

## **Michael Little keynote address to the 11th Australasian Conference on Child Abuse and Neglect (ACCAN)**

It is a great honour to be invited to address the conference. I know both a lot and a little about Australia. My parents lived here for many years, so I have visited often, and I have been to New Zealand just once. But I know very little about the detail of what you do, or the different cultural traditions in your countries.

I have worked on child protection issues and child well-being around the world and what I have learned is that children from culture to culture do not differ markedly in their development, or the risks to that development. In the economically rich countries, at the broad level, there is also not much difference in the kinds of services on offer.

But there are huge difference in local traditions and contexts, both within families and across services. So I can say a lot about the broad aspect of children's lives and services to support the health, development and safety. And I hope you will forgive me if I stray into the areas I don't know well regarding micro aspects of family life and services.

Another apology right at the beginning, I hope I am going to be challenging to the way you go about supporting and protecting children in Australasia. I don't think economically developed countries do a very good job of bringing up children, or addressing their rights. I have spent 20 years trying to use high quality evidence to change children's services, including health, education, social care and youth justice provision. All things being equal, I expect to spend the next 20 years continuing to push.

I know there are some great things happening with regard to children's health and development in Australia and New Zealand. That is one of the reasons I accepted the invitation to speak. But I don't see anything to suggest that radical change is not needed here also, and I will try and explain why.

A final apology to kick things off, I don't believe in child protection systems. I lead an organisation, the Dartington Social Research Unit, that is dedicated to better outcomes for children. This is not a vision statement. We do research, we then act on that research to make a difference in children's services, and then we disseminate the results, positive and negative, as widely as we can. We are not satisfied until we see good scientific evidence that our work has produced real improvements in children's health and development.

All of our work has led us to conclude that child protection is not a separate part of children's services. Child protection should be integral to all parts of children's services, and not separate.

All of our work has led us to conclude that reducing the causes of child maltreatment is one of most obvious routes to improving children's health and development. And removing the causes of maltreatment is the job of government, communities, families, children and young people, housing, health, education and all children's services, not just child protective services.

All of our work has led us to conclude that child protection is an issue for all children, and not just the poor who predominate in child protection and child welfare systems. One of my rules of thumb is the 'my child' test. I ask myself would I allow this policy, this intervention, this process for my own children? If the answer is 'no', then I don't have much time for it.

Ok, well what do I have to say? I am going to talk about some of the muddles we get ourselves into in child protection, and how they hold back the work that needs to get done. And along the way I am going to suggest new ways of thinking, and also how we have applied these new ways to the reform of children's services in UK, Ireland and, to a lesser extent, in other EU states and the US. If I have time I am going to talk about a radical new way of thinking about your children in care system here, which from the little I have learned, is probably not serving the needs of children.

### *False divides*

Child protection is an emotive topic. It is easy to forget that 40 years ago a small group of scientists and activists were struggling to bring the problems of child maltreatment to public and political notice. They needed evidence, and they needed to bang the table hard. It is perhaps unsurprising that a lot of controversies were created in their wake.

Most of us in this room who have been part of the process of achieving better protection from maltreatment for children will have been drawn into many ideological arguments at times. Arguments with the public, with policy makers, and sometimes with each other.

### SLIDE 3

During my career, I have found myself intervening in strong arguments about whether it was better to boost the child protection system, and intervene more strongly to rescue children from abusive environments. Or whether it is better to improve family support, on the basis that much abuse is the consequence of stresses on the family.

In the last decade, I have found myself studying and helping children's services reconcile arguments between people who feel that an ounce of prevention is better than a pound of treatment; that it is better to stand upstream and stop the children being dropped in the river than to try and pull them out and resuscitate. On the other

side of this argument are those that rightly demand that we intervene and improve treatment for victims of child abuse.

Currently, there is a lot of debate in Europe about the connection between the 'local' and the 'central'. Surely it is better for people in their own communities and practitioners in local agencies to be making decisions about children's services, for finding solutions to the needs of local children than to expect policy makers in central government to work all this out?

On the other side of this divide is the idea that central government has the best access to international evidence, to extra resources, and it can mandate that services get implemented to uniformly to a high standard.

I could give you many more examples of significant differences of opinion within the child protection community, and between it and the people we seek to influence. But one more will suffice for the purposes of today. And the last example may be relatively new to you here, but I suspect it will press strongly on your thinking in the next five years or so.

Since the first calls for better protection for children gathered strength four decades ago, there has been a revolution in prevention science. We now know so much more than we did about the potential causes of impairments to children's health and development. We now know so much more about prevention programmes that have proven impact on children's well-being.

But this science has had relatively little impact on children's services, and hardly any on child protection services. That is because, say the critics, evidence gathered in the United States is not necessarily relevant to local communities in Queensland, or findings from the Dunedin Longitudinal Study in New Zealand are not transferable to inner city, ethnically diverse London. What is needed they say is local evidence, and much greater attention to what local people say and want. Some go as far as to say that the child's voice or the family perspective is more important than science. A view I should say that is very attractive to policy makers.

So what are you? Are you child protection or family support? Are you for prevention or better treatment? Is it best to impose policy from the top, or build it from the bottom? Are you pro community engagement, and the child's voice, or are you looking for rigorous evidence from prevention science?

All of us will have views on these matters. But I want to demonstrate to you that these divisions that we all get drawn into have been and continue to be largely unproductive.

SLIDE 4

I want to demonstrate to you how a combination of good evidence, strong community engagement and ownership of children's services and a clear method for bringing stakeholders together and giving them a language to communicate effectively with each other can achieve significantly better results.

Lets take each of these potential differences in opinion one by one and see what we can learn from them.

### *False Divide 1: Child protection or family support*

In 1995, with colleagues from Dartington, I wrote a book called *Child Protection: Messages from Research*.

#### SLIDE5

It was known by the colour of its cover as the 'Blue Book'. It is one of a series of overviews commissioned by UK Government over a 25 year period that bring together the latest evidence on various aspects of children's services. It was written after three years of deliberation involving 20 or so researchers, plus senior policy makers and practitioners from around the country.

There was huge interest in the book, and in the year after its publication I talked to over 10,000 practitioners around the England, and presented here in Australia also.

At the heart of the book is the need to reconcile a debate that was live at the time between more child protection and more family support. What, the politicians wanted to know was, what should we do?

My starting point for any question is always evidence. What is actually happening to children and families? What we found was this.

#### SLIDES 6, 7 & 8

*(Michael then described a slide contained in the podcast that described what happened to children referred into what were called the 'child protection' and 'family support' systems in the early 1990s in England and Wales. It shows how despite a lot of activity, most children on the child protection side of the diagram generally either got a highly intrusive intervention, such as placement in care, or no help at all. By contrast, children referred into the 'children in need' system, who on most criteria had similar life experiences, got support rapidly, but it tended to comprise 'thin' family support such as information, small amounts of money or advice. At the time, the research indicated that family support rather than being an alternative to child protection was an important avenue for protecting children from maltreatment).*

At the time, the publication of the Blue Book the debate about child protection or

family support was fierce. The book and the talking to people about it that followed helped policy makers and practitioners see what they do in a new light. And so it shaped child protection policy in UK for over a decade.

So the book was very well received and people still talk about it fondly today. But looking back on it now I don't think it made much impact on the health and development of children.

The evidence was all about systems. It didn't tell you about the causes of maltreatment or its effects on children's well-being. It told you that children in child protection systems got lots of scrutiny but few services, but it didn't tell you whether their mental health or educational progress was enhanced or hindered as a result. It told you that those funneled to family support got help straight-away, but we did not yet know that this 'thin' intervention that the families liked so much had very little impact on their children's well-being.

The Blue Book was for policy makers and practitioners. It was and remains meaningless to children and families. There was no attempt to engage communities to apply the results as we with policy makers and practitioners.

And while the Blue Book spoke to all disciplines involved in child protection, it did not represent a common language in the sense that it urged a common purpose about what we wanted to achieve for children's health and development. A purpose that would cross the disciplines and involve children and families. And most important of all be relevant to ALL children, and not just those from disadvantaged circumstances.

But we can conclude from the work that we are neither for child protection or family support. It is a false divide. We see family support as an important way of protecting children from maltreatment.

### *False Divide 2: Prevention or Treatment*

Well let us consider another potential divide in thinking about our work. Are you for Prevention or Treatment?

I am going to show you now some evidence from Ireland. Many of you will have some family links to Ireland and will know that it is not only the place you once knew. It now has the fourth highest GDP per capita in the world, so it has many rich people as well as a disproportionate amount of poor.

The data I am going to show you was collected by my colleague Vashti Berry. Her study is designed to be representative of all children in Dublin, the capital city of the Republic. So it includes ordinary children, like my own, like your children or your siblings, as well as children that might have had untypical experiences.

## SLIDES 9 TO 14

*(Michael then gave some preliminary, as yet unpublished, results from Vashti Berry's study. The salient points in the slides contained in the podcast were that: (a) conflict is ubiquitous in families; what matters is how conflict is resolved; (b) typical conflict resolution tactics include 'reasoning', 'psychological aggression and/or minor physical violence', and 'severe violence'. (c) the most common tactics in ordinary families are 'psychological aggression and/or minor physical violence'; (d) aggression and minor violence increases the odds of disorders in children by three and half times; severe violence increases the odds 11 times; (e) however, most children exposed to severe violence do not develop a disorder. Regardless of the consequences, children have a right not to be victims of severe violence; (f) aggression and violence, minor and severe, also negatively affects day to day behaviour of children; (g) it follows therefore that a child protection prevention model that focuses on the potential causes of impairments to children's health and development could involve improving reasoning and reducing aggression in all families; (h) such a strategy could be expected to reduce psychiatric disorders, and improve ordinary behaviour by children; (i) to be effective, it would work alongside a treatment strategy that responded to the mental health needs of children who continue to live in risky environments).*

The example I have given is just one of many I could give about the potential to better connect prevention and treatment in the context of child protection. I chose what we call a public health approach to prevention -looking to serve all children- in honour of Fiona Stanley who was profiled in yesterday's edition of Prevention Action.

## SLIDE 15

This is a daily, online publication from Dartington. It is free, and carries stories from around the world on prevention science, innovation and impact on children's well-being. Every story this week comes from Australia, indicating the considerable potential that exists in this country. I urge you to use this resource, and contribute.

Many of you will know Fiona Stanley. She is a pediatrician, researcher and advocate. When she qualified as a doctor she found herself bringing poor, often indigenous children, into Perth hospitals where they would cure disease and then send the child back to the impoverished environments that led to the illness. Unsurprisingly, they got sick again. Stanley has been at the forefront of a movement to move medicine into the communities in which children live and solve the causes of ill-health, and not just the symptoms.

I think that idea applies equally to child protection. Encouraging me and you - ordinary parents so to speak- to make small changes to the way we parent can not only benefit our children, it can also, as the illustrations showed, reduce the

proportion of children that suffer from severe violence.

But as importantly, it makes child protection relevant to everyone, whereas at the moment it is largely reserved for poor families. Most of us don't want our own children to go anywhere near the child protection system because it is for poor families. Poor families feel stigmatised by the child protection system, because it is mainly for poor families. Make it a system for all, and you will change the perception of those who need intensive support.

A little anecdote that connects the point to the Australian context. On Sunday I arrived in Australia, picked up my bags and got into a taxi. The driver asked where I had come from and said "you must be here for something important to come all the way from England", and I told him I was attending this congress. "Oh, yes he said, child protection is massive issue here in Australia" and he proceeded to talk for about 20 minutes about problems in the indigenous communities.

Well child protection is not an issue for just indigenous communities. It is not just an issue for poor families. It is an issue for all communities, and all families. It is an issue for me and my children, and it is an issue for the Taxi driver's children.

So looking forward I see huge opportunities to better connect prevention and treatment in the child protection context. There is clearly evidence of the potential. Incidentally, we routinely collect data like those I just described at government, local government and community level. It is neither difficult nor expensive. And local data is always much more powerful than international evidence.

I am sure there would be much greater community engagement and ownership with child protection if it combined prevention and intervention approaches in the way I describe.

To make it work we need a common language. Prevention cannot be imposed on a population. You cannot tell people how to parent. But most parents want to do the best for their children and are anxious for advice. Those of us working in child protection need to communicate more effectively with each other, and find new ways of supporting broader populations.

### *False Divide 3: Top Down or Bottom-up*

So let me take another example of an issue that can be a source of tension within the child protection community, and between it and broader society.

### SLIDE 16

You probably know this man. Before the Iraq War he was trying to build a reputation for the reform of public sector services, and for improved prevention and early

intervention for children's health and development. He promised to eradicate child poverty by 2020. I don't want to talk about the nature of the services he introduced, I want to talk about how changes in policy occurred.

I am going to use a fictitious example of a prevention service. I am going to call it Super-start. Most big prevention and early intention programmes tend to have the word 'start' in the logo, Headstart, Sure Start, Early Start et cetera. In England there have been dozens of programmes and initiatives like this introduced since 1997 when Blair came to power.

The person on the right hand side is David Cameron, and he leads one of the opposition parties in UK. Cameron has to find some things that mark him apart from Blair and the new Prime Minister of Britain, Gordon Brown. And one of those things is the source of innovation.

Most initiatives in UK over the last 10 years have started with the Prime Minister or the Minister of Finance. They are usually big ideas, like SuperStart. They are dreamed up in central government, and after a little bit of consultation rolled out across the country. They are imposed from the centre, and locally people feel they are suffering from what we call 'initiativeitis'.

Cameron wants to change that. He wants to support local organisations like the equally fictitious 'Little Children' that know what is happening in their local communities, know what is needed to boost child well-being.

Blair and his successor Brown represent a Top-down approach to children's services, and Cameron a 'bottom-up' approach.

Which is right? I am sure most of us in this room have some strong feelings about this. But once again, I don't believe either approach is either correct or exclusive of the other.

A couple of times now I have referred to evidence, community engagement and ownership and common language. How does a top-down and bottom-up approach shape up against these criteria.

First evidence. If UK is typical, the top-down approach has resulted in a 'cosmetic' approach to evidence. What does this mean? Well essentially, people at the top, in this case in government, decide what it is they want to do and then they look for evidence to make their decisions look better. Evidence becomes an optional extra.

I am over-stating the case here. But I could give you a whole presentation on how UK Government has side-stepped research and evaluation. The trouble with evidence is that its inconvenient. It says things that don't fit with ordinary understanding. So Government selects those bits that fit with its understanding, and

overlooks those bits that do not.

This is true in the design stage, and it is also true in the evaluation stage, probably in the end with disastrous consequences. One of our flagship programmes is called Sure Start. Another one of those 'starts'. It offers early years services in all disadvantaged communities in England. It is so expensive, several billion pounds sterling, it appears as a line item on the Government bill each year. And a very expensive evaluation was commissioned. But despite all the advice given, Government decided the evaluation should not use the most rigorous methods.

The first results appeared last year. They were not positive. In fact, it appeared to show that children in comparison groups were doing better than those in the SureStart areas.

But what are we to make of this? One reading is that Surestart not only fails to improve child outcomes, it actually makes them worse. Another reading is the evaluation is not set up to tell us about outcomes, and we have a good programme but a lousy evaluation. In fact we will never know which of these scenarios is true.

Well what if David Cameron got his way and we adopted a 'bottom-up' approach? Would we get any better evidence? Experience would not lead us to be optimistic. I don't know how it is in Australia and New Zealand but local organisations in England tend to behave much like central government in looking for evidence that fits their case, and then commissioning low quality evaluations that can be leaned upon to bring out the positive features of the programme. I know this is not a popular thing to say, but I am afraid it is probably true.

After 10 years of central control, there is much that is attractive in Mr Cameron's proposition that we should give more control to local communities and agencies. But more control to do what? To do more of the same, when we know current arrangements are not improving the lives of children or reducing the incidence of maltreatment? To design new interventions without learning from innovations from around the world, without using the best methods to find out what is happening to local children, or to find out what impact their interventions have on child outcomes? There is no guarantee that switching the focus from central to local would make matters any better.

We can see this when we examine common language from top down and bottom up perspectives. The central government leadership in UK has involved telling local authorities and agencies what to do. But of course people don't always do what they are told. The result is what we call 'low fidelity' implementation. Any large SuperStart type initiative actually turns into 300 programmes implemented in different ways around the country. We know that some do very well, adding value to the central government ideas. We also know that some do very badly, and while I am skeptical about the idea that these prevention programmes produce poorer outcomes, I am

pretty sure that in many cases the money could be spent much better on other child development and child protection services.

If we have good ideas about how to protect children from maltreatment or reduce impairments to their health and development or boost their well-being, and by the way we have lots of good ideas, here in Australia, in New Zealand and elsewhere in the world, then we should implement them faithfully, and with high levels of fidelity.

So when it comes to questions about top down or bottom up, I again feel we need to find a bridge. As it turns out this bridge can also make a better connection between prevention science -which is changing our understanding of the development of children who are victims of maltreatment- and community engagement -which will allow the leadership, local entrepreneurial spirit, and ownership of people who manage, deliver and use children's services.

So as I begin to draw to a close, let me try and suggest some solutions to these problems, and try and apply the ideas to some of the challenges you are facing here in Australia, and also in New Zealand.

### *New connections*

The next illustration concerns an approach that connects the top with the bottom, and links prevention science to community engagement. In Ireland, we have been working in about 15 communities and with 15 agencies in other sites to design, implement and rigorously evaluate new prevention and early intervention services that will improve children's health and development. Most of these programmes have a child protection dimension.

The money and broad requirement to think preventatively about child outcomes comes from the top. Rigour in the service design process is also a central requirement. To get funded the communities and agencies must demonstrate that the logic underpinning the service; they have to be able to explain why the intervention will improve children's health and development, and by how much. And they have to back up these arguments with strong local and international evidence.

Very often we involve international experts, and we take people from local communities to see best practice elsewhere in Europe and in North America. (I can see from our visit here this week that much could also be learned from Australasia also). Point is, there are international forces operating beyond central government on this work.

However, the ideas, ownership and responsibility to implement new programmes with high degrees of fidelity and to subject them to the most stringent evaluation methods rests with the 15 agencies and 15 communities.

The idea behind the initial investments, which amount to about US\$200 million, is that future government investments will be directed towards those programmes developed locally and that are proven to improve children's well being or better protect them from maltreatment. So the learning at a local level can be shared and will influence what is happening across Ireland. Indeed, as we are finding from the huge international interest in the work, since children in Ireland do not differ greatly from other children around the world, the learning can be useful in Europe, North America, and maybe even in Australasia?

But how do we connect local forces with the rigour demanded by prevention science? Indeed, how do we reconcile differences between agencies at a local level?

We have been using a methodology developed at Dartington in the wake of the Blue Book I mentioned earlier, and published a decade ago. In disseminating that publication I worked with health, education, social care, police and youth justice practitioners and managers who wanted the same thing -better protection of children from maltreatment- but who used the same words to mean quite different things. Often people had quite different ways of thinking about a problem. And consequently there were a lot of misunderstandings.

Common Language has grown into a series of practice tools, training materials, resources such as databases of good practice from around the world, and emerging good practice; and there is a glossary of terms.

You can read more about Common Language at

<http://www.commonlanguage.org.uk/>

and materials were also handed out as you came in.

We have used Common Language to facilitate a discussion within communities about how best to improve the lives of their children, or with agencies about how best to improve the development and better protect children they serve.

There are many illustrations I could give about how we apply the methods, but I will keep it to one. The critical element is bringing people together. We always have a core group of people who are selected to represent the key stakeholders for children in the community or agency. There are generally around 20 to 25 people in these groups, and they represent health, education, social care, police, youth justice, voluntary organisations, community activists, national policy makers and, most importantly, children and families who use the services.

The process takes between six and nine months. The core group are trained and the same people remain in the group from start to finish. They really get to know each other. At some point in the process we take them away for a five day residential to

undertake the main planning work. We lock them in a room, and they don't come out until the job is done.

So how do we get them to communicate effectively? We use Common Language, which is essentially a way of thinking about children.

#### SLIDE 18

One part of Common Language will be familiar to many of you. Its called a logic model. We get the core group of people to focus on the outcomes they want to achieve for children. By outcomes we mean aspects of health or development, such as better emotional well-being, improved behaviour, better social skills et cetera. About three fifths of the process (thats three full days in the five day residential) is devoted to outcomes.

It interests me that left to their own devices, communities come up with similar lists of outcomes they want to achieve for their children. But if we were to impose a list, they would resist, and try to change it.

Once the outcomes are established, we then ask people to think about the activities that will achieve those outcomes, and the logic behind their thinking. This is where the term 'logic model' comes from. It is not logical to think that thinly spread family support, such as information, or small amounts of money, will protect children from the effects of maltreatment; it is logical to expect changes in parenting, such as reductions in psychological aggression or minor physical violence, will have benefits.

Once the activities are identified, we discuss the investments, the money, the people, the local goodwill that will be needed to make sure the activities are delivered as planned.

And finally, we bring in specialists to help the group to identify a handful of outputs that will tell us whether the plan is working as intended. (It is a long story, but I am passionate about getting people to collect much less information and do much more with it).

#### SLIDE 19

Its not rocket science this is it? But it does happen to be the reverse of what currently happens. But what about the evidence, and the community ownership. As the process continues we subject the group to external challenges.

#### SLIDE 20

*(Michael then described the process for bringing stakeholders together to design, implement and evaluate services using Common Language methods. The core*

*group focus only on the four concepts, Outcomes, Activities, Investments and Outputs. They bring their own experience to bear. But then the group are challenged with high quality epidemiology on the children they are seeking to support; information on the views of children, young people and families in the geographical area being targeted; data on national policy, not to dictate priorities but to ensure there is a reasonable fit; a check on the 'what works' evidence base, including visits to promising models in Europe and North America. Once a design begins to emerge, it is checked with people living in the communities to be supported, by way of 'town hall' meetings, or radio phone-ins and other methods. Finally, a plan to rigorously evaluate the strategy is drawn up).*

The result of this work has been real local innovation that has been informed by the best science, local evidence and voices of children and families. The emerging services involve a mixture of public health and targeted prevention models.

Most importantly the services being designed are 'thick' in nature, not 'thin' like the family support services we discovered in the Blue Book days. We know nowadays that child maltreatment can change the functioning of the brain; it can alter the way children think. We have always known that, left unchecked, child maltreatment carries on for several years. So why do we expect a small payment, or a brief intervention to make a difference. Significant impairments to children's development deserve significant interventions.

The first results of the work are beginning to come out. Last week I was in Belfast where the first evaluation results of a mentoring programme demonstrated improved reading ability for primary school children. I know its not a child protection outcome, but I cannot tell you how thrilling it was to be involved with a group who beyond any doubt had improved the well-being of about 900 children, and along the way created learning that will be used all across Ireland, and probably across the world.

If you ever have doubts about rigorous evaluation, think of what it must feel like to have devised a programme that is then shown, using methods accepted as the best by all scientists and serious policy makers around the world, to impact on child well-being. Its a very good feeling.

The success of the work in Ireland has led to other challenges. This year we used the same methods in Birmingham, which is the biggest local authority in Europe, with a quarter of a million children and an annual expenditure on children of \$3 billion. We are using the methods to get all agencies in the City to think differently about children's health, development and safety. Watch this space, as they say.

#### *Resources on which to draw*

The Ireland and Birmingham work may be relevant to what is happening here in Australia, and possibly in New Zealand. For the purposes of illustration, let me

concentrate on Australia.

## SLIDE 21

If we think about epidemiology, you have some of the leading thinkers in the world here, and a methodology called the Australian Early Development Index that is being used in I think 60 communities to collect high quality local data quickly. (The method was profiled in yesterday's Prevention Action by the way).

If we think about the consumer view, I can see from this conference programme that there are many highly innovative ways of involving children and getting a better sense of what they believe to be important for the health, development and safety.

If we think of national policy, well I have to be careful here because I don't know enough about your politics, but it is not all negative and I sense from my reading of the newspapers as preparation for this conference that politicians want to do the right thing but they don't know what to do.

If we think about the 'what works' evidence, we have profiled in Prevention Action this week two programmes that have demonstrated impacts on children's well-being and that are achieving world attention.

So there are a lot of resources here, but how well are they being connected? Is the epidemiology being used by local people to sponsor local innovation? Is that innovation drawing on the best knowledge about child protection and prevention from around the world? Is the innovation locally fitting with some kind of national agenda, or maybe even an Australasian agenda?

It is this kind of connection work that I suspect is needed here. My advice for what it is worth is that connection does not come from being nice to people; or putting people together and hoping for the best. And it never comes from telling people what to do.

Connection and innovation involves heavy duty work that has to be underpinned by rigorous methodologies.

### *Another Practical Example; Children in Care & Prevention*

Very quickly now, and as a challenge to you all, I am going to whisk through a final practical example of what you can do to break down old divides and better protect children.

I have been told that you have 7,000 children in care here in Queensland. My quick back of the envelope calculations tell me that is too many. I talked to people in New South Wales recently, and I found the same. I cannot speak for the other states, or

New Zealand. But I know from experience in UK local authorities and from New York, where we were part of a team that reduced the numbers of children in care from 50,000 to 32,000, and which continued to decline to today's figure of 18,000; we learned from this experience that taking too many children into care means that children that come into care get a worse deal.

I have also been told that 60% of children coming into care are from indigenous communities. I am skating on thin ice here because I don't know sufficient about the context but if the figures are right, to my naive eye this tells me something wrong in society as a whole, in Australian society I mean. For this situation to happen, some basic prevention services must be absent; and the relationship between the majority and minority population must be badly askew. Well before the ice breaks, if you did want to do something about this situation, here is how we have been thinking about it at Dartington.

#### SLIDES 22-26

*(Michael then went through a series of slide intended to reflect Dartington's approach to reducing numbers of children in care and building effective prevention and early intervention services. He made an analogy between children in care as a tank full with water. The first task is to reduce pressure on the tank by allowing water out. One method for this is application of the Common Language Going Home and Threshold tools, to identify children who can safely be returned to live with relatives. The second task is to pay attention to children's length of stay. Even small reductions in length of stay -and most reductions coincide with the needs of the child- will further reduce pressure on the tank of water. The third task is to get more consistency into decisions about who is admitted to care. In most contexts, there is huge variation in such decision making. The fourth task is to then bring together groups of policy makers, practitioners, children and families to design, implement and evaluate new 'thick' prevention services that can be used as an alternative for practitioners looking to improve the well-being of children who otherwise might have come into care. Resources for the new services come from savings created by reductions in the numbers of children in care. It is hypothesised that having fewer children in care results in a better experience for those in care).*

#### *Conclusion*

Well I think I have probably gone on far to long. I hope I have not offended anyone in the audience. At the same time, I hope I haven't left you thinking that all is well and nothing needs to change.

Shifting from poor children to all children; getting a better balance between heavy end interventions and prevention; turning the focus away from processes and towards outcomes; making child protection integral to all children's services; these are perhaps the most important things to change.

Getting better evidence is also important, both about the potential causes and potential solutions. You have great methods emerging in Australia, and you have the world's leading longitudinal study in New Zealand. But the data is still too far removed from communities and local agencies, and too little of it is being used to improve children's services, including child protection.

Above all else I sense a need for better connection between the parts. You have great evidence; you have significant community engagement; you are obviously doing more than most to listen to children, and I would hope to families; you are contributing to the well of knowledge about 'what works', and I hope drawing on that knowledge. But how do these things get brought together to produce real innovation and strong local ownership?

I hope my talk has given some insight into how we think about these issues. As I said at the outset, what happens in Europe and North America where we do most of work does not translate wholesale into what should happen in Australasia. But for those of you wishing to learn more about the approach we take, in addition to the resources that were distributed when you came in;

SLIDE 27

the Prevention Action site will give you daily on-line news about child development and children's services around the world, including some blogs over the next few days from the conference

my own website, the address is one the slide, will provide for the next few days materials relating to this talk, including podcast of the presentation

you can get more information on our methods at the Common Language website,

and if you go to [www.dartington-i.org](http://www.dartington-i.org) you will find people talking about how these methods work in practice.

So, thank you for your patience. I am happy to take questions, and then I am much looking forward to swopping this role as presenter for another as delegate and to learn more about what you are doing to improve the lives of children and families. Thank you again.