EDITORIAL

The South African Children's Act

South Africa's transition to democracy necessitated an extensive process of law reform. All existing legislation had to be aligned with the Constitution of 1996 and with the country's obligations under international law. At the time of transition, the Child Care Act (No. 74 of 1983) regulated matters such as adoption and provision for children in need of care and protection. It was, however, like most apartheid law, a racist statute providing for differential treatment of children according to their racial classification. These provisions were removed by amendment in 1996, but much more radical change was required to give effect to the rights provided to children in terms of Section 28 of the 1996 Constitution and international treaties such as the UN Convention on the Rights of the Child (UNCRC) (ratified on 16 June 1996) and the African Charter on the Rights and Welfare of Children (ACRWC) (signed in 2000).

The process of South African child law reform began in earnest in late 1990s. Following a highly inclusive (and often contested) process, the Children's Act (No. 38 of 2005) was passed. However, this statute contained a number of areas of provincial competence that required further development. These were debated in the Children's Bill process that resulted in the Children's Amendment Act (No. 41 of 2007). At the time of writing, regulations that set the administrative procedures associated with the legislation were being finalised. Regulations are crucially important as they provide standards against which the provisions in the Act can be monitored. The Act and its Regulations fall under the remit of the Department of Social Development.

It is of note that provincial MEC's for Social Development are required by law to make budgetary provision for all sections of the Act that are their responsibility, but the actual amounts are determined by the provincial treasury. Bids for funding under the Children's Act have to compete with the demands of other government sectors for programme support, so funding cannot necessarily be expected to follow need.

Every section of the Act has implications for the development and psychological well-being of children. For example, and while not obviously related to child mental health, Section 130(2) of the Act, provides for children 12 years or older to give consent for an HIV test. Those under the age of 12 may also consent {S130(2a(ii)} if of sufficient maturity 'to understand the benefits, risks and social implications of such a test'. While these may be radical provisions, they are designed to take account of situations where the parents may prevent children from testing, which would not be in their best interests, and in circumstances where a child lives for example on the streets, or in a child-headed household. The notion of *maturity* clearly has reference to the child's developmental level – a status mental health professionals may be called upon to assess as a result of this section of the law.

There are some sections of the new law that are of more direct relevance to child and adolescent mental health specialists – particularly those that deal with early intervention and child protection. The remainder of this commentary provides a brief account of their key features.

Prevention and early intervention (Chapter 8 of the Act)

One of the interesting features of the Act, and an advance on its predecessor, is recognition of the importance of services to vulnerable families and children in order to reduce the probability of abuse and neglect, and the need for statutory intervention. In the previous Act, the focus was on statutory care rather than early intervention and the intention of the new legislation is to shift the emphasis to the latter while strengthening statutory processes.

DOI: 10.2989/JCAMH.2009.21.2.1.1009

Journal of Child & Adolescent Mental Health is co-published by NISC (Pty) Ltd and Routledge, Taylor & Francis Group

In Section 144(1) the legislators have recognised some of the key risk factors for child maltreatment and neglect by specifying a list of interventions to address these problems. For example, the Act mentions interventions to improve parenting skills and non-violent discipline, as well as the provision of 'psychological, rehabilitation and therapeutic programmes' to children. The courts may also order such services following investigation of the child's circumstances. For example, the children's court may find that substance abuse in the home is a threat to the child's well-being, and order the parents to seek treatment. Parents struggling with child care or discipline may be ordered to undergo parent training.

It is salutary that the need for early intervention is recognised. But the gap between policy and service delivery is likely to be significant. A major challenge in providing the legislated services is the sheer scale of family vulnerability. Long-term poverty in the majority of households, high levels of domestic and community violence, substance abuse, and the failures of care associated with AIDS, provide a toxic cocktail of risk to child and family well-being.

The need to support vulnerable families is significant, but the human resources available to assist are simply not sufficient. For example, and based on Barberton's (2006) costing of the Children's Act, if *all* the social workers employed in the Western Cape in 2005 were deployed *to provide statutory services to children alone,* the ratio would be *one* social worker to *2 200* children, leaving *almost no* social workers to deliver preventive and other services to children and adults. Also, families may be ordered to seek parent training, but does it exist in their area, and what is its quality?

The Draft Standards for the Act (Chapter 11) provide a list of 'musts' for early intervention – e.g. these programmes 'strengthen and support family structures and build capacity' (p. 155). Thus, therapeutic programmes 'must' be provided by suitably qualified staff. Appropriate, but given the limitations on qualified staff and funding these are very lofty aims.

It is also crucial that a sound evidence base underpins these efforts. Vulnerable multi-problem amilies are very challenging for practitioners. The evidence is that they need intensive inputs to produce change. It is disturbing that there is *no* mention in the standards of the need for *quality* evidence-based interventions, and for research to test local cost-effective options.

However, this gap presents local researchers with an opportunity to provide the evidence required to support early preventive interventions. Another opportunity exists for tertiary institutions to provide the training necessary for professionals and lay practitioners to deliver cost-efficient and quality services.

In order to extend the range of personnel available to provide support to vulnerable families, we have to think out of the professional box. Innovative approaches to service delivery by paraprofessionals trained in home visitation, counselling and crisis intervention are needed to supplement scarce social worker resources. While there is a well developed evidence base for programmes of this kind in high-income countries, those that pass muster are intensive, long term and expensive (Eckenrode *et al.* 2000). There is no South African data on effective interventions for vulnerable families, although promising results have been obtained in a South African trial designed to improve mother–child attachment in depressed women living in poor households through provision of support by trained lay persons (Cooper *et al.* 2002, Tomlinson 1999, Tomlinson, Cooper and Murray 2005). There are a number of other examples, including the Parents Anonymous programme based in Cape Town which seeks to improve parenting and reduce abuse risk, and the Perinatal Mental Health Project which provides assessment and counselling training to nurses who are then able to support depressed women both prenatally and once the child is born.[1] Many of these women live in vulnerable families.

Child protection (Chapters 7, 9, 11 and 12 of the Act)

Early intervention, as discussed above, is of course a component of child protection. Various elements of child protective services are addressed in separate chapters of the amended Act, including statutory care and the various placement options for children found in need of care. For present purposes, discussion is limited to two related aspects: mandated reporting and the Child Protection Register.

In terms of Section 110(1) of the amended Act, a wide range of professionals (including social workers, psychiatrists and psychologists) have the duty to report if they have reasonable grounds to believe that abuse or neglect is occurring. Failure to report is a breach of the law.

Mandated reporting seeks to improve child protection by identifying cases that might otherwise not come to light. It can potentially be a useful tool for child abuse and neglect-incidence studies, and can be used to track the progress of children through the child protection system. It was included in the 1983 Child Care Act, but the range of mandated reporters is much wider in the new law. Mandated reporting raises important ethical issues for professionals. For example, if a child reports abuse to a therapist or an adult reports abusing a child, and where the clinician believes this is likely to be true, she or he is obliged to make a report. This legal responsibility outweighs ethical considerations of confidentiality despite the fact that the therapeutic relationship will be affected or may have to terminate.

In terms of Section 111 of the amended Act, reports are supposed to be placed on Section A of the National Child Protection Register. This is a potentially useful instrument that includes comprehensive details of the case, including information on the alleged perpetrator. It also includes fields that can be used to track the progress of investigations, criminal prosecutions, and services to which the child is referred. As the social worker proceeds with an investigation into the veracity or otherwise of the report, the Register must be updated. Should the report not be confirmed, the name of the alleged perpetrator must be removed from the register.

Mandated reporting is not without its detractors. Recent studies in the Western Cape have shown that the system is not functioning due to a lack of staff capacity (Dawes and Ward 2008, Dawes *et al.* 2006).

A more serious problem concerns the significant resources that have to be allocated to investigations in South Africa's resource-poor child welfare environment (Loffell 2004, 2007). This is an issue that has also attracted critical attention in the much better resourced United States. Melton (2005) reports that *less than two thirds* of investigations result in substantiated reports. Investigations also draw much needed services away from early intervention, prevention and rehabilitation. Given the very poor social work client ratios in South Africa, this scenario is even more likely to play itself out here.

The National Child Protection Register Section B contains the particulars of those deemed unsuitable to work with children. This determination may be made by a children's court, a criminal or civil court, or 'any forum established or recognised by law in any disciplinary proceedings concerning the conduct of that person relating to a child {Act No. 38 of 2005, Section 120(1c)}. Placement on the Register does therefore *not* require that the person has been convicted of a criminal offence. However, where specified crimes to children have been perpetrated – including murder, assault and sexual offences – the offender would be placed on the Register. Persons charged with such offences but found unable to stand trial by reason of mental illness or intellectual disability in terms of the Criminal Procedure Act (Act No. 51 of 1977), would also be deemed unsuitable.

Mental health professionals may be called upon to provide professional opinions in these matters. However, a key consequence of placement on the Register is that the person is prohibited from working in children's services, including clinical and educational institutions. In terms of Section 126(1a) of the amended Act, before a person is permitted to work with children, service providers (including heads of state departments) are required to establish whether or not an employee's name appears in Part B of the Register. This has to be done within 12 months of the promulgation of the Act. Given the enormous number of checks that will have to be made, it is extremely doubtful that this time frame will be achievable.

Summing up

The Children's Act (as amended) is a fine piece of law that has the potential to bring about services that would enhance both the development and protection of children. However, like so much of our law and policy, it is way ahead of the capacity to deliver services at ground level. However, it should be recognised that this law is aspirational (as indeed our Constitution was). It enables us to hold government to account; it provides for much needed services; specifies responsibilities; and points us toward a situation in which the rights and well-being of vulnerable children in particular can be realised.

To realise its promise of improved preventive and rehabilitative services, there is no doubt that a significant scaling up of finance and staffing will be required. For those in the field of child and adolescent mental health, both researchers and practitioners, the Act presents the challenge of developing an evidence base for cost-effective interventions to improve prevention and support for vulnerable families. It also presents training institutions with the opportunity to establish courses that equip practitioners for new roles.

Endnote

[1] For more information on the Perinatal Mental Health Project, see the project website at http://www.psychiatry.uct.ac.za/pmhp/.

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