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PUNISHING WELFARE

Genealogies of Child Abuse

David McCallum *

Official statistics on child protection in Australia suggest that child abuse is at crisis levels, providing a context for the most recent legislative and regulatory changes in child protection in Victoria; these promote community-managed services, voluntary care agreements, informal legal processes and fast-tracking of child intervention. This article sets out the rudiments of a genealogical account of the category of child abuse, placing the present events in the context of historical shifts in how the problem of child abuse is conceived and acted upon. It draws attention to new forms of power in relation to the policing of children and families, and their corresponding modes of subjectification that seek to fabricate individual responsibility for the underlying social arrangements surrounding children and families.

Introduction

Australia appears to be experiencing an epidemic of child abuse. The number of child protection notifications increased nationally by more than 50 per cent during the last five years, from 198,355 in 2002–03 to 309,517 in 2006–07. Aggregate numbers of children in out-of-home care throughout Australia rose from 18,880 children in 2002 to 25,454, an increase of 35 per cent.¹ The rate of Aboriginal and Torres Strait Islander children in out-of-home care was over seven times the rate of non-Indigenous children. Published statistics on notifications and substantiations of child abuse and out-of-home care in Australia require careful analysis because each state and territory has its own legislation, policies and practices in relation to child protection. New South Wales, Queensland, the Australian Capital Territory and the Northern Territory all record significant increases in out-of-home care, a doubling over 10 years to 2006, and in the case of the Northern Territory a fourfold increase. Statistics on child abuse are regularly cited as evidence that Australia is experiencing a crisis in child protection, with regular media reports on escalating levels of family violence, child deaths under the watch of state child protection services and claims that physical, sexual and psychological abuse affects more than 170,000 Australian children annually and costs the community almost \$11 billion a year.²

Some policy analysts have observed how these increases are related to changing definitions of child abuse. For example, Cashmore traced the move

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¹ Australian Institute of Health and Welfare (2007), p xi.

² Access Economics (2008); McCallum (2008).

from the discovery of ‘battered babies’ in the 1960s and the exposure of child sexual assault in the 1990s, showing ever-increasing numbers of children reported to state authorities due to increased community awareness of child maltreatment and the introduction of mandatory reporting.³ The definition of abuse has broadened to also include physical abuse of children of all ages, neglect, emotional abuse and sexual abuse, and more recently the effects on children’s social and emotional development of exposure to domestic violence.⁴ In this view, increased numbers of cases of abuse appearing in published statistics may 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 counted as abuse on the other. Public reporting of raw data tends to smudge over category differences, such as paedophilia and incest, as well as older categories such as child cruelty and poverty-induced neglect.

More recently, managing child protection under programs broadly described as ‘risk management’ is understood to have expanded the numbers of children placed on protection orders or brought into out-of-home care.⁵ Such shifts in the way problem children and families are governed have effects on the work of counting agencies, and hence the production of official statistics. Differences in counting produce significant interstate disparities in rates of abuse — for example, in 2006–07, the number of substantiated cases in New South Wales was 37,094, compared with Victoria’s 6,828 cases.⁶ This represents a slight reduction in Victoria and a fivefold increase in New South Wales, over the same seven-year period. During 2006–07, all notifications in Victoria were referred to a ‘Child First’ team, consisting of child protection officers and community organisations supplying family services, who then decided which support services were required and whether child protection should be involved at all.⁷

This article argues that published statistics represent not just an expansion of the definition of child abuse but also a response to, and a condition of possibility for, particular practices of governing children and families. Focusing on the state of Victoria, it presents an overview of twentieth century management of problem children through philanthropic, medical and legal knowledges, and provides a historical context to the recent shaping of the problem of child abuse. In presenting the rudiments of a genealogy of the category of child abuse, I argue against interpretations that would depict the history of child maltreatment and child protection as a linear progression of liberation for the child — a ‘long and contested process which transformed the child from parental property to potential citizen and a holder of human rights’.⁸ The article suggests that conceptions of the problem child are contingent on

³ Cashmore (2001).

⁴ Cashmore (2001), p 1.

⁵ O’Malley (2005).

⁶ Australian Institute of Health and Welfare (2007).

⁷ Wynhausen (2007); McCallum (2008).

⁸ Scott and Swain (2002), p xi.

historically specific conditions for managing the problem child that have shifted over time. In the final section, the article points to recent changes in statutory and administrative arrangements for child protection in Victoria, embodied in the *Children, Youth and Families Act 2005*, which introduced new forms of power in relation to families, in the name of community management.

Systems of Knowledge

Child Savers and the Police

Knowledge of the ‘problem child’ in the late nineteenth century was a product of networks of charity workers and the police that had been established through the more general policing of destitute, disorderly and dissolute elements of the adult population in Victoria.⁹ In 1910, the recorded categories of children brought to the Victorian Children’s Aid Society Home included foundlings, neglected children removed from parents or found wandering, children whose parents had been locked up, children who had absconded from various other institutions, and children who had been charged with offences such as loitering, begging, theft and gambling on the streets. Charity workers relayed information about the child from and between the police and the court. In the form of questions, instructions, advice and information, a formal and informal dialogue began to take place that established a space for special knowledge of the child by the agent, which then found its way into the committal procedure. While they were being investigated and assessed, children were kept in the Home, which was effectively a remand centre and an annexe of police work — by 1904, the Chief Commissioner of Police paid the yearly rent of the Society’s premises.¹⁰ Strong links between the so-called ‘child savers’ and police and penal apparatus were apparent from the moment of establishing an organised system of interventions regarding children in 1864, following the creation of the Department of Industrial and Reformatory Schools.¹¹

From the earliest reports of the Society in 1893, women of the Children’s Aid Society became witnesses, speaking for the child in the court.¹² The object of knowledge was the child’s ‘habits’, with information collected from neighbours and other informants, including knowledge of the father and mother’s character and the state of the house. As keepers of this knowledge, the charity workers helped shape decisions about the disposition of children, and in this sense assisted a prosecution of the child in all cases, ranging from neglect to criminal offending. Charity workers considered the home — particularly a home in the countryside — as a kind of ready-made mechanism for the reform of habit. Domestic routine was seen as a kind of processing machine, preventing those with bad habits from becoming ‘habitual’. Children placed in country homes away from their evil surroundings and under judicious supervision would be:

⁹ Victorian Children’s Aid Society Records [VCAS] (1893–94).

¹⁰ VCAS (1904).

¹¹ McCallum (1993), pp 142–43.

¹² VCAS (November 1893–September 1894).

treated as members of the family, thus changing the whole course of their lives, forgetting their old names and taking the names of their foster-parents ... The children have an opportunity of learning gradually and naturally the laws of right conduct and high principle which are simply a part of the everyday life of the ordinary home ... if left unchecked until they reach the age of fourteen or fifteen the struggle for truth and right is indeed a hard one, and they rebel against the necessary restraint and discipline of a well-ordered home, and long to return to their old life of freedom.¹³

Children under care of the Department of Neglected Children and Reformatory Schools in foster homes or sent into service – not necessarily offenders, but children who were reported to the Department as exhibiting ‘depraved habits’ and ‘serious misconduct’ — were subject to a *de facto* indeterminate sentencing in the form of a transfer to reformatories, at the discretion of the minister and bypassing a court appearance. The provisions had particular implications for Aboriginal children. Under its Act, the Aborigines Board was initially able to transfer children described as ‘half-caste’ orphans to the DNCRS, but from 1900 this provision was extended to all ‘suitable’ Aboriginal children, whether orphans or otherwise, ‘in order that they may have the advantages of being dealt with in the same way as other wards of the State’.¹⁴ There was also strong doubt over the legal basis on which Aboriginal children were removed from their parents and communities.¹⁵ The Victorian *Children’s Court Act 1906* required that these previously informal arrangements for providing specialist knowledge of habit be transferred from philanthropy to newly appointed government probation officers, who henceforth were to ‘inquire and furnish the court with information as to the child’s habits, conduct and mode of living’.¹⁶

Discourses on habit, then, were a product of a network of relations between police, penal and reform institutions, and proto-social workers that was established throughout the nineteenth century. These arrangements signified a strong continuity between adult and juvenile administration of the habitual criminal, showing that penalty and philanthropy had clear lines of connection rather than separation, and also indicating that the invention of so-called ‘welfarist’ approaches such as the Children’s Court in 1906 retained close associations with the adult penal system. The moves towards ‘informal power’ and a decentring of law,¹⁷ implicated in the newly created child experts and the practice of bypassing courts, became conditions of possibility for the regular transport of bodies between institutions for the neglected and the criminal that remained in place throughout the rest of the twentieth century.¹⁸ In particular, the

¹³ VCAS (1897–1908), Report for Year Ending 30 September 1900.

¹⁴ Victoria (1901); McCallum (2004).

¹⁵ Powell and Kennedy (2005), p 44.

¹⁶ Victoria (1906).

¹⁷ Harrington (1992), p 177; van Krieken (2001), pp 6–7; Hunt (1992).

¹⁸ Carrington (1993).

networks were a condition of possibility for the collection of social information that permitted a calculation of the pathological family to be performed. The object of knowledge was the child and its habits, which was information collected as part of an explicit strategy to try to guard against the neglected child becoming the criminal adult. Agencies responsible for the collection of this knowledge were the police and the welfare officer (first the charity worker and then the probation officer), whose activities took the form of deliberate social prophylactics aimed at securing the child from a criminal future.¹⁹ Despite these explicit rationalities, the effects of these practices secured new forms of government over a bounded population of both problem adults and children, in order to make calculations about habit.

The Doctor in the Clinic

One of the formative elements of the appearance of the modern concept of child abuse involved its characterisation as medical pathology, as Ian Hacking has demonstrated in the North American context.²⁰ In 1944 in Australia, a doctor replaced the charity worker and probation officer as the bearer of a special knowledge of the problem child. A psychiatrist, recruited from the adult prison system, was placed in charge of a new Children's Court Clinic advising the court about the 'conduct and habits' of a child coming before the court for being a neglected child, or on criminal charges. In Victoria, the Clinic employed psychologists, social workers and a nurse; it was headed by a psychiatrist, and worked closely with probation officers and other officials. Any case or incident could be referred to the Clinic for investigation — the psychiatrist would examine the child and interview the parents; the psychologist would most likely test the child with one of the new intelligence tests; while the social worker would visit the home and report back on the child's parents and living conditions. The psychiatrist would prepare a report on all this and submit a recommendation for disposal of the case to the court. Often what was at stake was whether the child would be returned home, or sent to an institution or into foster care — or, in the case of a child charged with a criminal offence, whether the child was put on probation, or was committed to a reformatory if the charge was proven. These procedures applied to both neglected and offending children and were prosecuted in the same court. Like that of the charity worker, the doctor's role was an extension of the judicial apparatus, providing opinion to the court on how the child was best dealt with. But there is also good evidence drawn from court records in the 1940s showing that the doctor acted as an adjunct to the prosecution, interviewing the child, cross-examining material brought by the social worker and making decisions on the 'character' of the child. It can be argued that he served less as a 'man of science' than as an adviser on aspects of the character and culpability of the child.²¹

¹⁹ McCallum (2004).

²⁰ Hacking (1991).

²¹ McCallum and Laurence (2007).

The central forensic role of medicine carved out during the 1940s was a contingent element in the governing of neglected and offending children, remaining in place only three decades before being overturned in the Victorian legislature. In the view of the welfare historian Donna Jaggs, offending and neglected children administered by the court during this period were constructed in a conceptual framework of 'deviancy', 'diagnosis' and 'treatment'.²² This medicalisation of deviance included the adoption of syndromes and pathologies to describe the phenomena appearing in the clinic, especially the pathologies of parents. However, there may need to be some caveats applied to this description. If we accept that medical science acted as part of the judicial/ administrative apparatus, it is difficult to draw a clear separation of bureaucracy and laboratory in the functioning of the Clinic.²³ According to Jaggs, the breaking out of this deviancy model was led by the 'avant-garde welfare thinking' of the Norgard Committee report, which led to the passing of the Victorian *Community Welfare Services Act 1979*.²⁴

The 1979 legislation was regarded as scandalous by many in the Children's Court and its attached clinic.²⁵ But for others the move was celebrated as a win for children's rights — perhaps the end of the era of institutionalising of children under the guise of 'treatment', and rather more consistent with knowing the child's 'best interests'.²⁶ Critics also made the observation that medical advice on the court's decision-making was not open to question by defendants, and its impact could be lessened or removed by court diversion programs in the hands of welfare professionals. So, instead of a psychiatrist making a recommendation to the court, the new Act made it possible for a social worker to oversee that decision. The word 'community' appeared in the name of the Act, in the name of the new government department, and in the strategy adopted to investigate and record child maltreatment. The authority of medicine and psychiatry was diminished, and instead social workers in the state Department of Community Services could make a recommendation on disposal directly to a court. The shift from the clinic to the community also shifted the locus of naming and counting of child maltreatment, providing the conditions for a massive increase in reporting of the phenomenon.

The Doctor in the Hospital

Meanwhile, during the 1950s and 1960s, a new category of person found itself attached to the hospital in the form of the 'battered baby'. The landmark paper published in 1962 by Colorado paediatricians under Kempe began what the Australian paediatrician Kim Oates claimed was 'a period of awareness of child abuse', which he wanted to distinguish from older forms of child cruelty and

²² Jaggs (1986).

²³ Latour and Woolgar (1979); McCallum and Laurence (2007).

²⁴ Victoria (1976); *Community Welfare Services Act 1979* (Vic).

²⁵ McCallum and Laurence (2008).

²⁶ Scutt (1977); Ainsworth (1992).

infanticide.²⁷ The American team looked at x-rays showing previously unexplained fractures in young children, and they used the deliberately emotive term ‘baby battering’ to draw wider attention to a problem that they thought was much more widespread than previously believed.

In their account of the history of this event, Picton and Boss argue that in Australia baby battering 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.²⁸ Similarly, an account of the early Society for the Prevention of Cruelty to Children had sought ‘a definition of child cruelty that was independent of poverty-induced neglect’.²⁹ But the discursive shift to the term ‘abuse’ was significant because it problematised issues of volition, agency or wilfulness that were implicated in earlier medical pathologising of parents, and subordinated distinctions between cruelty and poverty. As Hacking explained: ‘[C]hild abuse ... began with doctors in 1962, and among the opening assertions was that abusing parents are sick and in need of help.’³⁰ In Australia, Wurfel and Maxwell produced a study of the ‘battered child syndrome’ in South Australia,³¹ while in Victoria the Birrell brothers referred to the curiously-named ‘maltreatment syndrome in children’.³² Both were predicated on the assumption that parents needed help.³³

Birrell and Birrell — paediatrician and the police surgeon — published perhaps the first academic paper in Victoria using the term ‘child abuse’.³⁴ It seems their contention that child maltreatment was a widespread problem in Victoria received little support from many of their colleagues, and their suggestion to set up a child protection unit within the hospital was treated almost as a joke.³⁵ Doctor denial and a reluctance to publicly identify violence against children is present in a number of accounts: the Children’s Hospital in Melbourne confronted the problem of gonorrhoea in children, which it put down to infected linen or described as ‘mysterious in its origin’, and there were hesitant observations about the deliberate burning of children.³⁶ Children in the 1950s who presented with ‘multiple metaphyseal fractures, bruising, retinal detachment, and bilateral black eyes’ were given the diagnosis of metaphyseal fragility of bones,³⁷ although it was agreed that the reasons for these bone

²⁷ Oates (1985), p 44.

²⁸ Picton and Boss (1981), p 116.

²⁹ Scott and Swain (2002), p 7.

³⁰ Hacking (1991), p 287.

³¹ Wurfel and Maxwell (1965).

³² Birrell and Birrell (1966).

³³ Picton and Boss (1981), p 116.

³⁴ Birrell and Birrell (1966).

³⁵ Yule (1999), p 446.

³⁶ Yule (1999), pp 139, 146-7.

³⁷ Astley (1953),

fractures could be elicited 'by careful questioning of the parents'.³⁸ 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 properly identified. 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 ... it is more difficult to tell parents he is reporting them that it is for them to accept his action.³⁹

Although particular events of child murder precipitated the introduction of mandatory reporting of child maltreatment from the 1970s in Australia, it is suggested that the regulation of doctors may also have been a response to their reluctance to make the diagnosis. However, by the early 1980s, researchers claimed there were no reliable studies that could give even approximate estimates of the extent of child abuse in Australia.⁴⁰

Paediatrics: Inquiries into Cruelty and Neglect

In parallel with inquiries into neglect in the Children's Court Clinic, and into maltreatment and battering by pathological parents, child abuse also emerged in the hospital by means of a long-standing medical problem known as 'non-organic failure to thrive'. The pathologising of growth failure in infancy began in early twentieth century studies in the United States, 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'.⁴¹ Widowson cited emotional deprivation as a key factor after comparing the growth of children in two orphanages in postwar Germany, one of which had a more caring house mother than the other. Oates 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 six to eight months of age, only 19 experienced 'severe reactions and growth disturbance following the separation'.⁴² A Melbourne study in 1959 cited 'inadequate care' and 'adverse social circumstances and emotional deprivation' as the main causes of failure to thrive.⁴³ Whitten et al. in 1969 tested the idea of 'inadequate mothering' by confining children for two weeks in a windowless

³⁸ Silverman (1953).

³⁹ Oates (1985), p 59.

⁴⁰ Picton and Boss (1981), p 120.

⁴¹ Oates (1985).

⁴² Oates (1985), pp 5–15.

⁴³ Williams (1959).

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 when they were unstimulated. Again, Oates suggested that these 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'.⁴⁴ Some studies explicitly warned that the concept of maternal deprivation suggested mothers were at fault, whereas the underlying causes were shown to be lack of 'social supports'.

While many of these inquiries continued to emphasise individual pathologies, the main causes of failure to thrive continued to be poverty, overcrowding, unemployment, illegitimacy and seriously disturbed marital relationships. Other studies cited family separation, unemployment, financial difficulties and poor communication between parents. According to Oates, there was little medical evidence suggesting the parents were 'sick'. In their study of medical records in the Royal Alexandra Hospital in Sydney in 1967–69, Oates and Yu presented a socioeconomic status evaluation showing that children with failure to thrive came from large, unstable, poorly educated, low-income families.⁴⁵ They often changed addresses, the mothers were married in the late teenage years, bottle-fed their children, and it was usually the last-born who failed to thrive.⁴⁶ The response to these adverse social conditions was for the physician to provide family support and counselling, and to provide a 'community' solution with the aid of social workers.⁴⁷ Nearly all the families came from low socioeconomic groups, although Oates explained that none of the studies used comparison groups, so it was 'not possible to evaluate the effect of social class on this condition'.⁴⁸ In the few case-control studies involving stable, intact families with favourable economic circumstances, mothers of infants with failure to thrive tended to score lower on the vocabulary test of the Stanford-Binet intelligence scale. Concluding his review of family studies, Oates reported no evidence of psychiatric disorders in the children, even though some exhibited mild behavioural disorders.⁴⁹

But, despite evidence in the Australian studies of reservations about concepts like maternal deprivation, as well as the absence of pathology in the examination of the children and the evidence of failure to thrive in poor families, the American *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed) in 1980 designated failure to thrive as a 'reactive attachment disorder of infancy', once again emphasising the failure of mothers in their bonding relationships.⁵⁰

⁴⁴ Oates (1985), p 16.

⁴⁵ Oates and Yu (1971).

⁴⁶ Oates and Yu (1971), p 202.

⁴⁷ Oates (1982).

⁴⁸ Oates (1985), p 21.

⁴⁹ Oates (1985).

⁵⁰ American Psychiatric Association (1980).

From the mid-1970s, most of the states and territories had 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.⁵¹ The early Australian studies replicated the counting exercises that had begun in Europe and North America a decade before; all showed startling evidence of an epidemic of abuse. A study in 1977 from the Royal Alexander Hospital for Children in Sydney showed that 40 per cent of children under age five presenting to the casualty department with injuries or burns had features 'strongly suggesting child abuse'.⁵² From the earliest surveys, however, researchers were still reluctant to assess the actual incidence of child abuse, since their figures were based only on cases brought to the attention of authorities. In 1977, New South Wales made it mandatory for medical practitioners to notify cases of child abuse.

In the same publication where Oates evaluated evidence of failure to thrive, he laid out a separate history of the phenomenon he called child abuse, claiming its origins to be in cases of child cruelty in places like 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, Oates argued, 'they were not aware that the syndrome of child abuse was being described to them'.⁵³ 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'.⁵⁴ However, this kind of teleological account fails to recognise the specific discursive features of child abuse that appear in the present. In the next section, these characteristics are reviewed in relation to recent legislation in Victoria. A crisis of numbers has effects in governmental strategies that render whole populations (rather than individuals) subject to the gaze of children and family services. As distinct from century-old distinctions between child cruelty and neglect through poverty, the present category of child abuse renders the phenomenon an action with intent which returns agency for maltreatment back on to parents and families themselves.

Forensic Investigation to Risk Management

In the policy discussion preceding the Victorian *Children, Youth and Families Act 2005*, the new Act would seek to reflect international trends in responding to the needs of children and families.⁵⁵ Australia, the United Kingdom and North America had earlier adopted a 'regulatory' child protection orientation to child abuse, as distinct from the family service orientation long practised in countries

⁵¹ Oates (1985), pp 41–67.

⁵² Oates (1985), pp 41–67.

⁵³ Oates (1985), p 43.

⁵⁴ Oates (1985), p 43.

⁵⁵ *Children, Youth and Families Act 2005* (Vic).

like Sweden, Germany, Belgium and The Netherlands. In the lead-up to the new Bill, policy analysis claimed that the family services approach provided easier access to a wider range of services and assistance than regulatory systems.⁵⁶ 'Family service systems' placed more emphasis on working voluntarily with parents over longer periods, compared with the earlier, more coercive approach. A regulatory approach worked well when responding to episodes of significant harm, but was less effective in dealing with more chronic cases of ongoing neglect. Recent approaches to reform have stressed 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, however:

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*.⁵⁷

In 2003, a government-ordered review claimed that if the current administrative arrangements for child protection were maintained, 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; child protection could no longer be an 'emergency service'.⁵⁸ So the virtues of the new order would in large part be based on the necessity for changing the substantiation processes. There would be more preventative and diversionary strategies, less resort to statutory and court processes, and a greater opportunity for children to become part of a family by acting earlier to provide permanent care. This will be achieved through building 'community partnerships' and encouraging vulnerable families to access support by providing more responsive and flexible services. These strategies would be supported by an expanded 'community infrastructure'. In the DHS *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'.⁵⁹ Now exposing the seasonality of the term 'community', Oates' community-based solutions in the 1980s had become a gaze on to the assessment of the family needs of whole populations.⁶⁰

Here, the reformist aspirations for protecting children were unmistakable. Child protection cases would be managed in the community, and decisions

⁵⁶ Victorian Department of Human Services (DHS) (2003), p vii.

⁵⁷ DHS (2003), p viii, emphasis in original.

⁵⁸ DHS (2003), p vi.

⁵⁹ DHS (2003), p xiv.

⁶⁰ Bauman (2000).

about either reunification or out-of-home care would be fast-tracked. What did this mean? First, in terms of formal legal process, 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 longer term out-of-home care arrangement.⁶¹ Second, managing cases in the community was to be achieved through 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.⁶² 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 six months. In the case of long-term child care agreements, the period may not exceed two years. Agreements may be terminated by any party giving notice in writing. Under the previous *Children's and Young Persons Act 1989* guidelines, 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.⁶³

Close observers of the child protection system noted a similar reversal of the onus of proof in New South Wales:

Everyone agrees that children must be protected from abuse and neglect. But any system designed to do this must act within the principles of natural justice and procedural fairness. The fact is that the rules of evidence do not apply in the Children's Court, and recent amendments to the Act have reversed the onus of proof and this means that parents in certain circumstances now have to rebut the position put forward by the Department that they are unsafe parents (s 106A).⁶⁴

There is also criticism of 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 recorded many of the concerns in interviews with members of the Victorian Bar and through a detailed examination of the new Act.⁶⁵ There are 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, a clear policy reversal from the 1980s. 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

⁶¹ Power (2005), p 1.

⁶² *Community Services Act 1970* (Vic).

⁶³ *Children's and Young Persons Act 1989* (Vic).

⁶⁴ Ainsworth et al (2007).

⁶⁵ Dutta (2005).

available. Court officers claim that court-ordered services are not provided in the required timeframe in an estimated 50–70 per cent 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’.⁶⁶

Summary and Conclusions

This article commenced a discussion of policies and policing of child abuse by examining issues around counting and the production of knowledge of the child, which related to the administrative requirements of the agencies — philanthropic, police, medical, welfare — charged with managing the problem child. The aim was to convey the levels of contingency in accounting for problem children, in the first instance children whose habits made them vulnerable to criminality. 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 has brought many more children under investigation. For example, a welfare administration’s demand to ‘know in order to protect’ has produced massive surges in the numbers of children ‘known to the agency’. In recent times, child abuse would occur in 20 per cent of all children, a circumstance which policy-makers acknowledged made the problem child ungovernable under existing forms of regulation. At least one jurisdiction has acknowledged that risk management approaches involving mandatory reporting could be improved by raising the bar on reportable events,⁶⁷ and the Victorian Department of Human Services has reduced the incidence of reported child abuse by means of changes to administrative processes.

Ian Hacking argues that an avalanche of printed numbers produces categories in which people might be thought and might think about themselves.⁶⁸ In **their** classification by recording authorities, the phenomenon of child abuse is rendered into categories of individual actions: ‘physical abuse’, ‘sexual abuse’, ‘neglect’, ‘emotional abuse’.⁶⁹ The foregoing are perpetrations. They involve illegal acts committed against children for which any reasonable person could have nothing but abhorrence. Removed from this problematic are phenomena that cannot be thought of as resulting from the responsible actions of individuals, such as poverty and social disintegration. In the new legislation in Victoria, the calculation of parental needs constitutes a governmental gaze over whole populations that in the first instance signals the possibility of permanent removal of children, with the onus placed on parents to provide evidence that they are able to safely manage their children. In this sense, the present workings of child protection may take on the appearance of much older techniques

⁶⁶ Dutta (2005), p 10.

⁶⁷ NSW Department of Community Services (2008).

⁶⁸ Hacking (1982).

⁶⁹ AIHW (2007).

evident in the late nineteenth century networks between police and philanthropy, rather than the point of arrival of a progressive liberation of childhood.

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