CHAPTER 2

CHANGING ATTITUDES AND APPROACHES TOWARDS INSTITUTIONAL AND OTHER FORMS OF SUBSTITUTE CARE

Historical background

2.1 The historical basis for the provision of substitute care in Australia is to be found in the early days of colonial settlement. In the first half of the nineteenth century, orphan schools or barracks were set up by governments and churches to accommodate the significant number of neglected and destitute children. Many of these children were taken into care not only because they were orphans or had committed offences but also because of the inability of their parents to provide for them. During this period welfare policy was based on the traditions and practices of British poor law and was dominated by the concept of indoor relief through the establishment of reformatories, workhouses and industrial schools where children were trained in habits of industry and order. It was not until many years later that provision was made for external forms of assistance such as direct cash payments, public housing, and health and welfare services. The philosophy behind this early policy emphasised the removal of children from what was considered to be the malign and corrupting influence of their parents and the placement of them in 'asylums' away from their families and society.[1]

2.2 Towards the end of the nineteenth century the barrack system was largely replaced by the 'boarding-out' system as a result of increasing concern about the effect on children of placement in large asylums and training institutions. This system signalled the beginning of foster care. It not only recognised the value of the individual and the importance of family life, but also placed emphasis on giving 'neglected' children a 'fresh start' in life, albeit away from their own parents. Legislation giving increased statutory recognition to private persons and voluntary organisations willing to take charge of neglected children reflected this changed emphasis. The main function of government departments was to establish central depots to receive children committed to care by the courts and then to arrange for their transfer to approved voluntary institutions, approved private homes or approved employers.

2.3 During the early part of the twentieth century child care theory and practice continued to be dominated by the concept of child removal. Over time the 'boarding-out' system decreased in importance and from the 1930s was superseded by the placement of children in approved voluntary institutions. For example, by 1955 in Victoria, 60 per cent of State wards in substitute care were placed in voluntary institutions and only 21 per cent were boarded out; the remaining children were placed in adoptive homes, supervised employment or public welfare institutions.[2] Up until World War II and for some time later child welfare policy was concerned primarily with decisions about the responsibilities of parents, particularly the legal procedures to be followed in the removal of children and the proper authority to be exercised by those to whom legal or de facto guardianship had been transferred. Concern with legal accountability was reflected in the administration and staffing of child welfare institutions. As a result minimal attention was paid to developing creative programs of child care.[3]

De-institutionalisation and other changes in public policy

2.4 By the 1940s welfare organisations began to acknowledge the importance of keeping the child within its natural family. Studies conducted following the Second World War drew attention to the adverse effects of institutional care on child development. This

concern gained momentum during the 1950s and 1960s when attitudes were increasingly influenced by theories about child attachment, child development and maternal deprivation. It led government and non-government child welfare agencies to review the institutionalisation of children in particular, and their respective child welfare policies in general, and culminated during the 1950s in a drive towards 'de-institutionalisation'. This process involved the closure of many large institutions and the replacement of this form of care with the practices of adoption and fostering. Enthusiasm for foster care, however, declined in the face of high breakdown rates, difficulties in recruiting suitable foster parents and the lack of government commitment to the provision of adequate support services.[4]

2.5 The de-institutionalisation of residential care was followed by other reforms involving the modification and decentralisation of large residential establishments, the division of older buildings into smaller living units, the elimination of dormitory-style care and the development of alternative concepts such as family group homes. Since this time there has been a gradual movement of children out of large-scale institutions into smaller units although these are often located on the same site or in the same locality as the original establishment. These changes are still continuing, reflecting the trend towards providing institutional care in a form resembling the family setting as closely as possible.

2.6 In the last decade the provision of residential care services for children has also been influenced by the concept of normalisation.[5] This principle aims to create conditions which allow children removed from their own family environments to live as normal a life as possible. The principle is applied most commonly to those who are intellectually disabled, but is equally relevant to other groups, such as children who are physically disabled, or children placed in corrective care. This conceptual approach also emphasises the need for the localisation of services so that, where possible, children are maintained in a familiar environment. Importance is also attached to the participation of all relevant parties in the decision-making processes leading to the placement of the child in substitute care.

2.7 More recently, other changes have been introduced which emphasise the planning and, where appropriate, permanency of a child's placement in care. Further developments stress the importance of applying diversionary measures in the first instance to prevent the admission of children to care. In most cases restoration to the natural family is a key concept and objective. These principles are embodied in recent innovations such as the adoption in Western Australia and elsewhere of elements of the permanency planning approach developed in the United States of America, the introduction of the diversionary program for female adolescents in Queensland (known as the Proctor Program), and the development of the Intensive Neighbourhood Care Scheme for young offenders in South Australia.

2.8 These changes in public policy reflect a significant shift during the past decade from a child-centred focus to a focus on the child as part of the family. Previously, government and non-government policies and programs concentrated on the provision of institutional or other forms of substitute care and directed little attention towards the reasons for the admission of children to care. In effect, there was a disproportionate emphasis on the single task of arranging substitute care as an end in itself. The primary responsibility for the welfare of the child was considered to rest with parents who were expected to maintain their children with as little assistance from outside agencies as possible. Unaided, many families were unable to meet these responsibilities. Such policies not only reinforced social and economic divisions within the community but also resulted in 'child welfare' acquiring negative connotations that have proved difficult to erase.

2.9 The importance of child-parent relationships in meeting the emotional and personal developmental needs of children is now widely recognised. It is generally accepted that the child should be raised in his or her own family wherever possible. Moreover, it is also agreed there should be adequate income maintenance provisions and community support services available to families with dependent children — parent education courses, homemaker services, counselling services and day care facilities — to assist in this process. Thus, an orientation towards the family and the family within a community context is viewed as the most appropriate perspective for child welfare policy planning and service delivery. This approach is being reflected in the development of preventive strategies aimed at providing support for families at the local level to prevent family breakdown and avoid the need for children to be removed from their homes and placed in substitute care.

Development of preventive policies

2.10 The concept of prevention can be viewed in terms of primary, secondary and tertiary prevention. In the social welfare field, the primary level of prevention usually refers to those processes and instrumentalities that aim to strengthen support systems for families, but without singling out any individual or family believed to be at risk. In secondary prevention, intervention is focussed on individuals or families because they are considered to be at risk. The tertiary level of prevention is regarded as the point at which rehabilitation becomes necessary because the primary and secondary stages of preventive care have not been effective or appropriate. Most preventive services fall within the secondary and tertiary levels. However, because of the interdependency between the three levels of preventive strategies, the effectiveness of measures provided at the secondary and tertiary levels is necessarily limited by the adequacy of forms of assistance at the primary level. The success of preventive policies applied at the secondary and tertiary levels is also limited by the dangers of labelling and stigmatisation.

2.11 Evidence received by the Committee emphasised the need for governments to attach greater importance to the development of primary preventive programs aimed at overcoming or minimising the precipitating causes of family breakdown and subsequent relinquishment of children to substitute care. Preventive services of a primary nature are most effectively applied at the local community level. The sharing of resources and responsibility by community members can often help foster both neighbourhood participation and service delivery at the grass roots level and thereby ensure that services and facilities are both relevant and accessible. In short, the objective of this approach is to promote the well-being of the family through the development of local networks of supportive and preventive services with maximum community participation and control.

2.12 In the absence of more appropriate preventive welfare services, the school is often seen by default as the one institution where family needs for support can be identified and preventive measures instituted. Often problems at home are manifested in a child's behaviour at school, as for example through truancy, poor motivation and school performance, disruptive and anti-social behaviour, juvenile delinquency and other practices such as alcohol consumption, drug abuse and the inhalation of volatile fumes and substances (i.e. petrol, glue and aerosol sniffing). However, schools generally do not have sufficient or appropriate resources to deal with these situations and it does not seem reasonable to suggest that they should take on a preventive or interventionist role in this area without proper support structures and trained staff. Similarly, it seems unreasonable to expect kindergarten and day care centres, where the needs of families for additional support may also be reflected in a child's behaviour, to intervene without the necessary skills and resources required for this work.

2.13 The provision of adequate and accessible health services, embodying preventive health care as well as medical treatment, is an important element in the spectrum of local community services for the promotion of the welfare of children and their families. As the Commonwealth Department of Health pointed out, there has been a tendency in Australia for the institutional health sector to be better developed than the community sector.[6] The Department saw the further development of appropriate community health services, including crisis management services and domiciliary support services, as highly desirable. It claimed that such developments could reduce the need for some children to be admitted to substitute care or reduce the period of care required.

2.14 During the 1970s there was mounting pressure on both Commonwealth and State governments to direct more attention towards the development of primary preventive services designed to assist families in the task of raising children. At the federal level, the Commonwealth Government has gradually made available a range of direct cash payments to families with dependent children and, since 1976, has supported the provision of certain in-kind benefits such as day care and other community-based family support services. At the State and Territory government level, comprehensive policies for children and families have developed and in most States are supported by new legislation.[7] Recent reviews of departmental structures and practices, and the regionalisation of services also reflect a growing emphasis on preventive programs.[8] Despite these changes in public policy, the traditional approach towards directing resources to establishing networks of government and non-government services to provide stop-gap assistance to families in crisis persists in most States. Regrettably, the responsibility of governments to direct assistance to helping those in immediate need continues to override attempts to develop and promote longer-term preventive strategies, particularly at the primary level.

2.15 The need for preventive policies and programs has arisen largely as a result of the changing nature of the contemporary family, the increasing pressures on family life, and because of changing attitudes towards the role of government in assisting families in their child-rearing responsibilities. Since the early 1970s the family has undergone significant change, not only in its structure and composition, but also in its role and function within society. The nuclear family, in particular, has been subject to new tensions by changes to the traditional roles of family members, especially the increasing participation of women in the paid workforce. The greater mobility of families, together with the expansion of dormitory suburbs and growing suburban isolation, has meant that traditional support structures provided by extended family and community networks no longer exist for many. This period has also witnessed an increase in the number of single parent families, a higher incidence of marital breakdown, and an increase in the number of children who experience a series of family situations ranging from two parent families to single parent families, blended or reconstituted households.

2.16 Other factors that have influenced demands for change by governments towards the provision of preventive services are related to the present socio-economic climate, particularly the growth in unemployment, in which many families are no longer capable of providing adequately for their members' needs. Changing attitudes within the community have in turn lent greater support to the notion that governments should assume more direct responsibility for the basic social and economic well-being of families, especially those who are disadvantaged by circumstances and situations beyond their control.

2.17 The significance of these changes is reflected in the increasing reliance of the family with dependent children on outside agencies to assist in their child-rearing tasks. For example, the growing demand for all types of child care services has been well

documented.[9] A degree of dependence on such community services is now viewed as a common aspect of ordinary family life whereby certain needs of children, parents and the family unit itself are met. It is, however, of concern to the Committee that, if the generally well-functioning family is becoming increasingly dependent on assistance from these external sources, then the needs of those families that have difficulty functioning at a minimally acceptable level must necessarily be far greater. In this respect, the issue of substitute care needs to be considered in the context of the ability (or inability) of the disadvantaged family to cope alone with its child-rearing tasks and it is therefore in response to these needs that preventive policies and programs should be framed.

Changing approaches towards the treatment of Aboriginal children in care

2.18 Early policy and practice concerned with the placement of Aboriginal children in substitute care differed markedly from those for non-Aboriginal children. Differences in approach were embodied in separate laws pertaining to the care and treatment of Aboriginal children and the rights of their parents.[10] The child care practices of the nineteenth century and early twentieth century which were dominated by the physical removal of children from what was perceived to be the undesirable influence of their parents, together with subsequent government assimilation and integration policies, were particularly detrimental to the well-being and future of Aboriginal children, their families and their communities.

2.19 The historical background to the placement of Aboriginal children in substitute care has been characterised not only by their involuntary removal from their families but also by their placement under the control of non-Aboriginal people either in missions, orphanages, government welfare institutions or domestic service. Evidence shows that during the 1950s and 1960s there was considerable unofficial adoption traffic in Aboriginal children who were moved to other States by non-Aboriginals.[11] Because of the increasing popularity of foster care during this period, large numbers of Aboriginal children were also fostered with white families. It is significant that the success of this measure was limited and characterised by high breakdown rates.[12] Although studies undertaken in the post World War II period recognised the adverse effects of a child's removal from his or her family and placement in institutional care, the impact of such treatment on Aboriginal children was underestimated. Aboriginal children not only endured maternal deprivation but also suffered from feelings of alienation with an accompanying loss of Aboriginal identity, customs and values. This contributed to a disproportionate number of Aboriginal children remaining within the welfare system or being admitted to correctional care.

2.20 While there are no longer deliberate public policies of removing Aboriginal children from their parents and communities, Aboriginal people have continued to face other difficulties in the child welfare area. A major problem has been the reluctance of welfare authorities to accept the basic differences between Aboriginal and non-Aboriginal societies in terms of family concepts and child care practices, particularly the concept of the extended Aboriginal family and the complex system of kinship relationships and obligations that are of fundamental importance in the Aboriginal child-rearing process. A further difficulty has been the lack of any official recognition of the importance to Aboriginal people of their Aboriginality. Submissions received from Aboriginal groups stressed the need to recognise Aboriginal cultural identity and heritage and the importance of Aboriginal people having primary responsibility for the placement of Aboriginal children in substitute care.

2.21 The negative attitude held by most welfare authorities towards the appropriateness of placing Aboriginal children in the care of their own people has persisted until recently. It was not until the mid-1970s that official recognition was given to the value of establishing Aboriginal-based child care organisations for the purpose of keeping or re-uniting Aboriginal children with their own or other Aboriginal families. Moves to set up such organisations began following the participation of Aboriginal people in the first national conference on adoption held in 1976. The establishment of the first Aboriginal child care agencies in Victoria and New South Wales heralded the beginning of a new direction for Aboriginal child welfare policy and practice in Australia. Similar agencies now exist in all States and Territories except Tasmania and the Australian Capital Territory.[13] In carrying out their functions these organisations share the following aims and objectives:

- the preservation of Aboriginal families and the prevention of institutionalisation;
- the collocation of siblings in institutions and the re-uniting of families;
- the development of self-help programs and the provision of resources which are supportive of Aboriginal families, within both Aboriginal and non-Aboriginal communities; and
- the development of culturally relevant policies for Aboriginal child and family welfare services.

2.22 Despite the establishment of Aboriginal child care agencies and wider recognition of the importance of Aboriginality to Aboriginal children, their families and communities, it is a matter for concern that Aboriginal children continue to be over-represented in substitute care; continue to be placed in institutions far removed from their families and communities; and continue to be fostered with white foster parents. There are a number of possible explanations for this. During the inquiry the Committee received evidence in several States that the placement of Aboriginal children in white foster homes or institutions is unavoidable in some cases despite attempts to place them with Aboriginal families. This is because Aboriginal families are either not available or, for various reasons, are unable to accept responsibility for foster children. Evidence of this situation related predominantly to children living in large urban centres. Notwithstanding this evidence, the Committee believes the continued over-representation of Aboriginal children in substitute care and the removal of these children from their communities can be attributed in the main to the low level of direct involvement of Aboriginal people in the decision-making processes affecting the placement of their children in care.

2.23 Recognition of the role of Aboriginal child care agencies by State welfare departments has unfortunately been slower than might have been hoped. Only in Victoria is there a requirement that the Aboriginal child care agency be consulted in all cases involving the placement of Aboriginal children, although informal consultation and referral occur between State welfare authorities and Aboriginal child care agencies in other States. The success of the Victorian agency in resolving Aboriginal family problems, finding Aboriginal placements for children, and working effectively with white families caring for Aboriginal children has been notable.

2.24 Aboriginal people are now seeking the following three reforms in connection with the placement of their children in substitute care: the acceptance and application of an Aboriginal child placement principle; greater participation in the planning of child care placements and the administration of the child welfare system; and legal recognition of these measures. The Aboriginal child placement principle embodies the concept that, wherever reasonably possible, Aboriginal children should, as a first preference, be placed with a member of the child's extended family; secondly, that they should be placed with other members of the child's community; and thirdly, that they should be placed with other Aboriginal families.

2.25 The importance of the Aboriginal child placement principle has been recognised at the Commonwealth level through the Minister for Aboriginal Affairs who has agreed to consider the need for Commonwealth legislation covering Aboriginal adoption and fostering where appropriate action has not been taken by State and Territory welfare authorities. Following this initiative, joint Commonwealth/State working parties have been established in the States and the Northern Territory to consider, in consultation with Aboriginal people, future policy development in this area. The Committee understands that all State and Territory Welfare Ministers have accepted the Aboriginal child placement principle although to date only the Northern Territory has incorporated the concept in legislation.[14]

2.26 The Committee believes Aboriginal participation in the child welfare system should be promoted and facilitated at all levels, and endorses the conclusions and recommendations of the 1982 report of the Australian Law Reform Commission on the custody, fostering and adoption of Aboriginal children which proposed that the involvement of Aboriginal people in decisions directly affecting them should be given legislative support.[15] The Committee also considers that participation should be further facilitated by ensuring that Aboriginal child care agencies are provided with adequate resources to carry out their functions. These agencies provide the most effective means for delivering child welfare services that are sensitive and responsive to Aboriginal attitudes and cultural needs, and are accessible to Aboriginal people. The Committee welcomes the recent establishment of a national body to represent these agencies but believes that government support for the body must be matched by the provision of adequate financial assistance if it is to fulfil its role in this area of child welfare.

Changing approaches towards the treatment of disabled children in care

2.27 Early child welfare policies and practices relating to disabled children also focussed on the removal of the child from the family and the child's committal to institutional care. In the past, residential care for disabled children has not, in general, been humane, with a high incidence of neglect and overcrowded conditions. Until recently, government funding of substitute care services for disabled children gave little attention to providing for their social and educational development and, in the main, was directed towards large residential institutions administered under a custodial system of care. The emphasis on institutional care and the under-development of domiciliary and community support services have been major factors inhibiting the participation of disabled children (and adults) in the community.[16]

2.28 Problems arising from the segregation of these children from the wider society have been compounded by community attitudes and government funding policies towards different diagnostic categories. For example, public resources and manpower have tended to be more readily available for services catering for the needs of those with physical disabilities than for the needs of those with mental disabilities. In addition, professional assessment and diagnostic services have not been available to determine the needs of persons with similar disabilities but different levels of handicap and different service requirements. Past service provision has therefore tended to place all disabled children in the same type of care.[17]

2.29 Attitudes towards the disabled are changing. In Australia, as in many other Western countries, the object of recent legislation has been to reduce the social and economic consequences of illness and disability for individuals, their families and the community at large. It is now recognised that there are humanitarian as well as economic

reasons for the public to invest in the promotion of health, the prevention of illness and the rehabilitation of disabled people. Increasing attention has been given to understanding the costs of ill health to the individual as well as to society and to the assessment of the effectiveness and costs of alternative efforts to improve the health and well-being of the population.[18] Moreover, there is greater awareness today of the personal, social and economic problems arising from hospitalisation and institutionalisation, with moves towards greater provision of health and social care within the community.[19]

2.30 National campaigns and international initiatives have helped promote awareness of the rights of disabled people to share in as many aspects of community life as possible. As reflected in the Declaration of the 1981 International Year of Disabled Persons, 'thinking on human rights (has) led to international recognition that handicapped people should be accorded the same status and treatment as the rest of society'.[20] In an attempt to ensure the fuller participation, equality and integration of disabled people within the community, concepts such as 'de-institutionalisation', and 'normalisation' are of particular importance for children with disabilities living in substitute care. Such concepts have special implications for the application of early intervention programs, the type of substitute care used, the provision of education services and facilities, and the availability of support services for families with disabled children living at home.

2.31 A further change in attitudes towards the care of children with disabilities can be seen in the emphasis now being placed by some academic and professional authorities on the need for a 'developmental model' of residential care for the disabled, particularly children. This model is usually contrasted with the traditional 'custodial model' (now widely regarded with disfavour) and the still prevalent 'medical model' in which the handicapped condition is deemed a chronic illness best dealt with by a high level of professional medical care. While these models are by no means mutually exclusive, it is argued that the developmental model recognises that disabled people are capable of progressively developing skills through appropriate training. On the other hand, the medical and custodial models give rise to perceptions and the categorisation of disabled people as 'sick'. They also tend to provide a range of support services within a single establishment or infrastructure which minimises contact with the general community. In addition, they are characterised by staffing regimes dominated by medical and paramedical personnel and an absence of social skills therapists and other support staff. For children with disabilities for whom early intervention is particularly important, the medical model may well overlook or neglect crucial socialisation and education needs.[21]

2.32 This is not to say that all institutional facilities could or should be disbanded. The critical issue is the degree to which the 'institutional' characteristics of regimentation and de-personalisation which create barriers between the disabled and the wider community can be avoided or at least minimised. Initiatives by governments and others that have attempted to achieve this have been taken in the education area (e.g. through the introduction in 1977 of the Commonwealth Government's Children in Residential Institutions Program and, more recently, the Severely Handicapped Children's Program introduced in 1981), in the provision of direct financial assistance to families caring for their disabled children at home (e.g. through the introduction in 1975 of the Handicapped Child's Allowance), and in the trend towards the de-institutionalisation of care (e.g. through the expanded Handicapped Persons Welfare Program). Despite these developments, changes in policy and attitudes affecting the provision of child care arrangements for children with disabilities have tended to be slow, limited and often exploratory in nature. As a result, children with disabilities and varying degrees of handicap are among those still over-represented in institutional and other forms of substitute care.

Changing approaches towards the treatment of young offenders in care

2.33 Changing policies towards protective care have been accompanied by a commitment to the development of community-based alternatives to institutional corrective care. Most States and Territories have conducted reviews of their corrective services for young offenders and have advocated the use of community-based care combined with training and rehabilitation programs.[22] Many States are now applying diversionary principles whereby children are directed away from the courts in the first instance and are dealt with by special juvenile aid panels designed to assist them in addressing the social, economic or personal problems which may have led to the commitment of offences, and to determine what disciplinary and/or rehabilitation measures are necessary or appropriate in light of the young offender's background or family circumstances.[23] Law enforcement agencies and the courts are also demonstrating a greater sensitivity to the problems of young people in crisis as well as a greater reluctance to charge, convict or institutionalise young offenders.[24]

2.34 The de-institutionalisation approach towards children who have offended against the law has been tested for a number of years in other countries. For example, in New Zealand 'periodic detention centres' have been developed where the concept of reparative work within the community is applied in conjunction with limited deprivation of freedom. These centres vary in their mode of operation, but most follow a rigid disciplinary model and make provision for young offenders to undertake community work, education and recreational pursuits. Periods of formal detention are kept to a minimum enabling detainees to continue their schooling, training or employment and face the normal responsibilities of community life.[25]

2.35 Possibly the most notable development in this area has occurred in South Australia with the introduction in 1979 of the Intensive Neighbourhood Care Scheme. Under this Scheme, young offenders are placed with carefully selected and trained foster parents as an alternative to being placed under secure care in either remand or detention centres. A majority of cases are remand cases where the normal period of placement is approximately two weeks. Children who commit more serious offences are placed under longer-term care ranging from three months to a maximum period of one year. The main aim of the Scheme is to keep children out of secure care and to expose them to the benefits of a stable home life. Although the attitude of the courts was somewhat cautious when the Scheme was introduced, it is now well accepted by the judiciary, and it is unusual for a recommendation concerning the placement of a young offender under the Scheme not to be accepted. Reviews of the Scheme's effectiveness have been encouraging, showing that the behaviour of young children placed under this system has improved and that the rate of recidivism has been reduced significantly amongst this group.

ENDNOTES

1. In 1811 the colony of New South Wales provided asylum for the mentally retarded and insane and probably included children among its admissions. In 1826 the New South Wales Orphans' Schools Act gave official recognition to private organisations in the provision of community services for children. In South Australia the Adelaide Lunatic Asylum was opened in 1852 and the Parkside Asylum was opened in 1870, both accepting imbecile children. Since 1898 Minda has provided care for intellectually disabled children in South Australia and the Northern Territory. In 1861 the Sisters of Mercy established a home for Queensland's orphaned children in rented cottages at New Farm. In Victoria the Social Welfare Department reported in 1883 that 8199 children had been placed in institutional care.

2. L.J. Tierney, *Children Who Need Help — A Study of Child Welfare Policy and Administration in Victoria*, Melbourne University Press, Melbourne, 1963, p. 22.

3. ibid., p. 22.

4. D. McCotter and H. Oxnam, *Children in Limbo — An Investigation into the Circumstances and Needs of Children in Long-Term Care in Western Australia*, Report and Appendices, Department for Community Welfare, Perth, 1981.

5. W. Wolfensberger, *The Principle of Normalization in Human Services*, National Institute on Mental Retardation, Toronto, 1972.

6. Commonwealth Department of Health Submission, September 1982.

7. For example, in 1984 the Queensland Minister for Welfare Services and Ethnic Affairs tabled the Family and Community Development Bill and stated that the key aspect of the Bill was the preservation of the family. He commented that 'The well-being of the family unit is fundamental to the growth and development of any community, and thus every concerned Queenslander will have a commitment to the provision of services and programs that support and assist family functioning'. He also stated that 'A principle which is adopted in the Bill is that in the first instance all efforts must be made to assist families responsible for the rearing of children, to provide adequate care and nurturing for their children within the family context.'

8. See also *Transcript of Evidence*, Submissions, pp. 1456-58; Residential and Alternate Care Task Force (Mr V.J. Dalton, Chairman), *Final Report*, Sydney, February 1982; McCotter and Oxnam, op. cit.; and the Welfare and Community Services Review (J. Carter, Review Director), *The Wellbeing of the People*, Western Australian Government Printer, Perth, August 1984.

9. Department of Social Security, *Annual Reports*, 1976-84; various surveys of child care services by the Australian Bureau of Statistics 1980-84; T. Sweeney and A. Jamrozik, *Perspectives in Child Care: Experience of Parents and Service Providers*, SWRC Reports and Proceedings No. 44, Social Welfare Research Centre, University of New South Wales, Sydney, April 1984; and I. Keniston and the Carnegie Council on Children, *All Our Children — The American Family Under Pressure*, Harcourt Brace and Jovanovich, New York, 1977.

10. In New South Wales the denial of parental rights was given legislative sanction in 1915 with an amendment to the Aborigines Protection Act, 1909 which permitted children to be removed and put into service without parental consent. In 1921 the New South Wales Aborigines Welfare Board Annual Report stated that 'the continuation of this policy of disassociating the children from camp life must eventually solve the Aboriginal problem'. Certainly, no value was placed on the concept of Aboriginality. In fact many of the policies of the native welfare and Aboriginal protection boards were based on assumptions of genetic inferiority and a belief that the Aboriginal people were a dying race. In 1911 the New South Wales Aborigines Welfare Board Annual Report stated that 'to allow these children to remain on the Reserve to grow up in comparative idleness in the midst of more or less vicious surroundings would be, to say the least, an injustice to the children themselves, and a positive menace to the State'. For further information see P. Read, 'The Stolen Generations — The Removal of Aboriginal Children in New South Wales 1883 to 1969', paper prepared for the Aboriginal Children's Research Project (New South Wales Family and Children's Services Agency), New South Wales Ministry of Aboriginal Affairs, 1982.

11. *Transcript of Evidence*, Submissions, p. 1119.

12. ibid., p. 1120.

13. A further recent initiative by Aboriginal people has been the development of multi-purpose Aboriginal child care centres. These centres combine early educational services and child care and parent education activities. The centres are complementary to and interrelated with the Aboriginal child care agencies and together combine developmental, remedial and advocacy approaches towards meeting the welfare needs of Aboriginal children and families.

14. Advice on this matter was received from the Department of Aboriginal Affairs on 28 May 1985. The Australian Law Reform Commission is currently examining the need for a Commonwealth Aboriginal child placement Act.

15. Australian Law Reform Commission, Reference on Aboriginal Customary Law (Dr J.R. Crawford, Commissioner), *Aboriginal Customary Law: Child Custody, Fostering and Adoption*, Research Paper No. 4, August 1982.

16. Family Services Committee, *Families and Social Services in Australia — A Report to the Minister for Social Security*, AGPS, Canberra, 1978, Vol. 1, p. 70. For example, disabled people in institutions who may have preferred to live in the community were often unable to do so largely because they were constrained in their

choice of housing. This was due to the limited range of accommodation available as well as the lack of appropriate support services to meet their needs.

17. *Transcript of Evidence*, Submissions, p. 1127.
18. Family Services Committee, op. cit., p. 67.
19. Hospitals and Health Services Commission, *A Review of the Community Health Program*, AGPS, Canberra, 1976.
20. Royal Commission on Human Relationships (Justice Elizabeth Evatt, Chairman), *Final Report, Volume 5*, AGPS, Canberra, 1977, p. 114.
21. *Transcript of Evidence*, Submissions, p. 1180.
22. Recent reviews include the reports by E.J. Edwards, *The Treatment of Juvenile Offenders: A Study of the Treatment of Juvenile Offenders in Western Australia as Part of an Overall Review of the Child Welfare Act*, Department for Community Welfare, Perth, July 1982; Australian Law Reform Commission (Dr J.A. Seymour, Commissioner), *Child Welfare*, Report No. 18, AGPS, Canberra, 1981; the Victorian Child Welfare Practice and Legislation Review Committee (Dr T. Carney, Chairman), *Discussion Paper*, September 1983; and Committee of Enquiry into Child Care Services in Victoria (Mr Norgard, Chairman), *Report*, Government Printer, Melbourne, 1976.
23. *Seymour Report*, op. cit., p. 80.
24. Commonwealth Department of Education and Youth Affairs, *Children and Young People in Institutional Care*, Canberra, June 1984.
25. ibid.