'inadequate care' and 'adverse social circumstances and emotional deprivation' as the main causes of failure to thrive (Williams, 1959). Whitten et al. (1969) tested the idea of 'inadequate mothering' by confining children for two weeks in a windowless room with minimal handling and attention but with a generous diet. All but two had accelerated weight gain, and when they were later given stimulation, fondling and social contact, they made the same weight gain as that a when they were unstimulated. Oates (1985) suggested that weight gains were not dependent on levels of stimulation or mothering, and other tests suggested that ' … the problem in growth failure in maternal deprivation is due to inadequate caloric intake rather than to some psychological cause' (Oates, 1985: 16). Some studies explicitly warned that the use of the concept maternal derivation suggested mothers were at fault, when the underlying causes were the lack of 'social supports' (ibid).

The most common causes of failure to thrive in these studies were poverty, overcrowding, unemployment, illegitimacy and seriously disturbed marital relationships;

other studies found family separation, unemployment, financial difficulties and poor communication between parents. In their study of medical records in the Royal Alexandra Hospital in Sydney in 1967-9, Oates and Yu (1971) showed that children with failure to thrive came from unstable families which were large, poorly educated and had low income. They often changed addresses, the mothers were married in late teenage years, bottle-fed their children, and it was usually the last born that failed to thrive (Oates and Yu, 1971: 202). The response to these adverse social conditions was for the physician to provide family support and counselling, and to enrol the aid of social workers and appropriate community services (Oates, 1982). Nearly all the families came from lower socio-economic groups, but as Oates (1985: 21) explained, none of the studies used comparison groups so it was '... not possible to evaluate the effect of social class on this condition'. In the few 'case-control' studies involving stable, intact families with favourable economic circumstances, mothers of infants with nonorganic failure to thrive tended to score lower on the vocabulary test of the Stanford-Binet intelligence scale. In concluding his review of family studies, Oates (1985) reported no evidence of psychiatric disorders in the children although some exhibited mild behavioural disorders. But despite all the caveats placed on interpreting the studies, the American Diagnostic and Statistical Manual (3rd. Edition) in 1980 designated failure to thrive as a 'reactive attachment disorder of infancy', which emphasised the maternal-infant bonding aspect of the disorder (American Psychiatric Association, 1980).

In the same publication as Oates evaluated evidence of failure to thrive, he laid out a quite separate history of the phenomenon he called child abuse, with its origins in infanticide, early versions of 'family planning', and cases of child cruelty in such places as factories and mines. When members of the Royal Society of Medicine in London in 1888 were presented with details of fractures and swellings in children presenting at the Hospital for Sick Children, according to Oates they '... were not aware that the syndrome of child abuse was being described to them' (Oates, 1985: 43). He described a specific medical interest in child abuse beginning with Tardieu's (1860) study of 32 children in Paris who had been battered to death: 'his description clearly stated the demographic, social, psychiatric, and medical features that eventually came to be recognised as the battered child syndrome' (ibid). But well into the 20th century, medical opinion identified children who presented with 'multiple metaphyseal fractures, bruising, retinal detachment, and bilateral black eyes' as a new condition called mataphyseal fragility of bones (Astley in 1953), although Silverman in 1953 reported that the history of these kinds of child bone fractures could be elicited 'by careful questioning of the parents'. By the time Kempe's battered child syndrome appeared in 1962, there had been over a century of medical inquiry into children who had been injured in one way or another by their parents but not been identified as a problem. Was the turning of the corner made possible by the invention of a syndrome? Even after this time, as Oates reported in the Australian *New Doctor* journal in 1971, making a diagnosis was difficult because of the doctor's poor training, reluctance to become involved in court action, and their 'own denial':

> Doctors may also feel uncomfortable when confronted with an abused child and his parents, and are likely to accept at face value a most unlikely explanation for the injury rather than seek its real cause ... Doctors who have worked with such families will understand the feelings of Sanders when he says that in his experience it is more difficult to tell parents he is reporting them that it is for them to accept his action (Oates, 1885: 59).

From 1977, New South Wales made it mandatory for medical practitioners to notify cases of child abuse. From the mid-1970s most of the States and Territories announced policies on child abuse, created management structures for dealing with it, developed 'treatment programs', and devised legislation that would clarify the definition of child abuse (Oates, 1985: 41-67). The early Australian studies replicated the counting

exercises that had begun in Europe and North America a decade before, all showing startling evidence of an epidemic of abuse. A study in 1977 from the Royal Alexander Hospital for Children in Sydney published in the *Medical Journal of Australia*, showed that 40 percent of children under age 5 presenting to the casualty department with injuries or burns had features strongly suggesting of child abuse (ibid). From the earliest surveys, however, researchers expressed doubt about the actual incidence of child abuse since their figures were based only on cases brought to the attention of authorities.

2.3   FORENSIC INVESTIGATION TO RISK MANAGEMENT

The Australian Institute of Health and Welfare points to the main factor in understanding rising rates of out-of-home care as the changing definition of child abuse. In the past 10 years, the definition of child abuse and neglect has changed and broadened, and this is most likely to result in increasing identification of abusive situations.

> The focus of child protection in many jurisdictions has shifted away from the identification and investigation of narrowly defined incidents of child abuse and neglect towards a broader assessment of whether a child or young person has suffered harm. This broader approach seeks to assess the child's protective needs (AIHW, 2006:6).

Most jurisdictions have introduced options for responding to less serious reports through the provision of family support services, leading to a reduction in the numbers of investigations and substantiations of child abuse. However, in most states the shift towards risk assessment has changed the kind of intervention thought to be most effective in dealing with what are called 'complex and chronic' features of families regularly coming into contact with child protection services. In other words, the crisis of numbers that has appeared in the Victorian situation described above may be more related to changing management practices that just a changed or expanded definition of abuse. A study conducted by the Victorian Department of Human Services in 2002 made an assessment of families subject to rising rates of renotifications and resubstantiations, finding an underlying pattern of low income, substance abuse, mental health issues and sole parenting in these families that was not addressed by incident-driven child protection processes (AIHW, 2006:7). Two-thirds of substantiations of child protection notifications concerned children neglected or suffering from emotional abuse. Importantly, a government-ordered review in 2003 claimed that if the current child protection arrangements continued, one in five children in the cohort born in Victoria in 2003 would be notified for suspected child abuse or neglect during their childhood or adolescence, making it difficult to reconcile these figures with the intent of the *Children and Young Person's Act* (1989) that child protection would be an emergency service (DHS, 2003: vi). Cashmore (2001:4) summed up the shift in emphasis observed in other states' legislation:

> The definitions of 'abuse' and 'neglect' in recent legislation in NSW and Queensland now focus on 'harm' and 'risk of harm'. The aim is to shift the emphasis from a forensic investigation of allegations of abuse or neglect to a broader assessment of whether a child or young person has suffered harm or is likely to suffer harm. While a forensic approach tries to determine whether acts of commission (abuse) or omission (neglect) have occurred, an assessment approach is more concerned with whether parents are able to protect their children and meet their needs.

These developments as they affected Victoria eventually led to the enactment of the *Children, Youth and Families Act* (2005), and can be understood to be a reflection of international trends in the politics of 'need interpretation'. For example, Australia, the UK and North America have adopted a 'regulatory' child protection orientation to child abuse, as distinct from the family service orientation long-practiced in countries like Sweden, Germany, Belgium and the Netherlands. According to policy analysis, there is clear

evidence that the family services approach provides easier access to a wider range of services and assistance than the child protection systems (DHS, 2003: vii). Family service systems place more emphasis on working voluntarily with parents over longer periods, compared with the more restrictive and coercive approach. The regulatory approach works well when responding to episodes of significant harm but is less effective in dealing with more chronic cases of ongoing neglect. Recent approaches to regulatory reform stress the need for a spectrum of responses to families' needs, while retaining the capacity to apply tough sanctions. They need to work in partnership with other agencies, and they work best when people see the system as procedurally fair and treat people with respect. Importantly,

> child protection regulation should build on, or interact more with, parents' own 'private regulation', or self-regulation. Government regulation should respond to how effectively private regulation is working *and can be encouraged to work better* (DHS, 2003: viii *emphasis in original*).

Reforms in the US and UK have also stressed a greater focus on permanency for children in out-of-home care. A major negative impact of the regulatory approach is the effect of regulation on children who are given a number of short-term placements. 'Intermediate level responses' seek agreement with families and other relevant parties on a plan and necessary support measures to keep the child safe, and hence avoid formal statutory child protection intervention and court proceedings.

So there are to be more preventative and diversionary strategies, less resort to statutory and court processes, earlier intervention and permanent care arrangements, and a greater opportunity for children to become part of a family by acting earlier to provide permanent care. Policy advocates explain that this will be achieved through building community partnerships, and encouraging vulnerable families to access support by providing more responsive and flexible services. These strategies will be supported by an expanded community infrastructure. In the DHS (2003) *Final Report of the Child Protection Outcomes Project*, community infrastructure is described as Community Child and Family Support Centres in local areas, locally coordinated 'community based' services including child protection, family support, health, police and schools, and the development of 'intermediate level responses that allow for dialogue and deliberation with families outside of formal legal processes' (DHS, 2003: xiv).

2.4 THE NEW VICTORIAN ACT

A Bill to enact the *Children, Youth and Families Act* was passed in the Victorian Parliament in late-2005. The main effects were that child protection cases will be managed in the 'community', and decisions about either reunification or out-of-home care will be speeded up. DHS would be required to explain to the Children's Court why it would not be in the best interests of a child or young person to work towards a stable, longer term out-of-home care arrangement (Power, 2005: 1). Managing cases in the community is intended to be achieved by means of voluntary child care agreements to place children in out-of-home care, a provision borrowed from the *Community Services Act* (1970) that was amalgamated into the new 2005 *Act.* These written agreements between a parent and a service provider must take into account the wishes of the child, and the parties may agree to one or more extensions for a period not exceeding 6 months. In the case of long term child care agreements, the period may not exceed 2 years. Agreements may be terminated by any party giving notice in writing. Under the previous *Children's and Young Persons Act* (1989) a precondition for making a permanent care order was that the child's parent had not had care of the child for a period of at least two years.

Many aspects of the shift in child protection practices written in the new *Act* have been criticised by key stakeholders. The most challenging of these criticisms relate to the

increasingly interventionist, 'fast-track' approach to permanent removal, and claims of inadequate safeguards or court scrutiny of the procedures for placing children in care. Dutta (2005) recorded many of the concerns in interviews with members of the Victorian Bar and through a detailed examination of the *Act*. They have to do with apparent large increases in child interventions, making it easier to remove children and place them in permanent care. Permanent care is a strong priority, rather than reunification, and permanent care orders can be made as soon as six months after a child has been removed, much the same as adoption orders. There are concerns that legal advice is rarely provided in circumstances where child care agreements are sought by an agency, and also the possibility that minors, non-English speakers and people with intellectual disabilities can sign agreements. Agreements may require parents to access services before they can apply to resume care of their child, although there are no mechanisms to ensure that the services, particularly counselling and psychology, are actually available. In Dutta's evidence, court officers claim that court-ordered services are not provided in the required time-frame in an estimated 50-70% of cases.

> There are no safeguards to ensure moves to permanent care will not take place when the opportunity for reunification has been prevented by inadequate service provision (Dutta, 2005: 10).

3   CONCLUSIONS

3.1   COMMENTARY

We commenced a discussion of policies and policing of child abuse by entering the room of present strained relations in Victoria's residential accommodation for children in need of care and protection. The aim was to convey the levels of contingency in accounting for the numbers of children placed in care, and especially to show how the definition of child abuse has been held to account for increases in the sheer numbers of children coming under the scrutiny of protective services. While there is evidence that expanded definitions led to a wider net of abusive behaviours and conditions, there is equally good evidence that a change of protection management practices have brought many more children under investigation. In addition, there seems to be no clear linear progression in the 'coming into being' of the concept of child abuse. As the experience in Victoria shows, 'child maltreatment syndrome' appeared alongside 'non-organic failure to thrive' in the prefiguring of child abuse as a distinct category of behaviours and conditions that was of interest to medicine. As medicine did not speak with one voice, neither did the others: law, justice administration, social work.

Yet the rudiments of the current era of community approaches in problems of child protection were laid down in Victoria nearly 30 years ago. The *Community Welfare Services Act* (1979) provided the underpinning for fundamental changes in the way child matters were to be handled in law. Instead of a psychiatrist making the final decision about how a case involving a child is to be disposed of, the new *Act* made it possible for a social worker to oversee that decision. The word community appeared in the name of the *Act* and in the name of the new government Department. One important change was that the ultimate authority of medicine and psychiatry in decisions over children was removed, and instead social workers in the State Department of Community Services could make a final recommendation to a court. But the by-word was that the child would be managed in the community.

This event was regarded as scandalous by many in the Children's Court and its attached Clinic. But the move was celebrated by others as a win for children's rights – perhaps the end of the era of institutionalizing of child offenders under the guise of 'treatment', much more consistent with knowing the child's 'best interests' (Scutt, 1977; Ainsworth, 1992). Both offending and neglected children administered by the Court had been constructed in a conceptual framework of 'deviancy' and into a framework of 'diagnosis' and 'treatment', and the breaking out of this deviancy model was led by the 'avant-garde

welfare thinking' of the Norgard Committee report (Victoria, 1976), which led in turn to the new Community Welfare Service Act (McCallum and Laurence, 2007; Jaggs, 1986).

As with the doctor Oates' (1985) recommendation for a community approach to child abuse, the social workers saw the court processes and a heavily professional engagement as a constraint on the successful integration of the problem child and an amelioration of poverty and social dislocation that was associated, in their studies, with the appearance of child abuse. Community was posed as a solution to a series of individual events of abuse.   Its varied conceptions allowed for community to be teachers, doctors, social workers, police. (Bauman, 2000). Recent additions to this armoury in Australia are the soldiers. A crisis in child abuse highlighted in the paper by Peter Kirby in Victoria, that one in five children in the cohort born in Victoria in 2003 would be notified for suspected child abuse or neglect during their childhood or adolescence (Victoria, 2003), offers another perspective on the military takeover of Aboriginal occupied lands. In these kinds of manoeuvres, 'community' becomes a significant matter in locating the problem of child abuse.   It achieves this by registering levels self-governing activities on the part of parents and other related indices of risk.

4   REFERENCES

Age (newspaper), 02/06/07, at theage.com.au/news/national/children-lost-in-court, accessed 12/06/07

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of mental disorders* (3rd Edition), Washington DC.

Australian Institute of Health and Welfare (AIHW) 2007. Child protection Australia 2005–06. Child welfare series no. 40. AIHW Cat. no. CWS 28. Canberra: AIHW, at http://www.aihw.gov.au/publications/cws/cpa05-06/cpa05-06.pdf., accessed 14 February 2007

Australian Institute of Criminology (2005), Juveniles in detention in Australia, 1981-2005, at http://www.aic.gov.au/publications/tbp/tbp022/ , accessed 16 February 2007.

Bauman, Z. (2000) *Community: seeking safety in an insecure world,* Cambridge, Polity Press

Carrington, K. (1993) *Offending Girls. Sex, youth and justice*, Sydney, Allen and Unwin.

Cashmore, J. (2001) 'Child Protection in the New Millenium', *Social Policy Research Centre Newsletter*, No.79, 1-5.

Dutta, R. (2005) 'The Next Generation. The implications of the Children's Youth and Fmilies Bill for the Children's Court of Victoria', Victorian Parliamentary Internship Report, Melbourne, Parliament of Victoria Library.

Ferguson, D.M., Fleming, J., and O'Neill, D.P (1972) *Child Abuse in New Zealand*, Wellington, Department of Social Welfare, Government Printer.

Hacking, Ian (1991) 'The making and mounding of child abuse', *Critical Inquiry*, 17, 257-288.

Jaggs, D. (1986) *Neglected and criminal: foundations of child welfare legislation in Victoria*, Melbourne, Centre for Youth and Community Studies, Phillip Institute of Technology.

Oates, R.K. and Yu, J.S. (1971) 'Children with Non-Organic Failure to Thrive. A Community Problem', *The Medical Journal of Australia*, July 24, 1971, pp. 199-203.

Oates, K. (1982) *Child Abuse. A community concern*, London, Butterworths.

Oates, K. (1985) *Child Abuse and Neglect: What Happens Eventually*, Sydney, Butterworths.

Picton, C. and Boss, P. (1981) *Child Welfare in Australia: An Introduction*, Sydney, Harcourt Brace Jovanovich.

Power, P. (2005) 'Children, Youth and Families Act 2005', Melbourne, Children's Court of Victoria.

Sunday Age (Newspaper), 11 February 2007.

Victoria (2003). Department of Human Services (2003) Protecting Children. The Child Protection Outcomes Project, Final Report of the Victorian Department of Human ServicesMelbourne, Community Care Division, VDHS, at

http://www.dhs.vic.gov.au/pdpd/pdfs/finalreport.pdf, accessed 23 February 2007

Victoria (2002). Department of Human Services (2002) An integrated strategy for child protection and placement services, Melbourne, Community Care Division, VDHS, at
www.dhs.vic.gov.au

Williams, H.E. (1959) 'Failure to thrive in infancy', *Medical Journal of Australia*, 2, 345-349.

Yule, P. (1999) *The Royal Children's Hospital. A history of faith, science and love*, Rushcutters Bay, Halstead Press.