Current issues in child protection policy and practice: Informing the NT Department of Health and Community Services child protection review

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National Child Protection Clearinghouse

The National Child Protection Clearinghouse has operated from the Australian Institute of Family Studies since 1995. The Clearinghouse is funded by the Australian Government Department of Family and Community Services as part of its response to the problem of child abuse and neglect. The Clearinghouse collects, produces and distributes information and resources, conducts research, and offers specialist advice on the latest developments in child abuse prevention, child protection and associated family violence.

About the author

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Organisation of this Report

This report has been developed as an amalgam of a number of National Child Protection Clearinghouse publications (listed below), in order to meet specific requests for information received from the NT Department of Health and Community Services. The report is divided into a number of chapters designed to explore aspects of policy directions and service delivery in the child protection and family support fields.

National Child Protection Clearinghouse publications:


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EXECUTIVE SUMMARY

The aim of this report is to provide an overview of current issues for Australian child protection systems, and in particular, to inform the child protection review currently being undertaken in the Northern Territory (NT). In response to requests from the NT Department of Health and Community Services, the author draws on Australian and overseas experiences to describe trends that are currently shaping child protection services, and to discuss a number of key aspects of service delivery. These include: models of the child protection intake process, interagency coordination and collaboration, the role of family support services, and responding to child abuse and other family violence in Indigenous and rural and remote communities. Finally, consideration is given to the development of a better evidence-base to inform policy and practice, based around the development of better partnerships between government, service providers and the research community.

Child protection and family support services

Child protection services, via child protection workers, are expected to be able to correctly determine if a child is subject to child abuse and neglect, the severity of the maltreatment, and the risk of future maltreatment, and to develop effective means to ensure a child’s safety. However, societal expectations have often outstripped current knowledge of the causes of child abuse and neglect, the process of making child protection decisions and the influence various factors in isolation or combination may exert.

In Australia, the earliest form of child protection developed within weeks of the first white settlements being established in New South Wales (Gandevia 1978). Over the next century a strong voluntary or ‘non-government’ child welfare sector was developed in Australia (Picton & Boss 1981). However, it was not until after the modern ‘discovery’ of child maltreatment, prompted by Kempe and colleagues 1962 paper on the ‘battered-child syndrome’ (Kempe et al. 1962), that governments really began to take significant responsibility for looking after children’s welfare. By the 1970s, statutory child protection services had been developed and were operational within the various Australian states and territories. The 1970s and 1980s were characterised by the development and refinement of systems for investigating and managing child maltreatment cases and the increased ‘professionalisation’ of the child protection response (Liddell 1993).

In the 1980s and 1990s, the desire to enhance the professional response to child maltreatment, along with the need for greater accountability, led to the widespread adoption (following a U.S. trend) of a variety of professional decision making aids, guides or checklists, commonly referred to as ‘risk assessment’ measures. The intention was to provide child protection workers with additional resources they could use when assessing the risk of abuse or neglect to a child. Specifically, the aids could assist workers in determining: if abuse or neglect had occurred; the risk of further harm; and whether the child should be removed from her/his parents’ care.

By the early- to mid-1990s, statutory child protection services in the Australian states/territories, like those in other western countries, struggled to cope with ever-increasing numbers of reports of suspected child maltreatment and fewer resources (Tomison 1996c). These pressures, some caused or exacerbated by an over-emphasis on cost-effectiveness and bureaucratic structures at the expense of professional practice, led governments and child protection services to seek alternative approaches for managing child abuse and neglect.

The shift to ‘family support’ child protection models

It became apparent that a substantial proportion of the child maltreatment allegations referred to child protection services did not involve concerns deemed by the statutory services as requiring their involvement (Audit Commission 1994; Dartington Social Research Unit 1995; Tomison 1996c). Many of the reports that were received involved families who had not maltreated their child but who had more generic problems, such as financial or housing difficulties, an incapacitated caregiver, or serious stress problems. Although such ‘at risk’ families may...
require assistance, they would not necessarily require child protection intervention. Further, their labelling as cases of child abuse or neglect was placing an additional burden on what were generally limited child protection resources (Tomison 1996c).

In response to the substantial increase in service demand, most Australian state and territory governments subsequently adopted ‘new’ models of child protection and family support (Tomison 1996c), based predominantly on the recommendations proposed in the U.K. Department of Health’s Child Protection: Messages from Research report (Dartington Social Research Unit 1995). Such approaches were often not new, but involved a revisiting or recapitulation of solutions previously tried and tested since the development of child protection services. One of the major differences was that there was now substantial formal recognition of the vital role played by the broader child and family welfare system in supporting families.

Thus, the last decade has been characterised by a substantial reinvestment in a rapidly changing family support sector (Tomison 2001), and growing recognition of the need to work strategically to ensure the best response for families and improved societal health and wellbeing. Concomitantly, interest in the prevention of child abuse and neglect has also increased substantially over the last 20 years, partly as a result of research that has demonstrated the social and economic benefits of preventing, rather than responding to, child abuse and neglect.

Issues in family support

In addition to the reinvestment in family support, there have been three clear, interrelated prevention trends evident in policy and practice, with respect to the response to a number of social ills including crime, substance abuse, domestic violence and child maltreatment. These are: the renewed popularity of early intervention and prevention approaches, particularly those targeting the first three years of life; the development of ‘health promotion’ or wellness initiatives designed to enhance child and family health and wellbeing; and ‘whole of community’ approaches, where the aim is to involve the wider community in working with government and the professional sectors to prevent child maltreatment and other social ills and/or strengthening families and communities.

Although there has been a general dearth of information available on the role and effectiveness of family support services operating across the nation, a number of service trends have become evident. These include:

- crisis services, addressing issues such as family violence, have increasingly been complemented by services that build on family strengths (capacity-building) and the creation of resiliency using a solution-focused approach;
- family support services have generally taken better account of the wider structural or community-level factors that might impact on service delivery, such as poverty, social isolation, and a lack of key support services;
- a strong investment in early childhood and early intervention programs, based on empirical evidence of the effectiveness of such programs; and the importance of ensuring a positive environment for children’s optimal development, particularly in the first three years of life;
- an increased focus on service integration or interagency coordination and the development of cross-sectoral responses to family violence and other ills;
- encouraging the voluntary engagement of ‘at risk’ families, or those whose child maltreatment concerns are not considered serious enough to warrant statutory action, to seek out and engage with family support services;
- a clear focus on the creation of flexible, innovative service solutions that are locally designed, and tailored to meet the needs of specific communities, including Indigenous Australian communities, and rural and remote communities;
- the recognition that to be effective, family support services must attempt to address holistically the needs of all of the family. This will involve a greater focus on the needs of all members of the family, including fathers, children themselves and key members of the extended family; and,
- a greater focus on measuring outcomes and evaluating program impact or outcomes in order to develop an evidence base better able to inform policy and practice.

Overall however, perhaps the issue in the provision of family support in the twenty-first century is the effective integration of statutory child protection services within the wider family support system.

Developments in Child Protection Practice

The renewed focus on resourcing services to support children and families in order to prevent the
development or recurrence of child abuse and neglect has resulted in child protection workers being provided with a greater range of options to select from when responding to a child abuse report (notification). These differentiated responses provide workers with more scope to tailor the assessment process to the perceived family needs and the level of risk to the child (Tomison 2002). The benefits of these ‘new’ systems are that, in principle, families are not unduly stigmatised or traumatised by inappropriate or unnecessary investigations, and are therefore more likely to accept assistance. In addition, family problems can be comprehensively assessed and (in theory) appropriate services put in place to address them, thus preventing the development of maltreating behaviour or reducing conditions detrimental to a child’s long-term development (Tomison 1996c).

However, some researchers and practitioners have raised concerns that the new models may not adequately protect children, with child protection departments failing to intervene in cases where children were at risk of harm. Further, the inadequate resourcing of family support agencies to cope with the high demand for services has meant that families, particularly families labelled as being ‘at risk’, or as having a generic welfare or family support concern, are no more likely to receive support or remediation of their problems than they would under the current existing ‘forensic investigation’ models of child protection (Tomison 1996c).

Key components of child protection service delivery

A number of inter-related key components of child protection systems that have developed (or been revisited) over the past few years are discussed, with particular reference to their operationalisation in Australian child protection systems. These key components are: central intake systems, differentiated response models, risk assessment and interagency coordination and collaboration.

Central intake

A central intake service is designed as the sole point of access for the receipt of reports of suspected child abuse and neglect. The intention is for a team of highly trained workers to make all intake decisions for a particular child protection service. Such services have been developed in order to reduce inter-regional, inter-office or inter-worker differences in decision making, and to ensure that local issues (such as resourcing) do not impact on the threshold for accepting a case. Thus, central intake services provide a means of standardising service response and increasing accountability. Both South Australia and New South Wales have implemented central intake systems, although the South Australian service is reported to have produced more positive results.

Differentiated intake response models

Allied with the development of central intake services, has been the development of differentiated response models for child protection intake processes. The three main models presently operating in Australia are described.

In 1997, the SA Department of Human Services introduced a three-tier response system to child protection notifications, differentiating between children in immediate danger (tier 1), children at risk (tier 2), and children primarily ‘in need’ where the risk of future abuse is low, but the family is identified as perhaps failing to cope with one or more social ills or ‘stressors’ (tier 3) (Department for Family and Community Services 1997; Heatherington 1998b).

In an evaluation by Parton and Mathews (2000), it was reported that the differentiated response system had enabled a better targeting of those cases rated as more severe and/or as involving high risk (especially sexual and physical abuse cases). They concluded that the new system had enabled the Department to prioritise its work and to more
effectively focus resources on serious child maltreatment matters despite increasing demand for services and an environment of rapid change. However, as predicted in Tomison (1996c), the failure to provide additional resources that would have increased agencies’ ability to cope with the demand for services, has meant that families, particularly families classified as ‘child concern report’, appeared no more likely to receive support than they would under the traditional ‘forensic investigation’ models of child protection.

An alternative to the ‘case streaming’ differentiated system applied in Western Australia, is the Enhanced Client Outcomes (ECO) differentiated response system that has been implemented in Victoria by the Department of Human Services (DHS). The aims of ECO are to reaffirm the importance of adequate risk assessment; to provide workers with a range of differential response options (19 in total), to promote interagency relationships; and to build on the principles of child centred family focused practice.

Put simply, ECO provides workers with an opportunity to use a graded scale of assessment and investigation, tailoring responses to identified concerns. Thus, families that appear to be suffering some form of generalised family dysfunction, rather than a child protection concern, are provided with a less intrusive professional response. This may involve family support agency workers making an assessment, rather than having two child protection workers conduct an unannounced home visit. In many ways ECO is a formalisation of practice as it was undertaken in the 1980s (at least in Victoria – Tomison 1999), recognising the expertise of other professionals and involving them collaboratively in case assessments and caseplanning, where appropriate.

An evaluation of the ECO pilot program demonstrated that ECO had increased the proportion of cases directly investigated within seven days in the pilot regions; enhanced workers’ information gathering and assessment processes; enabled staff to tailor their responses to the perceived demands of the notified cases, utilising a range of responses; and resulted in a substantial increase in the involvement of other service providers in the various stages of case practice (by DHS staff). Post full statewide implementation in 1999, many of the key aspects of the approach (which could be described as ‘core competencies’) have continued to be central aspects of Victorian child protection practice.

**In summary**

Although the benefits to be gained will vary depending upon the approach utilised, introduction of a central intake service and/or a differentiated response system does seem to provide some benefits to agencies in terms of resource targeting and prioritisation of more severe concerns. Perhaps more importantly with regard to differentiated response models, there is some evidence indicating that they can provide more scope for professional judgement at intake, by allowing workers to tailor a response to the given situation. Combined with the use of a solution-focused approach, a differentiated response system can offer a means of ensuring that all cases are responded to in a manner more likely to lead to client engagement, enhanced interagency collaboration and information sharing. Further, by explicitly working with the wider, resourced, child welfare/family support system to ensure adequate assessment and supports are provided for ‘at risk’ and maltreating families, such approaches appear to offer the potential for a reduction in the level of risk in the short and longer term.

**Risk Assessment**

Risk assessment can be defined as:

‘the systematic collection of information to determine the degree to which a child is likely to be abused or neglected in the future. [It also refers] … to an estimation of the likelihood that there will be an occurrence of child maltreatment in a case where maltreatment has not occurred’ (English & Pecora 1994:452).

The use of some form of risk assessment guide, measure or tool, is now widely used as part of the child protection intake process in Australia, as is perhaps evident from the descriptions of the central intake and differentiated response models provided above. Along with a desire to enhance worker decision making, the need for greater accountability and a more target response for limited child protection resources, have clearly helped to drive the introduction of risk assessment measures.

Risk assessment has several objectives: to help child protection workers identify situations where children are at risk of maltreatment; to improve consistency in service delivery; and to help child protection services determine the appropriate priorities within their caseloads (Browne & Saqi 1988; English & Pecora 1994). The instruments which have resulted, known as structured risk assessment measures, organise...
information related to risk (Schene 1996). Specifically, they ‘comprise risk factors selected for assessment and forms designed to capture the procedures and calculations needed to determine risk’ (Saunders & Goddard 1998:16).

The speedy adoption of structured risk assessment measures by U.S. child protection services has been repeated in Australia. However, in the U.S. risk measures are only allowed to be used after a child has already been defined as a substantiated case of child maltreatment (English & Pecora 1994). Thus, risk assessment is generally used to determine the appropriate levels of service to provide to the child and family, based upon an assessment of severity of the maltreatment (English & Pecora 1994). In contrast, some Australian state/territory child protection services have explicitly or implicitly developed screening and/or risk assessment tools for use at intake, as well as at later stages of the child protection case management process (Tomison 1996c; Department of Family & Community Services 1997; McPherson, Macnamara & Hemsworth 1997).

When considering structured risk assessment systems in the context of the overall field of child protection decision making research, there are two important questions:

- Does structured risk assessment offer the means of enhancing professionals’ decision making in child protection cases?
- Is the decision making research focus on structured risk assessment systems misplaced?

The perceived benefits

DePanfilis (1996) identified some of the potential benefits of risk assessment procedures. These included: good casework practice in operation; providing a base for the allocation and prioritisation of cases in risk-related groups; having case information readily available via the case record; broadening workers’ knowledge and investigation of relevant child maltreatment ‘risk’ factors; and, providing a basis for worker training and supervision.

Further, because structured risk assessment measures are designed to promote consistency in worker decision making and subsequent service provision (English & Pecora 1994; Schene 1996), the instruments can reduce arbitrary case classification and management practices (Stone 1993). They can also provide ‘a pseudo-scientific, ostensibly rational basis for decision-making’ (Saunders & Goddard 1998:22).

The overall efficacy of structured risk assessment measures however, is reduced for a number of definitional and methodological reasons. First, in essence, it is invalid to argue that the risk to an individual child can be predicted from an analysis of variables drawn from aggregated data for groups of children with common characteristics. Second, as Lyons et al. (1996) reported, despite many of the models appearing to have acceptable psychometric properties, such as internal consistency, inter-rater reliability and concurrent validity, the current level of predictive validity for the models ‘would not allow for major dependence on them for case decision making’ (Lyons et al. 1996:153).

Second, the approaches are often imperfectly implemented in practice; and third, proponents frequently ignore (and the measures fail to take into account) the effect of the in situ (real world) decision environment on the use and implementation of the measures. Child protection by its very nature is ‘dominated by significant moral, emotional and socio-political turbulence’ (McPherson et al. 1997:27). Overall, such factors led Goddard et al. to conclude that overall, the ‘current conceptualisation of risk assessment at best appears to provide a crude heuristic strategy to focus the attention of workers to particular forms of information during the investigation process’ (Goddard et al. 1996:60).

An alternative approach

Many researchers and practitioners, although acknowledging the importance of assessing risk in child protection practice (Saunders & Goddard 1998), have therefore maintained an allegiance to workers’ clinical judgement and the use of education and training to improve professionals’ child protection decision making rather than the use of structured decision making tools. However, the realities of current child protection work are that few workers have received extensive post-qualifying training in child maltreatment and child protection research and theory. The studies that have been done, suggest that workers do not rely on research and theory to make decisions. Thus, they lack the requisite information and a framework for the organisation of such information.

One approach to this issue is to support practice experience (and the concomitant provision of supervision) with a guide to inform practice. Such guides are not meant to be used to make the decisions, but to highlight issues for consideration and to provide a framework for conceptualising and
justifying a decision. Done properly (e.g. NSPCC guide – Cleaver et al. 1998; Victorian Risk Framework -Boffa & Armitage 1999), the development of a detailed guide, one that can supplement quality child protection training, may provide a positive outcome for child protection departments (providing consistency and accountability) and workers, while allowing for the complexity of child protection decision making. The guides may also form the basis for the development of a greater degree of shared understanding between child protection services and other professionals involved in child and family support. However, such guides will be of limited utility in central intake services, given workers’ role as gatekeepers, where decisions are made on the basis of the information gleaned from the source of referral and a family’s prior history of child protection involvement.

Interagency coordination and collaboration
Interagency (and interprofessional) coordination and communication have been well-documented as having the potential to enhance or undermine child protection and family support work. Ensuring effective interagency (or interprofessional) cooperation and coordination has been a common theme and an ongoing, significant issue for the provision of child protection and family support services for many years (e.g. Hallett & Birchall 1992; Morrison 1998).

A coordinated response to the problem of child abuse and neglect can produce more effective interventions; greater efficiency in the use of resources; improved service delivery by the avoidance of duplication and overlap between existing services; the minimisation of gaps or discontinuity of services; clarification of agency or professional roles and responsibilities in ‘frontier problems’ and demarcation disputes; and the delivery of comprehensive services (Hallett & Birchall 1992; Morrison 1998). Overall, the generally accepted objectives of a coordinated child protection response are to achieve: a comprehensive perspective in case assessment; comprehensive case plans or interventions; support and consultation for the workers involved in child protection; and the avoidance of duplication or gaps in service delivery (Hallett & Birchall 1992).

However, as Reid noted in 1969, interagency coordination is not a natural state of affairs and does not result merely from good intentions. While there would appear to be overall agreement that coordination in child protection is a necessary and valuable practice, effective coordination is difficult to achieve (for example, Jones et al. 1987; Morrison 1998). The desire for a coordinated response to child protection is often ‘asserted, rather than demonstrated, and [may be] taken to be self-evident’ (Hallett & Birchall 1992:18).

Conversely, service coordination problems, especially where many services are involved, have often been cited in the literature as leading to less than optimal case management (Jones et al. 1987; Hallett & Birchall 1992; Morrison 1998; Tomison 1999). There is the potential for children and families to miss out on services, or to become victims of duplicated services or incompatible treatments, potentially causing the child and family more distress (Hallett & Birchall, 1992). Poor coordination and cooperation have also been mentioned as contributing factors in a number of child abuse death inquiries (e.g. Goddard & Hiller 1992; Reder, Duncan & Gray 1993).

Inaccurate information, the failure to receive relevant case information, interagency disputes and/or ignorance of the role of other professionals involved in a case’s management, all reduce the ability of professionals to make informed decisions when dealing with suspected or substantiated child maltreatment cases. For these reasons many social scientists have argued for a clearly structured ‘teamwork’ approach to child abuse case management (e.g. Jones et al. 1987; Tomison 1999), and stressed the importance of the participating services being coordinated by a designated key worker and/or agency.

The mechanisms of coordination
There is the potential for agencies to develop a large variety of inter-organisational (or interprofessional) links for the purpose of coordinated service delivery. These may range from low-key, unstructured, informal links between workers from different agencies, to the formalised interrelationships which may occur with agencies or professions in (and between) particular organisational networks, to highly formalised, centralised coordination structures (Challis et al. 1988; Hallett & Birchall 1992).

The formal structures or mechanisms that commonly facilitate interagency and interprofessional coordination are referral protocols, case conferencing, and the development of multidisciplinary teams. However, a number of
authors have highlighted the important role that informal professional relationships and communication paths can play in combination with formal child protection structures (e.g. Challis et al. 1988; Morrison 1998; Tomison 1999). Although an over-reliance on informal communication methods and the circumventing of formal coordination and communication mechanisms may lead to the variety of interagency communication problems identified above, strong informal linkages operating in conjunction with more formal communication structures appear to lead to a more effective interagency network (Morrison 1998; Tomison 1999). Thus:

‘to be effective, interagency and interprofessional communication and collaboration should be based on formal structures, such as referral protocols, case conferencing procedures and the placement of substantiated cases onto a central register. The underlying formal structure can then be supplemented or enhanced by the development of informal links or ‘working relationships’ (Tomison 1999:353).

Interagency work in Australia

In order to create an environment that enhances cross-sectoral, interagency or multidisciplinary work, some Australian states and territories have adopted some form of joint investigation or formal multidisciplinary teams approach to assessment and case planning. Some of the more important interagency structures (with most having a basis in family support rather than purely forensic investigation) include: the NSW Joint Investigation Response Team (JIRT) – a combined police and child protection forensic investigation team; Queensland’s Suspected Child Abuse and Neglect (SCAN) Teams – a multidisciplinary case conference forum; New South Wales area child protection committees – regional coordination bodies; and Victoria’s Strengthening Families project – designed to provide a coordinated ‘wrap-around’ service model for ‘at risk’ families, where a key worker or designated service acts as a case coordinator and service broker, supervising and purchasing supports for a multi-service case plan.

In conclusion

It was noted earlier that the ‘new’ ‘family support’ models of child protection practice that were developed in the 1990s, were really a revisiting or recapitulation of solutions previously tried and tested. Rather than continue to develop ‘new’ versions of child protection case management systems, perhaps what is needed is greater recognition that the crux of effective child protection work is an adequately supported workforce, trained on a set of (clearly articulated) child protection ‘core competencies’, such as those identified under the Victorian ECO approach.

Rather than engage in a further round of dramatic policy and practice changes, it is noted that an investment in core child protection skills, such as risk assessment, interagency collaboration, and working effectively with children and families, along with the means to effectively monitor service provision, may provide a better return for governments, agencies, and most importantly children and their families, in the longer term.

Responding to child abuse and neglect in Indigenous and rural-remote communities

Accurate statistics about the incidence of family violence in Aboriginal communities are scarce (Bolger 1991). Although the statistics that are available are imperfect, they are sufficient to demonstrate that the occurrence of violence in Indigenous communities and among Indigenous people ‘is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole’ (Memmott, Stacy, Chambers & Keys 2001:6). O’Donoghue (2001) illustrates the extent of the problem of family violence, noting that many Indigenous children are growing up in communities where violence has become ‘a normal and ordinary part of life’ (O’Donoghue 2001:15).

Best practice responses and solutions to Indigenous family violence are difficult to find due to a dearth of programs and the lack of documented evaluations about the effectiveness of programs. The many reports on the problems within Indigenous communities conclude that the general failure to find solutions is exacerbated by a significant lack of resources, an on-going paternalistic approach towards Indigenous people and a reluctance to address the problem. A number of broad principles for programs are repeatedly identified in the literature. They include the need for major policy change which gives power and decision-making back to the Indigenous community, together with financial resources adequate to make a change and professional support to the community.
As in non-Indigenous communities, it is commonly believed that child abuse and neglect in Indigenous communities are caused by a multitude of factors (Belsky 1980; Memmott et al. 2001). However, the Indigenous perspective usually places considerably more emphasis on the impact of the wider community and societal causal factors. These factors include the high levels of poverty, unemployment, homelessness, ill health and substance abuse found in Indigenous communities, much of which arises from previous government policy of assimilation, as well as their experience of racism, dispossession and marginalisation (Cunneen & Libesman 2000).

Given that many overseas indigenous peoples are also struggling with the aftermath of colonisation, overseas child protection models trialed in other indigenous communities may provide possible solutions for Australia. Sweeney (1995) gives some information on models of child protection services in Canada, New Zealand and the United States where part or all protective responsibilities have been transferred to the Indigenous population. Cunneen & Libesman (2002) also provide a useful summary of international trends. For this report, innovations in practice for Canadian First Nations peoples will be highlighted.

Canada

Hill (2000) provides an overview of Canada’s First Nation tribes’ history since colonisation by Europeans, a history that is remarkably similar to that of Australia’s Indigenous peoples. It includes a period of the forced removal of children from their families (a ‘stolen generation’), and the continued high rates of children’s removal on child protection grounds (four times higher than the wider community). Since the late 1970s, there have been attempts to develop child protection and family support services run by (and for) the First Nations peoples. Hill (2000) outlines some key issues for consideration when developing services for the protection of children in Aboriginal communities. Underlying this approach was recognition of the ‘cycle of poverty and dependency perpetuated by the very services designed to resolve the social ills of First Nations communities …[and that] First Nations people [have] had to become active participants in the resolution of social problems that impacted them’ (Hill 2000:163).

Subsequently, Aboriginal foster care programs and child protection services – staffed and run by the Indigenous community and with statutory authority – have been provided in a way that recognised the cultural integrity of the people. The new services have been developed under the auspices of the non-Indigenous child protection agency, but were not a unit of that Department. In addition, a variety of family support programs were developed, particularly culturally-appropriate parent education programs for Indigenous parents, and the development of ancillary services, such as an Indigenous cooperative day nursery. It is interesting to note that the development of all these services, including the statutory services, was not an easy process.

While the implementation of such a model is not easy, it has also not necessarily led to significant improvements in Canadian First Nation communities’ health and wellbeing and/or a reduction in violence. However it does provide an example of how to move forward to develop more effective services for Australian Indigenous communities. Many of the tenets of the approach described by Hill have now been embraced by Indigenous groups and agencies (and to an extent, by government departments) in Australia. However, a statutory child protection service controlled and run by the Indigenous community has not been trialed yet.

Australian developments

In a similar vein to Canadian developments, the NISATSIC Inquiry recommended that new legislation be enacted, based on self-determination by Indigenous people, where far greater control over matters affecting young people is given to the Indigenous community (HREOC 1997; Cunneen & Libesman 2000). However, Cunneen & Libesman (2000) have argued for a complete revision of child protection services in relation to Indigenous Australians, they report that not one submission from an Indigenous organisation to the NISATSIC Inquiry found the current interventions from child protection/welfare departments to be an effective response to their child protection needs. The general model of operation of child protection services, based on ‘individualising’ and ‘pathologising’ a particular family, is culturally suited to white Australian culture, not Indigenous culture (Cunneen & Libesman 2002).

The literature offers a number of ‘best practice’ suggestions for intervention into family violence in Indigenous communities (Stanley, Tomison & Pocock 2003). It is commonly reported that effective intervention into family violence needs to address both the past traumas and present situational
problems and health disadvantages of Indigenous communities. Almost without exception the literature notes the need for inclusion/participation of the local community. Commentators provide a range of similar broad principles as a basis for all service provision in the Indigenous community. However, while there has been a lot of criticism of existing intervention models into family violence (Blagg 2000), few fully developed alternative models have been produced for Australian communities.

Building on Sweeney (1995), Blagg (2000) provides a summary of what appear to be core tenets that should be considered when planning services: participation; ownership/self-determination; infrastructure (training and education); and development of family support services needed to support child protection function.

With specific regard to statutory child protection roles, SNAICC has recommended the use of inclusive, participative processes to engage with Indigenous communities. It was noted that this should include the development of Elder Councils that could make a contribution to policymaking, resource provision, program development and service delivery. The Kurduju Committee, developed by the combined communities of Ali-Curung, Lajamanu and Yuendumu Law and Justice Committees in the Northern Territory, provide one example of how such partnerships may be enacted (Kurduju Committee Report 2001).

Overall, it would appear that the legacy of past practices is still impacting on both Indigenous peoples and present governments’ policy and practice associated with responding to Indigenous child welfare and child protection issues. Unfortunately, many of the well-intentioned policies, such as the use of Indigenous officers in child protection services, appear to have only resulted in superficial changes, rather than fundamental change. Many commentators have argued that the control of child protection services and other child welfare should be given to the Indigenous community. There are overseas precedents for this approach, although their effectiveness needs further examination.

Rural-remote communities

The ‘tyranny of distance’ produces a number of issues specific to rural and remote communities that impact on general service provision, and child protection and child abuse prevention in particular. First, rural and remote communities generally have limited access to health, welfare, education and support services, and the people are, by definition, geographically isolated. Second, in some communities, ensuring the confidentiality of service provision may be a greater issue than is the case in more populated urban areas. Social isolation, which is clearly exacerbated by geographical isolation, leading to a lack of connectedness or social supports, may have very real effects on community members’ quality of life and ability to cope with stressors.

At present, there is a dearth of literature reporting on effective child protection and family support practice in rural and remote communities. However, as is being recognised by governments and service providers with respect to Indigenous communities, what is apparent is the need to engage in partnership with remote communities in order to identify priorities and to develop flexible solutions suited to the local environment.

In many remote communities, workers often have to contend with professional isolation, a range of service gaps in the local community (at times including an absence of a regular police and statutory child protection presence), and thus, the necessity of undertaking roles or functions they would not usually perform. For example, in very small professional networks it is not uncommon for teachers and nursing staff to fulfil much more significant roles in child protection, the prevention of other family violence, and other social concerns. For governments and policymakers, the issues are therefore not just about the use of resources to better serve remote communities, but also about how to support existing professionals to provide an effective service in communities that may be suffering from significant social problems. And as Schorr notes, the most successful programs ‘grow deep roots in the community ... [and] cannot be imposed from without’ (1997:7).

Thus, there is a need to develop tailored, community-owned solutions rather than impose externally-developed plans. Given the lack of professional infrastructure and limited resources, whatever support system is developed for remote communities needs to be accepted by the people and tailored to meet their needs. A number of innovative approaches to service provision (and supporting professionals) in rural and remote communities are highlighted. For example, Foreman (1996) reported that health professionals in rural New South Wales identified a
dearth of appropriately-qualified workers in the Macquarie region. In response, some were reportedly willing to undergo specialist training (in addition to lobbying for funding of new specialist positions) in order to boost the region’s capacity to deal with child maltreatment concerns.

Baker (2000) presents an overview of the Workers with Families Project which operated from July to December 1999 in Toowoomba, Queensland which set out to develop partnerships between specialist child protection agencies and rural family support workers with the goal of extending effective early intervention responses to families where there were protective concerns (‘at risk’ families).

Crocker (1996) describes an innovative, community-based response by child protection teams in rural Newfoundland and Labrador, Canada. Like the Northern Territory, the regions host small populations spread over a significant geographical area. Here a range of local or regional multidisciplinary child protection teams were reconfigured to meet the needs of both professionals and the local communities. This involved a re-development of the teams to focus more on child abuse prevention, education and advocacy activities by a team that actively recruited community representatives who participate in the preventative activities. A smaller second tier (or core team) has been established for those professionals dealing directly with the cases of child abuse, in order to discuss case management issues. Overall, as Crocker notes:

‘the experience of child protection teams in this province demonstrates that by working together, rural [and remote] professionals and community people can develop appropriate responses to child abuse without depending on directions from government or any other agencies’ (1996:210).

Overcoming distance

In addition to the small numbers of professionals located in remote communities, consideration is given to mobile teams that can visit communities to provide support. Consideration is also given to developing information technology as a means of enhancing communication between professionals over distance, and for improving community members’ access to specialist supports. For example, the benefits accruing from a teleconference service set up by the Child Protection Unit at the New Children’s Hospital in Sydney to work closely with rural welfare and support services involved with child protection cases are described (Ryan 1997).

Finally, service ‘gaps’ in health and family support services often mean that whichever professionals and community workers are available ‘on the ground’ will have to pick up some of the work associated with preventing and responding to child maltreatment. Consideration should therefore be given to formally recognising and supporting this work, as a means of enhancing services for children and families. A key aspect of such a response is to develop training and support structures for workers. Developments in information technology are already providing new and effective ways to support professional supervision and consultation by enhancing professionals’ ability to communicate quickly and effectively over long distances.

Evidence-based practice in child protection: How do we better inform practice

A vital aspect of attempts to reform child protection and family support services is access to an evidence base that can allow policymakers to identify what appears to make good practice in child protection. In this section the aim is to explore the means by which evidence-based practice may be embraced to better inform practice. First, evidence-based practice can be defined as:

‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals’ (Sackett, Richardson, Rosenberg & Haynes 1997:2).

More specifically, it involves:

‘integrating individual practice expertise with the best available external evidence from systematic research as well as considering the values and expectations of clients’ (Gambrill 1999:346).

Unfortunately, many have taken evidence-based practice to mean that practice should be based upon experimental research evidence alone, and that all other practice is either not evidence-based or of a lower quality. Such a narrow approach was not envisaged by the original proponents of evidence-based medicine (Sackett et al. 1996), and is a common misunderstanding of the paradigm (Ramchandani, Joughin & Zwi 2001). Evidence based practice actually:

‘draws attention to the kind of evidence needed to rigorously test different kinds of practice-related claims. What is needed to critically appraise data regarding a question depends on what kind of question it is (e.g. question concerning effectiveness, validity of a measure, predictive
It is important therefore, to recognise that there are a variety of research methods that can provide a degree of experimental control, reliability and validity. The trick is to tailor the methods to the research question being investigated and any situational constraints. For those reasons the use of a multiple methods (or triangulation) approach is advocated. Combining quantitative and qualitative methods, and not necessarily excluding experimental research, this approach can provide a better understanding of applied social phenomena, such as child maltreatment and child protection work (Lewis 1998; Tomison 2000b).

Developing a comprehensive picture

What is also required when creating an evidence base, is the development of a comprehensive picture of what works. Research should consist of a hierarchy of steps that builds to a comprehensive evaluation of policy and practice, not merely a measure of outcome or ‘success’ which does not tell us why a particular initiative is successful.

It can be taken as a ‘given’ that there will be a general disparity between the levels of research funding available and the need for research in this field, but other issues also need to be addressed if both the conduct and use of research are to be facilitated. A key aspect of this process is the development of better partnerships between governments (funding agencies); service providers (government and non-government) and the research community. If done effectively, such a partnership would result in the development of better quality, ecologically-valid research. It would support the development of a service provider culture that has been taught to critically appraise and utilise research. This would require the tailoring of research messages for service provider needs and the development of education and training programs. It is hoped that the result would be better informed policy and service developments.

Conclusion: Child protection and family support in the 21st century

Acknowledging the realities of current child protection practice, this report has provided an overview of some of the issues in the identification, assessment and management of suspected child maltreatment cases in Australia. It is contended that the restructuring of Australian child protection systems – based predominantly on the U.K. experience and Messages from Research in the mid-1990s – has focused on enhancing case screening or gatekeeping, with a predominant focus on addressing ‘significant harm’. However, there has also been recognition of the need to adequately address wider family support needs as a means of preventing the occurrence (and recurrence) of child abuse and neglect.

For the most part, most policy changes have been translated into attempts to develop better identification and assessment practices, and the development of new risk assessment tools or guides. Few child protection systems, including the U.K. Social Service Departments (Parton 1997), have enacted policies to develop better partnerships between workers and families, or to ensure all families are actually assisted to remedy their problems, whether they be child protection matters, or generalised family dysfunction.

Most children at severe risk of maltreatment, or who are being seriously maltreated, are already known to statutory agencies. Child protection gatekeeping procedures, while perceived as still (inappropriately) allowing in cases where there are minimal maltreatment concerns, are generally quite successful at identifying children at serious risk. It is therefore concluded that for changes to identification and assessment processes to have meaning for children and their families, there must be a change in the conceptualisation of the roles of child protection and the wider child welfare and family support systems. Focusing on minor adjustments to the threshold for statutory action and enhanced accountability without adequately resourcing the child protection and wider family support systems will significantly reduce any possible benefits for children and families who are identified by the professional system, particularly those with generic welfare concerns. Thus, child protection ‘success’ clearly rests more with the provision of adequate family supports to ‘at risk’ and maltreating families than changes to intake assessment.

It is therefore argued that the ‘system’ must be conceptualised as a prevention-protection ‘continuum of action’, where regardless of the level of protective concerns, children and families receive some form of support to alleviate their concerns. Although it is unlikely that such a framework will be adopted in the short-term, it is proposed that the ‘continuum of action’ be retained as a benchmark.
against which future re-structuring and innovation in practice are measured.

What then for the future?

In the coming decades it can be expected that the adequate provision of family support will remain a driving force in the prevention of child maltreatment. It is likely that further evidence will be produced of the social and economic benefits of early intervention and family support services, leading to a continued focus on prevention, and in particular, an expansion of the family support services.

There is likely to be increased emphasis on ensuring greater accessibility to services, especially by those families most in need, and that the range of services available will be increased to better cater for children and families. It is hoped that any such expansion will include the provision of long-term monitoring and support options for families, particularly those with ongoing ‘chronic’ problems, as this is a serious gap in the existing family support system (Tomison 2001; 2002).

Continued efforts to strengthen and expand family support services, should also lead to a much stronger (and highly valued) role for the non-government sector. In many ways this can be considered a reclamation of the prominent role held by such agencies for much of the nineteenth and twentieth centuries (Tomison 2001). Should the preventative approach prove successful, there is likely to be a gradual de-emphasis on the government-run statutory child protection response. Much like the ideal proposed by supporters of the current ‘family support’ child protection models, only a small number of families – families that health surveillance, early intervention and family support services are unable to help – will receive a child protection response. In many ways such a system could look much like it did before the rise of statutory child protection agencies in the 1970s. Such a utopian system may also lead to greater attention being placed on addressing the structural forces impacting on families.
TERMINOLOGY

For the purposes of this report, a ‘child’ is defined as a person below the age of 18 years. The terms ‘child abuse and neglect’ and ‘child maltreatment’ are used interchangeably throughout this report. Using definitions developed by the Australian Institute of Health and Welfare (AIHW) (Broadbent & Bentley 1997), child abuse and neglect are defined for this report as:

- **Sexual abuse**: any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards (Angus & Hall 1996).
- **Physical abuse**: any non-accidental physical injury inflicted upon a child by a person having the care of a child.
- **Emotional abuse**: any act by a person having the care of a child which results in the child suffering any kind of significant emotional deprivation or trauma.
- **Neglect**: any serious omissions or commissions by a person having the care of a child which, within the bounds of cultural tradition, constitute a failure to provide conditions that are essential for the healthy physical and emotional development of a child.

Increasingly, children’s exposure to, or ‘witnessing’ of, domestic violence (that is, violence between intimate partners) is being considered as either a fifth category of abuse, or as a form of emotional abuse. Exposure to domestic violence encompasses a range of children’s experiences that go beyond merely seeing or hearing violence, such as: being physically assaulted or threatened; being used as a hostage or as a physical weapon against a spouse; and being forced to watch, or participate in, assaults (Tomison 2000a).

**Defining child abuse prevention**

‘Child abuse prevention’ is commonly classified into three main levels under a ‘public health’ model: primary, secondary and tertiary prevention (Helfer 1982; Rayner 1994).

**Primary prevention** is targeted at the community as a whole. Primary prevention programs generally comprise mass-media campaigns aimed at both children and adults, or school-based, personal safety-type programs for children. The aim of primary prevention programs is to prevent the occurrence of situations leading to maltreatment.

**Secondary prevention** programs target specific ‘at risk’ sections of the population. That is, those with special needs or who are in need of greater support, such as young parents, single parents, people with disabilities, and Indigenous peoples. Secondary prevention programs can be categorised as enhancing family functioning by providing various forms of family support and, in particular, by teaching parenting skills and increasing parents’ knowledge of child development and behavioural expectations.

**Tertiary prevention** refers to prevention initiatives aimed at preventing the recurrence of abuse or neglect in families where children have already been maltreated. Tertiary prevention therefore incorporates State and Territory statutory child protection services.

Unless otherwise stated, the term ‘child abuse prevention’ encompasses the prevention of all forms of child abuse and neglect.

**Defining family violence**

The generic term, ‘family violence’, will be used throughout this report to encompass the range of violence that is perpetrated within families, between family members. It has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms, rather than taking a focus on a particular form of intra-familial violence, such as child maltreatment or domestic violence. It is widely seen as the term that:

‘best encompasses the various forms of violence that may take place between family members. It is the most inclusive term, and is capable of encompassing changing ideas about what ‘family’ means in late 20th century Australia’ (Domestic Violence and Incest Resource Centre [DVIRC] 1998:36).
Family violence is the term adopted in Australian Federal Law (DVIRC 1998) and is also the term preferred generally by Aboriginal and Torres Strait Islander communities (Bagshaw et al. 1999; Tomison 2000a). Like all terms that describe aspects of intrafamilial violence, ‘family violence’ does however suffer from issues of definition (for example, how is ‘family’ defined?; what sorts of violence are encompassed by the term ‘family violence’?) (Tomison 2000a:2–3).
INTRODUCTION

The child protection system in Australia is quite fragmented. At the national level, the Australian Government has a role in the prevention of child maltreatment and some aspects of child and family support (particularly parent and relationship education). The Commonwealth also addresses issues of child abuse that arise through marriage dissolution in the Family Court of Australia. However, the responsibility for providing statutory child protection services, Children’s Courts and child welfare legislation rests with the individual Australian state/territory governments (Boss 1987; Goddard 1996).

As a consequence, there are major variations in child welfare laws governing children in need of care and protection, including how child abuse and neglect are defined. Further, there are differences between the states and territories with regard to the structure of the child protection system and the services that have been developed. This has led to substantial variation in the reporting, investigation and intervention in cases of suspected and/or substantiated child maltreatment (Goddard 1996; AIHW 2003). Yet in spite of the quite significant differences between the state/territory services, each service plays a similar role and has been affected by a number of inter-related issues that have impacted on the provision of child protection and child welfare/family support services across the western world¹.

In this report, the aim is to provide an overview of current issues for Australian child protection systems, and in particular, to inform the child protection review currently being undertaken in the Northern Territory. In response to requests from the NT Department of Health and Community Services, the author draws on Australian and overseas experiences to describe trends that are currently shaping child protection services, and to discuss a number of key aspects of service delivery. These include: models of the child protection intake process, interagency coordination and collaboration, the role of family support services, responding to child abuse and other family violence in Indigenous and rural and remote communities. Finally, consideration is given to the development of a better evidence base to inform policy and practice, based around the development of better partnerships between government, service providers and the research community.

¹ In responding to the need for change, it is worth noting that Australian child protection services have often drawn on (and adapted) U.S. and U.K. innovations and directions in the development and operation of child protection service systems.
Child protection services, via child protection workers, are expected to be able to correctly determine if a child is subject to child abuse or neglect, to determine the severity of the maltreatment, the risk of future maltreatment, and to develop effective means to ensure a child’s safety. However, societal expectations have often outstripped current knowledge of the causes of child abuse and neglect, the process of making child protection decisions and the influence various factors in isolation or combination may exert. In addition, society has not set concrete standards for what constitutes appropriate child care, nor has a series of factors been developed that can definitively indicate cases of high risk (Preston-Shoot & Agass 1990).

In essence, child protection workers make their decisions without a clear means of judging which cases are in need of immediate protection and which are not. Often these decisions are made without access to all relevant case information, and in many cases where the child’s caregivers are non-cooperative, workers are expected not only to determine if maltreatment has occurred when children present with physical injuries or behavioural symptoms, but they must also correctly assess cases where there are no identifiable signs of abuse or neglect. Unfortunately, there is no true recognition by the public as to the limitations of child protection work, or of the inherent difficulties faced by workers engaged in child protection, of the ‘shades of grey present in many child abuse cases’ (Preston-Shoot & Agass 1990:113). All too often, workers are ‘damned if they do’ and for removing children too frequently or inappropriately, and ‘damned if they don’t’ for failing to take action to protect children.

**The Child Protection Pendulum**

This dilemma highlights the conflicting values of child protection work – to protect children while maintaining or preserving families. Over time, the ‘threshold’ for protective investigation and intervention (taking statutory action to remove a child) has continually shifted in response to public concerns and resource issues. Thus, the decision to take action can be thought of as a child protection pendulum where workers’ emphasis has regularly ‘swung’ from erring on the side of caution and removing children at risk of maltreatment from their families, to the other extreme, focusing on keeping families together – even where there are serious concerns – and only removing children as a last resort (Dale 1998).

It should be noted that despite media stories highlighting what are perceived as child protection workers’ inappropriate removal of some children, the child protection system is generally quite non-interventionist. In less than one in ten reports do child protection services obtain a legal order from a Children’s Court to ensure a family complies with a treatment/support regime, to ensure child protection workers have regular access and supervision of the child and family for the purposes of monitoring the risk of harm, or apply to remove the child – temporarily or permanently – from the home. That is, contrary to public perceptions, child protection services do not focus on the prosecution and punishment of all maltreating parents. In the majority of cases reported to child protection services, the maltreatment concerns are not confirmed (‘substantiated’), or the concerns are confirmed but the family undertakes voluntarily to attempt to seek assistance and resolve their problems in order to reduce the risk of abuse or neglect.

**Child Protection in Australia**

In Australia, the earliest form of child protection developed within weeks of the first white settlements being established in New South Wales (Gandevia 1978), in response to what would be defined as neglect today. The settlement’s abandoned and neglected children, or children whose parents were considered ‘socially inadequate’ were boarded out with approved families, or later, resided in orphanages, the first of which was established on Norfolk Island in 1795 (Liddell 1993).

Over the next century a strong voluntary or ‘non-government’ child welfare sector was developed in Australia (and overseas) (Picton & Boss 1981), with the Christian churches becoming involved in running...
orphanages and occupying prominent positions within the non-government child welfare system – positions that are still held today. However, it was not until after the modern ‘discovery’ of child maltreatment, prompted by Kempe and colleagues 1962 paper on the ‘battered-child syndrome’ (Kempe et al. 1962), that governments really began to take significant responsibility for looking after children’s welfare. By the 1970s, statutory child protection services had been developed and were operational within the various Australian states and territories.

The 1970s and 1980s were characterised by the development and refinement of systems for investigating and managing child maltreatment cases (Liddell 1993) and the increased ‘professionalisation’ of the child protection response. In the 1980s and 1990s, the desire to enhance the professional response to child maltreatment, along with a strong desire for greater accountability (see below), led to the widespread adoption (following a U.S. trend) of a variety of professional decision making aids, guides or checklists, commonly referred to as ‘risk assessment’ measures. The intention was to provide child protection workers with additional resources they could use when assessing the risk of abuse or neglect to a child. Specifically, the aids could assist workers in determining: if abuse or neglect had occurred; the risk of further harm; and whether the child should be removed from her/his parents’ care.

**Economic rationalism**

Child protection services in many western countries have been shaped by the current political philosophy of economic rationalism, espoused by the 18th century Scottish academic, Adam Smith (McGurk 1997). Economic rationalism has resulted in a number of significant changes to child protection practice. First, the development of the user pays system, which has led to an increasing expectation on the part of governments for families and communities to look after and manage their own needs with minimal government intervention (McGurk 1997). Second, the welfare system and social policy has been framed in terms of cost-effectiveness and efficiency criteria, a particularly difficult task when applied to the prevention of child maltreatment and the protection of children. It has also resulted in the privatisation of government services and the introduction of compulsory competitive tendering.

In harsh economic times, particularly in the early 1990s, an economic rationalist approach translated into the rationing of resources and the increasing pressures and controls being applied to non-government family support and child welfare agencies. This forced some non-government agencies to close, many agencies were forced to amalgamate to survive, and the non-government sector’s ability to provide services and support for children and families was significantly hampered (Mitchell 1996). In practice, what this meant was that agencies’ ability to provide support for families affected by social problems, but who were not actually maltreating their children (so-called ‘at risk’ families) was severely reduced. These families were often not able to gain access to services, or were placed on long waiting lists as the depleted non-government system struggled to cope with the influx of clients referred by child protection services (Scott 1998).

**Bureaucratisation of child protection practice**

At the same time as the reductions in public spending on welfare and child protection began to take place, child protection work became increasingly driven by administrative requirements and the adherence to strict procedures (‘bureaucratisation’). Management issues rather than professional practice became central to child protection practice, with efficiency, effectiveness and a focus on accountability overriding and conflicting with professionals’ values and orientation towards the needs of children and their families (Liberman 1994).

It has been argued that the bureaucratisation of child protection practice has led to workers’ professional skills, knowledge, discretionary powers and decision making, being replaced by standardised practice, developed without a clear understanding of the complexity of child protection practice or of the dilemmas and the moral and political factors that workers must take into consideration when making decisions (Howe 1996).

**The legalisation of child protection practice**

Concomitantly, a legalistic framework and ‘rules of evidence’ were increasingly determining the facts of a case and whether abuse or neglect is serious enough to warrant protective intervention (Stanley 1997). Under a legalistic framework, developing a
legal response pervaded child protection practice and usurped the therapeutic needs of the child and family. A consequence of the adoption of the legalistic framework has been that attempts have been made to restrict definitions of maltreatment in order to limit coercion and stigma. This has conflicted with the therapeutic need to widen definitions and to increase the identification of ‘at risk’ or maltreating families in order to offer help (Hallett & Birchall 1992).

A further consequence of the law becoming the standard by which cases are judged and maltreatment defined, is that cases with legal consequences are, by definition, more likely to be singled out for attention (Lynch 1992). Emotional abuse or neglect, typically more difficult to prove legally, may therefore be less likely to receive adequate attention. In addition, there is a danger that maltreated children may receive less care and protection as a function of a lack of evidence, or until the evidence is such that the case is able to be dealt with under the legal system (Stanley 1997). Finally, the evidential standards required by courts may permeate the work of non-judicial agencies, with evidential issues dominating case investigations, with child protection concerns being subsumed and therapeutic work hampered by a focus on criminal concerns (Mouzakitis & Varghese 1985).

REFRAMING CHILD PROTECTION SERVICE PROVISION: THE SHIFT TO FAMILY SUPPORT

In the 1990s, statutory child protection services in the Australian states/territories, like those in other western countries, struggled to cope with ever-increasing numbers of reports of suspected child maltreatment and fewer resources (Tomison 1996c). These pressures, some caused or exacerbated by an over-emphasis on cost-effectiveness and bureaucratic structures at the expense of professional practice, led governments and child protection services to seek alternative approaches for managing child abuse and neglect.

It became apparent that a substantial proportion of the child maltreatment allegations referred to child protection services did not involve concerns deemed by the statutory services as requiring their involvement (Audit Commission 1994; Dartington Social Research Unit 1995; Tomison 1996c). Many of the reports involved families who had not maltreated their child but who had more generic problems, such as financial or housing difficulties, an incapacitated caregiver, or serious stress problems. Although such ‘at risk’ families may require assistance, it has been argued (Tomison 1996c) that they do not require child protection intervention. Further, their labelling as cases of child abuse or neglect was placing an additional burden on what were generally limited child protection resources (Tomison 1996c).

Despite the fact that legal action was not taken for the majority of families with whom child protection services were involved, it was argued that the style of intervention for all families had become ‘forensically driven’ (Tomison 1996c; Armytage, Boffa & Armitage 1998). This adoption of a ‘forensic’ or legalistic approach produced a number of negative consequences.

First, it led to the shifting of scarce child protection resources away from the provision of support to families where there was confirmed or ‘substantiated’ child maltreatment (tertiary prevention) to enable the conduct of investigations. Similar problems were identified in the United Kingdom (Audit Commission 1994; Dartington Social Research Unit 1995) and the United States. The U.S. Advisory Board on Child Abuse and Neglect (1993) concluded that the adoption of a forensic approach meant there was no realistic hope of meaningful treatment or family support to prevent a recurrence of child abuse and neglect, or to ameliorate its effects. As Kaufman and Zigler noted: ‘currently, investigation is the only “service” provided in response to many child abuse and neglect reports’ (1996:235).

Second, an under-resourced family support system was swamped by referrals from child protection services, effectively ending the bulk of the secondary prevention work that had been done with ‘at risk’ families and creating substantial waiting lists for all but the most severe child abuse cases (Tomison 1996c; 1999). In effect, the focus on child protection investigations at the expense of prevention and treatment services was ‘the same as having a health system in which ambulances and casualty departments are increased while immunisation programs and surgical wards are closed’ (Scott 1995:85).

Third, there was an emphasis on child protection services as the ‘expert’, and an alienation of essential non-government family support agencies and professionals from a partnership approach with statutory services with regard to the prevention,
support and protection of children (Armytage, Boffa & Armitage 1998).

Finally, the shift to forensic investigation also raised general questions in relation both to child protection services' screening or ‘gatekeeping practices’ and the nature and availability of broader child welfare and family support services in the community. Within this, the dilemma was described as one of distinguishing child protection problems from broader welfare concerns and, in all instances, delivering an appropriate response matched to the needs of the client children and families.

In developing alternative service models as a response to these critiques, attention therefore focused on the operation of both child protection services and the broader child and family welfare system that statutory child protection services operate within (Dartington Social Research Unit 1995). Most Australian State and Territory governments subsequently adopted ‘new’ models of child protection and family support (Tomison 1996c), based predominantly on the recommendations proposed in the U.K. Department of Health’s Child Protection: Messages from Research report (Dartington Social Research Unit 1995).

Such approaches were often not new, but involved a revisiting or recapitulation of solutions previously tried and tested since the development of child protection services. One of the major differences was that there was now substantial formal recognition of the vital role played by the broader child and family welfare system in supporting families, and thus in preventing the occurrence and recurrence of child abuse and neglect. In this section, the intention is to explore a number of central themes in the development and provision of family support services, particularly as it applies to the prevention of child abuse and other family violence in the twenty-first century.

INTEGRATING CHILD PROTECTION SERVICES INTO A WIDER CHILD AND FAMILY SUPPORT NETWORK

The increasing expansion and identification of social ills or issues (such as child abuse and parenting problems, youth suicide, bullying, domestic violence, substance abuse, relationship breakdown etc.), combined with a greater focus on the quality of family life and the health and wellbeing of family members (Tomison & Wise 1999), have produced significant demand for assistance as families and communities seek external support to assist them in achieving and maintaining a ‘reasonable’ standard of living, health and wellbeing. This has occurred as traditional forms of support provided by extended family and/or friends and neighbours appears to be decreasing (Bittman & Pixley 2000).

As a consequence, families have turned to governments and a range of family support services to assist them in dealing with the changing nature of society and the specific issues they may face. These ‘family support services’ can be broadly defined as seeking ‘to benefit families by improving their capacity to care for children and/or strengthening family relationships’ (AIHW 2001:xi). Typically, such services have focused on the provision of parent support, knowledge and skills development, and have been provided via centre-based group programs and/or home visitation services (e.g. Tomison & Poole 2000). [For an overview of parent education, see Tomison 1998; for recent analyses of the effectiveness of such programs, see Chalk & King 1998, and Shonkoff & Phillips 2000.]

Throughout the 1970s and 1980s, a range of family support services provided a variety of therapeutic supports to families in need. These services included nurse-based home visiting services, where there was some recognition by governments and practitioners that infant welfare nurses could play a greater role in identifying and supporting ‘at risk’ families. At this time, adequate resourcing and lower service demand meant that many services were able to counsel, treat or support not only statutory child protection clients, but many voluntary client families where identified child maltreatment concerns were deemed suitable for a community case plan (Tomison 1999). In addition, many families who voluntarily sought assistance for more general family dysfunctions or issues, and/or who were ‘at risk’ of maltreating their children (that is, secondary prevention cases), were also able to be provided with supports, although these were often of a short-term nature (Tomison 1999).

Valuing family support

With the reframing of child protection service provision in the 1990s, there was now substantial recognition that statutory child protection services could not operate effectively in isolation; and of the vital role played by the broader child and family welfare system in supporting families, and thus in preventing the occurrence and recurrence of child abuse and neglect. As Scott noted:
‘child protection services are merely one component in a complex web of child and family services at the primary, secondary and tertiary levels of prevention. The child protection service is heavily dependent on this broader infrastructure of statutory and non-statutory services’ (1995:85).

Thus, in the last decade there has been a substantial reinvestment in a rapidly changing family support sector (Tomison 2001), and growing recognition of the need to work strategically to ensure the best response for families and improved societal health and wellbeing.

Family support in the 21st century
Notwithstanding the dramatic resurgence of interest in family support in the 1990s, interest in the prevention of child abuse and neglect has increased substantially over the last 20 years. This trend has been due in part to the humanitarian desire to remedy or prevent the suffering of children, as noted above. It was boosted however by the recognition that the investigation-driven child protection response of the early 1990s would ultimately fail without adequate family support and other prevention services that could actually work with families to address their needs and to reduce any risks to children’s health and wellbeing.

However, there have been other reasons for the renewed interest in prevention. Harrington and Dubowitz (1993) contended that the greater interest resulted from the professional community’s discovery of the harmful and expensive outcomes that can result from child abuse and neglect. Such outcomes included physical and emotional harm, the transmission of abusive or violent behaviour through the generations from parent to child, and delinquency and/or adult criminal behaviour (see Widom 1992). Further, a small but growing body of evidence that prevention programs can produce greater social and economic benefits compared with crisis services, has also given impetus to a more prevention-focused service philosophy (e.g. Barnett 1993; Colorado Children’s Trust Fund 1995).

In the often-quoted Perry Preschool study, Barnett (1993) calculated that by the age of 27 years, for every dollar taxpayers spent on the preschool children enrolled in the Perry Preschool early intervention program (developed in the 1960s), there had been a subsequent saving of over seven dollars in health, welfare, criminal justice and social security expenditure. Such cost-benefit analyses have resulted in a revitalised attitude towards the effectiveness of such early intervention programs, given that not only were they able to assist the nation to attain educational targets, but they were ‘lucrative social investments’ (Zigler & Styfco 1996:144; Vimpani, Patton & Hayes 2002).

Trends in prevention
In the last decade, in addition to the reinvestment in family support, there have been three clear, interrelated prevention trends evident in policy and practice, with respect to the response to a number of social ills including crime, substance abuse, domestic violence and child maltreatment. These are: the renewed popularity of early intervention prevention approaches, particularly those targeting the first three years of life; the concomitant development of ‘health promotion’ or ‘wellness’ initiatives designed to enhance child and family health and wellbeing; and ‘whole of community’ approaches.

Early intervention services
Early intervention initiatives are allied with the promotion of health and wellbeing. A range of early intervention strategies and programs have been developed to ‘create growth-promoting environments for young children whose development is threatened by biological vulnerability or adverse life circumstances’ (Shonkoff & Phillips 2000:32).

The primary intention with an early intervention approach is to intervene to influence children’s, parents’ or families’ behaviours, in order to reduce the risk or to ameliorate the effects of less than optimal social and physical environments. The approach also aims to increase the chances of a:

‘more favorable developmental trajectory for each child. This is accomplished by attempting to identify and mitigate the influence of existing risk factors, as well as to identify and enhance the buffering capacity of available protective factors’ (Shonkoff & Phillips 2000:32).

Although early intervention approaches to prevent child maltreatment or other social ills may be beneficial from birth to adulthood, the early years of life in particular have become the predominant focus for intervention. Infancy is a period of developmental transition that has been identified as providing an ideal opportunity to enhance parental competencies and to reduce risks that may have implications for

**Neural development**

Interest in early intervention approaches has been strengthened by growing empirical evidence that early exposure to chronic violence, a lack of nurturing relationships and/or chaotic and cognitively ‘toxic’ environments (Garbarino 1995), may significantly alter a child’s neural development and result in a failure to learn, emotional and relationship difficulties and a predisposition to violent and/or impulsive behaviour (e.g. Pynoos, Steinberg & Wraith 1995; Shore 1997; De Bellis et al. 1999). That is, if a child’s sensory, cognitive and affective experiences are significantly below those required for optimal development, such as may occur in a chronically violent environment, the brain may develop in ways that are maladaptive in the long term (see Shonkoff & Phillips 2000, for an excellent overview).

Specifically, the child may develop a chronic fear response, such that neural systems governing stress response will become overactive, leading the child to be hypersensitive to the presence of cues signalling a threat. Alternatively, a child experiencing a violent environment may become unresponsive and overly withdrawn. In either case, although this ‘survival’ reaction may be an important adaptation for life in a violent home environment, it can be maladaptive in other environments, such as school, when the child needs to concentrate and make friends with peers.

**Service delivery**

When used as a preventative measure, early intervention approaches should incorporate both the promotion of health and wellbeing, and the prevention of social ills like child maltreatment (LeGreca & Varni 1993). It should be noted that there has been some recognition (e.g. Zigler & Styfco 1996; Tomison & Wise 1999; Brooks-Gunn 2003), that early intervention strategies, particularly if used in a limited way or in isolation, do not offer a ‘magic solution’ to remedying the social problems that may impact on children, such as poverty.

However, early intervention approaches, often closely linked with universal services, are generally perceived to be one of the most effective ways to ameliorate the effects of maltreatment (Widom 1992; Clark 1997; Tomison & Wise 1999). Family support services carrying out an early detection role, especially home visiting services, have been particularly noted for their success in identifying families at risk of maltreatment prior to the concerns reaching a level that would require protective intervention (Olds, Henderson, Chamberlin & Tatelbaum 1986a; Olds, Henderson, Tatelbaum & Chamberlin 1986b; Olds et al. 1997; Chalk & King 1998).

Whether they be similar to the Home Visitor service operating in the United Kingdom child protection system, the universal maternal and child health nurses of Scandinavia, or Australia’s infant welfare nurses, home-visiting programs are an important facet of a cohesive child abuse prevention strategy. Ideally they offer a universal primary preventative service with the flexibility to cater for the needs of ‘at risk’ or maltreating families (Vimpani et al. 1996). Where resources allow, such services are able to support and educate parents, and are more likely to detect problematic changes in family functioning (Drotar 1992). These services are also able to divert/refer families to the most appropriate support and can often alleviate the family situation without the necessity of statutory child protection services involvement.

The value of the preventative role played by the non-government sector, including early detection services, in preventing child abuse and neglect was relatively unacknowledged and undervalued during the recession of the late-1980s and early-1990s, particularly by governments intent on cost-cutting (Tomison 1999). It was not until the shift to a family support model of child protection practice in the mid-to late-1990s, and the publication of empirical evaluation studies, that the benefits of home visiting and other early intervention programs were recognised. Since then, governments have begun to reinvest in early intervention programs.

**Back to the future**

Much of the current approach to child abuse prevention results from a revisitation and extension of the programs and tenets of early intervention programs that were first begun in the United States 30 years ago (Tomison & Wise 1999). The U.S. Civil Rights movement provided the impetus to develop new ways of thinking and to overhaul the existing social structure. Education was seen as the key to eliminating social and economic class differences (Zigler & Styfco 1996; Ochiltree 1999) and resulted in attempts to improve the cognitive and social competence of disadvantaged young children.
Early intervention programs like Perry Preschool (Barnett 1993; Zigler & Styfco 1996), Head Start (Zigler & Styfco 1996), and the Elmira Prenatal/Early Infancy Project (Olds et al. 1986a; Olds et al. 1986b; Olds et al. 1997) have demonstrated some improvement in disadvantaged children’s lives, and may reduce the number of ‘at risk’ or maltreating families who will require more intensive support in order to reach an adequate level of parenting and overall functioning. Early intervention is therefore a vital, cost-effective component of any holistic approach to preventing social ills or promoting social competence (Barnett 1993; Emens et al. 1996; Zigler & Styfco 1996).

In Australia, the renewed interest in early intervention approaches has led to the creation of the National Investment For The Early Years (NIFTeY) organisation (Vimpani 2000). NIFTeY is dedicated to promoting the development, implementation and evaluation of strategies in the early years of life that advance the health, development and wellbeing of all children in Australia.

Strengthening families and communities – promoting resiliency
Strengthening families and communities has become a major component of efforts to prevent a variety of social ills, including child maltreatment. Researchers investigating the ‘risk factors’ that may heighten children’s vulnerability to social ills such as child abuse and neglect, have consistently identified some children who are able to achieve positive outcomes in the face of adversity – children who are ‘resilient’ despite facing stressful, high-risk situations (Kirby & Fraser 1997). Resilience appears to be determined by the presence of risk factors in combination or interaction with the positive forces (protective factors) that contribute to adaptive outcomes (Garmezy 1993).

The enhancement of protective factors or ‘strengths’ has become a key facet of prevention strategies. Governments are now using it as the basis for Australian community-level interventions, and as a valued part of a policy of promoting family and community health and wellbeing. For example, the Stronger Families and Communities Strategy (Department of Family and Community Services 2000), announced by the Commonwealth in April 2000, invested $240 million to help support and strengthen Australian families and communities. The Strategy takes a prevention and early intervention approach to helping families and communities build resilience and a capacity to manage problems before they become severe. It recognises the importance of the local community and the wider social and economic environment for the wellbeing of citizens, the special protective role that strong communities can have for the very young, and the importance of supporting families to care for their members.

The Strategy focuses on the importance of early childhood development, the needs of families with young children, improving marriage and family relationships, balancing work and family responsibilities and helping young people in positive ways. It also includes new initiatives to encourage potential community leaders, to build up the skills of volunteer workers, and to help communities develop their own solutions to problems and promote a ‘can do’ community spirit.

Overall, much of the current focus of family support services is on taking a whole of community approach to improving the health and wellbeing of children and families. The aim is to ensure that when faced with adversity or stress, communities are better equipped to cope and respond in a non-destructive way. This approach goes beyond direct prevention of maltreatment and is better described as a ‘wellness’ or health promotion approach (Prilleltensky & Peirson 1999; Tomison & Poole 2000).

Solution-focused practice
It also appears that a similar trend has begun among professionals working in the child protection and child welfare arenas. In family support work, many agencies have begun to re-focus their work with families to empower clients, focusing on a family’s potential for change and attempting to engage family members in a truly cooperative venture to find solutions to their issues (De Jong & Miller 1995).

Pioneered in the early 1960s by Otto, the underlying tenet of ‘solution focused’ or a ‘strengths perspective’ is that all families have strengths and capabilities (De Jong & Miller 1995). If practitioners take the time to identify and build on these qualities, rather than focusing on the correction of skills deficits or weaknesses, families are more likely to respond favourably to interventions and thus the likelihood of making a positive impact on the family unit is considerably enhanced (Dunst, Trivette & Deal 1988).

The overall objective is to develop a true partnership between family members and workers, involving the family as much as possible in case management.
decision-making and encouraging families both to set their own goals and to take responsibility for achieving them. Such competency-based, family-centred practice is not a denial of a family’s problems or shortcomings but a focus on client strengths is perceived to be a more fruitful means to address issues and achieve positive change.

As Durrant notes:

’a focus on strengths does not deny shortcomings – it suggests that focusing on the shortcomings is often not a helpful way in which to address them’ (cited in Scott & O’Neill 1996:xiii).

Such an approach to working with families is currently quite common in Australian family support and child protection systems [e.g. Western Australia – the Signs of Safety approach (Turnell & Edwards 1999)].

Developmental prevention

Although significant benefits may accrue through the adoption of a health promotion approach, it is contended that in order to prevent child maltreatment and other social ills more effectively, strategies are required that focus on both reducing risk factors and strengthening protective factors that foster resiliency (LeGreca & Varni 1993; Tremblay & Craig 1995; Cox 1997). As Cox (1997:253) notes:

‘truly ecological approaches that are developmentally attuned demand concurrent programs that work on protective as well as risk factors and that reflect and impact on processes working within and across various domains of the child’s world’.

Such an approach has already been adopted to prevent other social ills. For example, Tremblay and Craig (1995:156–57) describe developmental prevention, a key component of crime prevention strategies, as ‘interventions aiming to reduce risk factors and increase protective factors that are hypothesised to have a significant effect on an individual’s adjustment at later points of … development’.

‘Whole of community’ approaches

The African proverb, ‘It takes a village to raise a child’, epitomises the importance of the role of the wider community in raising children and young people. The larger socio-economic system in which child and family are embedded can influence family functioning, child development and the availability of helping resources, such as universal child and health services, within communities and neighbourhoods (Martin 1976; Garbarino 1977; U.S. Advisory Board on Child Abuse and Neglect 1993; Hashima & Amato 1994).

The importance of community has undergone a resurgence of interest (Korbin & Coulton 1996), with governments and the child welfare and family support sectors redesigning services to become more community-centred, and forging alliances with local communities to help improve the physical and social environment of communities (Cohen, Ooms & Hutchins 1995; Argyle & Brown 1998) and to develop ‘social capital’ (Coleman 1988; Fegan & Bowes 1999).

Until recently, despite the development of ecological theories of child maltreatment (for example, Garbarino 1977; Belsky 1980), researchers, policy makers and practitioners working to prevent child maltreatment have often perceived such structural forces as being beyond the scope of prevention. The tendency has been to tailor prevention activities to run within environmental or structural constraints (Parton 1991: Garbarino 1995). However, there has been growing recognition that preventing child maltreatment requires the development of the means to address the societal factors underpinning child maltreatment and other family violence (Altepeter & Walker 1992; Tomison 1997).

This, in turn, has led to the adoption of holistic prevention strategies with a focus on ‘whole of community’ approaches and early intervention strategies designed to influence a broad network of relationships and processes within the family and across the wider community (Wachtel 1994; Hay & Jones 1994; U.S. Advisory Board on Child Abuse and Neglect 1993; Tomison 1997; NSW Child Protection Council 1997; National Crime Prevention 1999b).

Issues in family support

With a few exceptions, such as the Australian national audit of child abuse prevention programs undertaken by the National Child Protection Clearinghouse (henceforth to be known as the ‘Australian Audit’) (Tomison & Poole 2000), there has been a dearth of information available on the role and nature of family support services operating across the nation. In 2001, on behalf of the Australian Community Services Ministers’ Advisory Council (CSMAC), the Australian Institute of Health and
Welfare (AIHW) published a report describing the family support services funded and/or delivered by the Commonwealth Government and State/Territory Governments (AIHW 2001). A number of service trends were evident.

- As noted above, crisis services addressing issues such as family violence were increasingly being complemented by services that built on family strengths (capacity-building) and the creation of resiliency using a solution-focused approach (Dunst, Trivette & Deal 1988; De Jong & Miller 1995). This approach was linked to the development of social capital (Coleman 1988) and creating family and community capacity to address and/or manage their own needs.

- There was a clear focus on the creation of innovative service solutions that were locally designed and delivered to meet the needs of specific communities. Further, services were being tailored to meet the needs of specific sections of the Australian population, including Indigenous Australians, culturally and linguistically diverse communities, people with disabilities or mental health issues, and rural and remote communities. Such services were set up to complement the more traditional generic family support services.

- Family support services were generally taking into account the wider community-level factors that might impact on service delivery, tailoring support programs to take into account the wider social and physical environmental context.

- A strong investment in early childhood and early intervention programs was evident.

- There was an increased focus on service integration or interagency coordination, and a greater focus on measuring outcomes and evaluating program impact or outcomes.

- Finally, there was recognition that to be effective, family support services must attempt to address holistically the needs of the family, including key members of the extended family.

In the following sections, building on the trends identified by AIHW (2001), some of the key issues or trends facing family support services in the twenty-first century are described.

Overcoming a legalistic approach – engaging with families

It has been argued that in the 1990s, a legalistic framework and ‘rules of evidence’ were increasingly determining the ‘facts’ of a child protection case, and whether abuse or neglect concerns were serious enough to warrant protective intervention (Mitchell 1996; Stanley 1997). It is contended that a focus on legalistic issues has pervaded child protection practice and usurped attempts to address the therapeutic needs of the child and family (Tomison 1999).

For example, one consequence of the adoption of a legalistic approach is that attempts have been made to restrict definitions of maltreatment in order to limit coercion and the stigma associated with being labelled as ‘maltreating’ to those families where a child is at significant risk. This approach conflicts with the therapeutic concern to widen definitions of what constitutes maltreatment, and to increase the identification of both ‘at risk’ and ‘maltreating’ families in order to offer support (Hallett & Birchall 1992).

A further consequence of the law becoming the standard by which cases are judged and maltreatment defined, is that cases with legal consequences are, by definition, more likely to be singled out for attention (Lynch 1992). Emotional abuse or neglect, typically more difficult to prove legally, may therefore be less likely to receive adequate attention (Stanley 1997). In addition, there is a danger that maltreated children may receive less care and protection as a function of a lack of evidence, or until the evidence is such that the case is able to be dealt with under the legal system (Stanley 1997).

Finally, the evidential standards required by courts may permeate the work of non-judicial agencies, thereby setting the parameters for practice (Besharov 1985). This may lead to forensic issues dominating case investigations, with child protection concerns subsumed by criminal concerns and therapeutic work hampered (Mouzakitis & Varghese 1985).

A focus on voluntary engagement

It has been argued that there is a need to shift both research and service delivery away from determinations of ‘guilt’ and ‘risk’ to focus more on the development of comprehensive needs assessment and the provision of services to support children and families (Kaufman & Zigler 1996). The key issue for preventing child abuse is therefore not the achievement of legal sanctions, but the determination of what governments and the wider community may do to prevent or reduce the harm done to children (U.S. Advisory Board on Child Welfare).
Abuse and Neglect 1993). The U.S. Advisory Board on Child Abuse and Neglect concluded that:

‘the most serious shortcoming of the nation’s system of intervention on behalf of children is that it depends upon a reporting and response process that has punitive connotations, and requires massive resources dedicated to the investigation of allegations. State and county child welfare programs have not been designed to get immediate help to families based on voluntary requests for assistance … If the nation ultimately is to reduce the dollars and personnel needed for investigating reports, more resources must be allocated to establishing voluntary, non-punitive access to help’ (1990:80).

In recent times, using differentiated child protection systems (see below), there has been some evidence of a shift in practice such that the focus is on service delivery and, more particularly, the encouragement of ‘at risk’ and non-statutory maltreating families to seek and accept assistance. Statutory intervention is kept as much as possible for use with those for whom family support, by itself, is inadequate, and there is a need to intervene to ensure a child’s safety (Tomison 2002). Many services have therefore adopted practice principles that promote cooperation between workers and families in order to achieve greater levels of parental cooperation and, subsequently, a better outcome for children and families (Tomison 1996c).

The importance of cooperation
The degree to which parents or caregivers cooperate with professionals has been identified as a factor affecting a variety of child protection case management decisions, such as whether to employ legal interventions in order to protect the child (e.g. Dalgleish & Drew 1989; English et al. 1998; Karski 1999). That is, parents who fail to recognise that there is a problem in the family, who exhibit hostility and/or who hinder professional involvement represent a higher risk to the child, as do parents who lack potential or motivation for change (Tomison 1999).

Some studies have suggested that cooperative parents make up a significantly smaller proportion of cases where legal protection is sought, than do cases where the parents are uncooperative (Craft & Clarkson 1985; Karski 1999). Other researchers have indicated that uncooperative parents fail to engage in therapeutic interventions, and thus are more likely to receive minimal intervention strategies (Goddard & Hiller 1992). Many child death inquiries have indicated that uncooperative parents have managed to avoid further protective investigations and professional case monitoring until after the child has died (e.g. Goddard & Hiller 1992; Reder, Duncan & Gray 1993).

From the findings of a large-scale tracking study of 295 suspected child abuse and neglect cases within a Victorian regional child protection network (Tomison 1999), it was apparent that the majority of substantiated cases and cases where legal action was taken involved parents whose level of cooperation was described as ‘ambivalent’ at best. Further, families rated as ‘uncooperative’ by workers, but who were engaged as voluntary clients, at times derailed case plans by failing to work with professionals and refusing referrals to services for assistance. As statutory intervention was generally considered to be inappropriate with these cases, the uncooperative or ambivalent caregivers were frequently left with the responsibility for their child’s care and protection, effectively without professional supervision or support. These ‘grey’ cases (Jones et al. 1987; Dalgleish et al. 1999) would be left to either improve to an adequate level of caregiving or to be renotified with similar or more serious concerns. Workers could perhaps then enforce cooperation through legal means.

The study therefore provides an insight into some of the difficulties faced by workers when attempting to work with families: in particular, the difficulties faced when working with families for whom there is insufficient evidence to take statutory action, or where the maltreatment concerns have been deemed suitable for remedy via voluntary work with the wider family support sector. The findings also support the move of family support services to adopt strength-based or solution-focused approaches to casework. Under this approach, the positive engagement of families and a focus on pre-existing family strengths and capabilities would appear to offer a better chance of promoting family change and reducing the risk to the child (De Jong & Miller 1995; DePanfilis & Wilson 1997; Turnell & Edwards 1999).

Access to services
One area becoming increasingly the focus of discussion is clients’ access to services. Why is it that those most in need of assistance often appear to fail to gain access to services? Why do a proportion of the families with significant support and child
safety needs, who manage to access services, disengage prior to completing the program?

Clearly, the demand for services by maltreating families (generally referred to by child protection services) or those in crisis, has often swamped services operating with a prevention/early intervention focus (see above). It is also apparent that this situation can create more demand, not less, as ‘at risk’ families unable to gain assistance when problems first arise may re-present with more serious child maltreatment concerns (Tomison 1996c).

Overall, there is growing recognition that to be truly effective, service sectors need to investigate this issue and develop methods of enhancing accessibility. It is apparent that governments have moved to enhance accessibility as part of their efforts to develop family and community capacity-building. A range of funded community development projects incorporate attempts to engage with local communities and to provide families with the skills to recognise a need and to seek out services before their problems reach crisis point (e.g. Department of Family and Community Services 2000).

Unfortunately, accessibility issues have not yet been explored fully, as research investigations of accessibility issues are still quite rare. The National Child Protection Clearinghouse recently undertook an exploratory study designed to gain further understanding of the issues around how families with a child at risk of being maltreated access programs designed to prevent maltreatment (Stanley & Kovacs 2003). The study investigated ‘at risk’ children and families’ access to 32 centre-based parent education and home visitation services in urban and rural areas of New South Wales and Victoria. Stanley and Kovacs assessed: how program design and implementation impact on accessibility for the service user; factors associated with the service users, such as knowledge of a program’s existence and design; and the means by which identified barriers to accessibility may be overcome.

It was found that most services were operating in catchment areas rated by the service providers as having low numbers of child abuse prevention services, and relatively high service demands perceived by the service providers as outstripping service availability in 57 per cent of areas. This was perhaps the key finding (and also one that might be expected) – that service accessibility and the nature of service provision itself will be determined largely by the availability of resources. A well-resourced sector is better able to meet demand for services, and to cater for a wider range of short and long term needs. Further, it enables services to devote resources to outreach work designed to ensure those most in need of assistance are able to be accessed and engaged for the purposes of providing support.

In the study, at least half of the services felt that there was a lack of community awareness about their program, while approximately half recognised that those families most in need (at ‘high risk’) were not accessing their services (or in some cases, were accessing but dropping out of the program). Yet few services formally advertised their services, or focused on targeting those most in need, because of generally high service usage by the local community (that is, they were working to capacity).

Some studies have shown that traditional advertisements in print media are not particularly effective at encouraging service usage (Howard & Chaplin 1997). Rather, it is face-to-face contact (i.e. having a shopfront or display in local shopping centres and other public venues – Dumka et al 1997; Howard & Chaplin 1997) that is more likely to facilitate access to services. Further, Henricson et al. (2001) contended that it is only by active or assertive engagement that families in need will be encouraged sufficiently to use services; that is, by home visits, telephone or mail contacts designed to maintain families’ motivation to attend services.

Stanley and Kovacs (2003) identified a range of methods reportedly used by service providers to facilitate access to services: developing program content relevant to local families’ and communities’ needs; encouraging new family clients to attend the service via follow-up telephone or letter contact after they had enrolled in a service (assertive outreach); and by providing child care, transport (to agencies), and social activities (including meals) where other family members could be included.

Access for all

A number of specific sections of the Australian population have been identified as being at greater risk of child abuse and neglect (Tomison & Poole 2000). Typically, these include young (adolescent) parents; Aboriginal and Torres Strait Islander communities; some culturally and linguistically diverse communities; families where a parent or child is affected by a physical or intellectual disability;
families where a parent or child is affected by a mental disorder; and rural and remote populations (the latter is discussed in Rural and Remote Communities below). Each sub-population brings with it particular engagement and access issues.

For example, the development of culturally-sensitive prevention programs specifically targeting Aboriginal and Torres Strait Islander or culturally and linguistically diverse (CALD) communities appears to be necessary to ensure access to services (Tomison & Poole 2000). Aboriginal and Torres Strait Islander peoples often prefer to attend services that offer culturally-relevant programs staffed and managed by their own communities (Wilson 1995; Tomison 1996b). Where there is inadequate access to such Indigenous services, families are more likely to fail to seek assistance.

Unfortunately, the availability and number of culturally-appropriate services is relatively low. In the Australian audit of prevention programs carried out by the National Child Protection Clearinghouse, Tomison and Poole (2000) reported that although 16 per cent (296) of the 1814 prevention programs collected were reported to target Aboriginal and Torres Strait Islander peoples, only 23 per cent of these programs (68 of the 296) appeared to have been specifically developed or tailored for the Indigenous population.

In order to enhance Aboriginal and Torres Strait Islander access to culturally appropriate services, a number of approaches have been put into place (Tomison & Poole 2000). First, there has been much work done around the provision of cross-cultural awareness training (for example, Deemal-Hall & McDonald 1998; Firebrace 1998), to ensure that non-Indigenous workers are sensitive to the needs of their Indigenous clients.

Second, cultural issues and sensitivities (for Indigenous and non-English-speaking communities) have been incorporated into a variety of programs, such as the Barnardos Family Work program that operates in a number of centres across New South Wales. Aboriginal and Torres Strait Islander communities have also been given a voice in the development of culturally-appropriate materials via representation on a range of decision-making bodies.

Finally, in an attempt to develop more Indigenous services, a number of government and non-government agencies have developed Aboriginal or Torres Strait Islander teams, or employed Indigenous workers to work with local communities. The Commonwealth, for example, as part of the National Rural Health Strategy (Department of Health and Aged Care 1996), has funded initiatives that support the funding and training of Aboriginal health education officers and other means of increasing Aboriginal and Torres Strait Islander involvement in the delivery of culturally-appropriate services and in the management of health services. The Government has also undertaken to accelerate the development of education programs for Aboriginal health workers, and to pilot various service delivery models to encourage and support nurses and Aboriginal and Torres Strait Islander health workers operating in rural and remote areas that are under-supplied with medical services.

Tailoring support to family needs

Just as attempts to engage with the range of Australian families requires the development of tailored solutions, any understanding of family support needs to be:

‘informed by an awareness of the diversity of family forms and recognition of the different responses of family members to challenges along their life course’ (McGurk 1997:v).

It therefore follows that an effective family support system requires the flexibility to meet families’ needs (both therapeutic and physical), particularly if a collaborative, solution-focused approach is to be effective. Further, the adoption of a systems approach to ‘family issues’ needs to be balanced against meeting the needs both of individual families, and individuals within families. This is clearest when considering the provision of support to children and young people.

Addressing children’s issues

A traditional assumption made in western societies (and thus, in western family policies) is that children’s needs will be met as dependants within the family context, with adults mediating their needs (Makrinoti 1994). While this may broadly be a correct assumption, there will often be times when the needs of the individual child or young person will require a tailored response (e.g. child abuse trauma; bullying; post-family breakdown) (Tomison 1997).

A number of authors, such as Makrinoti (1994) and Mason and Steadman (1997), refer to the ideology of ‘familism’ and its relationship to the oppression of children. The term *familism* is used to describe the
ways by which policies targeting children are frequently subsumed under other policies (Mason & Steadman 1997). Childhood is fused with the institution of the family such that children and their needs cannot be defined independently of the family. Children, therefore, do not exist as a ‘distinct social entity’, but are conceptualised as family dependants (Makrinoti 1994).

The question is, can children’s needs be met via the provision of generalised support to parents or the family as a whole?

In the last decade a range of ‘child focused’ services have been identified (Tomison & Poole 2000), where the focus of the program is predominantly on children and young people without the involvement of, or with a minimal focus on, their families. Child-focused programs constituted 19 per cent (342) of the 1814 programs identified in the Australian Audit, and were comprised of:

- adolescent parent support programs (mainly for young mothers);
- respite and substitute care services for children and families requiring ‘time out’ or emergency assistance;
- generalist support and counselling programs for ‘at risk’ and maltreated children and young people;
- school-based health promotion and resiliency programs;
- services for young people at risk of homelessness; and/or
- programs run in sexual assault centres or women’s refuges for children who had ‘witnessed’ domestic violence.

It should be noted that many of these programs were not designed to replace or supplant family-focused programs – that is, in general they did not attempt to explicitly address children’s needs as part of a wider parent or family-focused support program. Rather, the programs aimed to provide a specialist support service and/or support for children and young people estranged from their family. The general standard of the evaluations that were completed for the programs precluded a reliable assessment of their effectiveness (Tomison & Poole 2000). Overall then, is a child-focused approach effective? Does the adoption of a focus on an individual family member (child focus) preclude a family-centred focus? What is the impact on the provision of family support?

Wise has reported on an independent assessment, undertaken with colleagues, of an attempt to emphasise children’s needs within family support programs. This was achieved via the trial implementation of the U.K. Children in Need approach (Department of Health (U.K.) 2000) within an Australian family support system. Designed for use by service providers in cases where statutory child protection intervention was not required, the Children in Need system comprises a conceptual framework and accompanying practice tools that assist family support staff to adopt a ‘systematic “child-in-family” practice focus’ (Wise 2003).

Using worker feedback and other data sources, it was reported that some workers felt that a systematic child focus within the context of ‘family support’ would undermine the family’s trust (because of its similarity to child protection risk assessment processes), and thus negatively impact on engagement and service provision. However, it was also acknowledged by workers that careful practice would probably reduce the potential for family disengagement. Overall, Wise concluded that ‘it still needs to be determined whether more deliberate and systematic attention to individual children’s needs within family services leads to better outcomes for children and their families’ (Wise 2003).

Yet it was apparent that workers judged the Children in Need approach to be a useful framework for providing family support tailored to the needs of children and parents. What appeared to be required to adequately test the approach was the provision of better training for workers in child and family assessments, and appropriate service resourcing that would permit smaller worker caseloads and enable workers to focus on the needs of children and families, rather than deal with parental needs in isolation.

Generic or tailored family support

As noted above, the issue of generic versus specialist programs is perhaps most evident when assessing the needs of particular Australian communities. While tailored, culturally-sensitive prevention programs may be required for Aboriginal and Torres Strait Islander or culturally and linguistically diverse communities, it appears that flexible, generalist prevention programs may provide a suitable means for catering to the needs of children and families where a disability or mental disorder is present (Tomison 1996a). For these families, it is the provision of adequate resources that enable services to be provided for as long as families require them,
rather than the development of specialist services to meet particular family needs, which appears to be the crux of service provision. Unfortunately, existing family support services appear to be unable to provide the services required on an indefinite basis, and rationing of services is a common result (Tomison 1996a; Scott 1998; Tomison & Poole 2000).

Financial flexibility – ‘wrap-around’ services
Restrictive funding practices, such as the traditional allocation of block funds for specific services and/or client groups, have been identified as impacting detrimentally on the ability to support what are often multi-problem families by constraining therapeutic action and reducing the effectiveness of cross-sectoral or interagency work (Coughlin 1984; Cocks 1993).

In recent years there has been a growth in the number of ‘wrap-around services’ that tailor an individualised support package to a family’s needs (Ainsworth 1999; Tomison, Burgell & Burgell 1998). Wrap-around services can be defined as services:

‘where the use of flexible funds allow service coordinators to wrap the services around children and their families, rather than forcing children into existing service programs’ (Karp 1996:299).

Under such an approach, funding is allocated on a per client basis, enabling workers to develop a case plan and purchase a range of services or practical supports for children and families that are tailored to meet their individual needs (Audit Commission 1994; Dollard et al. 1994; Karp 1996; Tomison, Burgell & Burgell 1998; Edgar 1999). It should be noted that given the flexibility and potentially multifaceted nature of the support package, intensive service coordination is an ‘essential ingredient to the success of individualized, wrap-around services’ (Karp 1996:300–301). Further, that most ‘wrap-around’ models are based on the adoption of solution-focused or strengths-based approaches to practice, where the client family is engaged in identifying needs and developing potential solutions (e.g. Dunst, Trivette & Deal 1988; De Jong & Miller 1995).

Adopting an holistic approach
In order to address the needs of what are often multi-problem, disadvantaged, dysfunctional families, effective family support requires the adoption of an holistic approach to assessment and service provision. It has been demonstrated that attempts focusing primarily on remediating a single family problem are often not as effective as approaches that utilise a multifaceted, holistic approach. Such programs target the influence of constellations of family factors and/or problems, often working in collaboration with other services (Tomison 1996b; Durlak 1998).

Further, despite being able to make observable improvements to wellbeing and resiliency, it is important to recognise that no one program or activity has been entirely successful in enabling children and young people to develop optimally when the larger child rearing environment is not a conducive one. For example, in discussing the success of Head Start and the Perry Preschool program, Zigler and Styfco note that:

‘thirty years of experience with early intervention have yielded a clear but unwelcome truth: such programs cannot overpower poverty in shaping a child’s developmental outcome … although children do better than they would have without the [preschool program experience] they still do not approach the achievements of middle-class students … Such findings lead to the sobering conclusion that early childhood intervention alone cannot transform lives’ (1996:152).

Nor can it be expected that any program, in isolation, can deliver a ‘once-off inoculation’ that ensures children’s healthy development (Brooks-Gunn 2003). To adequately prevent child maltreatment (or to effectively support families), it is important that a range of programs are instituted and coordinated under a comprehensive strategy. This strategy should be ‘comprehensive, child-centered, family-focused and neighborhood-based … [and one which takes ] … children seriously as individuals’ (U.S. Advisory Board on Child Abuse and Neglect 1993:16-17).

The 1994 U.K. Audit Commission report identified the development of regional or area ‘strategic children’s services plans’ as a key aspect of an effective family support system. Under this approach a range of coordinated, flexible, non-stigmatising services are developed that can make best use of limited resources. Edgar (1999) proposed the development of similar ‘family resource zones’ in Australia.

Child and Family Centres
At the service level, the adoption of an holistic, multidisciplinary approach is exemplified by the continued development and refinement of Child and Family Centres. Child and Family Centres, frequently
referred to as ‘one-stop shops’, are multi-service community centres that adopt an holistic approach to preventing child maltreatment and promoting healthy communities, providing support to families on a number of dimensions (Tomison & Wise 1999).

Similar programs, known as Family Resource Centers in the United States, or ‘multi-component community-based programs’ in Canada (Prilleltensky & Peirson 1999), have been operating for some time (Tomison & Wise 1999). Designed to be non-stigmatising and easily accessible, such ‘one-stop shops’ offer highly integrated services that promote child and family wellbeing rather than allowing family problems to develop to the extent that secondary or tertiary prevention becomes the focus of centre activity.

The intention is to engage children and families in the local community, to promote health and wellbeing, and to encourage families proactively to seek assistance in order to ameliorate a variety of family problems prior to the development of a crisis. While retaining the flexibility to cater for more traditional preventative strategies, the centres are ideally placed to take early intervention and health promotion approaches, underpinned by their holistic service philosophy. The centres are also well placed to facilitate a sense of community and the development of social support networks within neighbourhoods.

Involving the wider professional community – cross-sectoral partnerships

As noted above, a developmental prevention approach (the enhancement of protective factors in combination with a reduction in risks) (Tremblay & Craig 1995) has been adopted in order to prevent a variety of social ills. As part of a developmental preventative strategy, most sectors have adopted universal early intervention and health promotion approaches to prevent social ills, and many of these interventions and initiatives share the same underlying philosophy and constructs. It is becoming common for complex health and social issues to be managed by a number of professionals (Jones et al. 1987). Within the Australian child welfare and family support systems, a variety of government and non-government agencies and professions are involved with different aspects of support and treatment.

Taking into account the need to consider and address a variety of sector-specific issues, what is apparent is the current high degree of congruence between the prevention of the various forms of violence and/or social ills, in terms of the priorities and strategies for action that have been proposed and undertaken.

Thus, the prevention of a range of social ills and the promotion of health and wellbeing would appear to be facilitated by increased cross-sectoral collaboration and coordination from government, researchers and non-government agencies, from policy-level linkages down to the enhancement of relationships between sectors and agencies at the service provision level. As Durlak notes:

‘those working with prevention in different fields must realize that the convergence of their approaches in targeting common risk and protective factors means that the results of their programs are likely to overlap … We are just beginning to learn how this occurs. Categorical approaches to prevention that focus on single domains of functioning should be expanded to more comprehensive programs with multiple goals. Future prevention programs, therefore, will need to be more multidisciplinary and collaborative. Also needed are comprehensive process and outcome assessments of how risk and protective factors influence outcomes in multiple domains’ (Durlak 1998:518).

Child abuse and domestic violence

A clear example in the Australian Audit of Child Abuse Prevention Programs of the growth of holistic, cross-sectoral approaches, was the finding that the majority of the 1814 programs collected had attempted to address domestic violence, in combination with the various forms of child maltreatment (Tomison & Poole 2000). Two thirds of all programs were reported as being designed to address issues of both domestic violence and the various forms of child maltreatment.

A more detailed assessment of family support programs revealed that 72 per cent (106) of the 148 family support programs addressing the recurrence of violence (that is, tertiary prevention), addressed issues of violence holistically (i.e. child maltreatment and domestic violence). Further, one-third of these programs (35) were being run in women’s refuges/shelters and other adult crisis or assault services. Thus, agencies traditionally not occupying a central child abuse prevention role had developed strategies and programs to prevent not just exposure to domestic violence, but wider child maltreatment concerns.
A failure to recognise the potential for cross-sectoral impact

A first step to further the development of cross-sectoral work, however, is to ensure that service providers recognise the role (or potential role) they may play in preventing various social ills. Services need to be aware of the potential for them to collaborate with various sectors under a broad developmental prevention approach. In the Australian Audit, attempts were made to access those agencies or community groups not traditionally considered to be part of the child abuse prevention network, who might be involved in child abuse prevention work. Such groups included: child care services; neighbourhood community centres; community nursing services; drug and alcohol services; disability services; and migrant resource centres (Tomison & Poole 2000).

A substantial number of these agencies were identified as operating programs that appeared to be clearly aimed at (or had an impact on) the prevention of child abuse and neglect (for example, they ran a parent education program). Yet frequently, the agencies’ staff did not view their work as child abuse prevention. This finding appeared mainly to be a reflection of services’ differing priorities and/or the adoption of a primary focus on other social ills or populations based on block funding agreements (for example, substance abuse prevention or general health surveillance). It appeared that the prevention of child abuse was a secondary objective of the programs, or an accidental or unforeseen benefit that went relatively unrecognised by some service staff.

The failure to articulate or acknowledge child abuse prevention as an aim within services, particularly in urban areas where service networks are more dissipated, is likely to impact on the extent to which services access interagency support, receive feedback on the value and relevance of their work, and contribute to the development of the child abuse prevention field as a whole. Further, the reduction of any sense of shared purpose between agencies in a local network will reduce opportunities to disseminate information both within and between agencies and the potential for collaborative and/or cross-sectoral work (Tomison & Poole 2000).

Thus, one option to facilitate the development of cross-sectoral work would appear to be assessing the extent to which child abuse prevention is formally (and informally) acknowledged as an objective of various services across the health, welfare, education and criminal justice sectors, and then identifying mechanisms to ensure that the potential for child abuse prevention is acknowledged, and the opportunities for interagency networking and information sharing are enhanced.

Overall, despite the greater recognition of cross-sectoral issues and the benefits of collaborative approaches, the potential benefits offered by involvement in interagency and, particularly, cross-sectoral collaborative partnerships still remain relatively untapped. Interagency (and interprofessional) coordination and communication have been well-documented as having the potential to enhance or undermine both child protection and family support work. The importance of interagency coordination is discussed in detail in the next section (see Developments in Child Protection Practice).

What then are the key issues that will drive the provision of family support in the next decades?

Future directions in family support

First, given the growing focus on evidence-based practice, greater investment in research should lead to an expansion of current knowledge of the social and economic benefits of a range of early intervention, prevention and family support services. Hopefully, this will provide a more accurate picture of the sorts of interventions and models of service provision that can produce the greatest social benefits and best meet the needs of Australian families (see Evidence-based practice below).

Second, there is a clear need for the continued development of multifaceted, comprehensive strategies designed to enhance the health and wellbeing of Australian families and communities. Early intervention approaches have demonstrated that they are a cost-effective means of supporting families and improving health and wellbeing. While such programs are clearly an important part of any strategy, they are not a panacea. No one initiative, in isolation or at only point in time, can be expected to support families adequately.

Such strategies will need to include the means to ensure strong coordinated cross-sectoral planning and service provision. The development of regional or area children’s services plans, as proposed in the U.K. Audit Commission report (1994), is one model worth exploring further. Further, despite the inherent difficulties in achieving effective coordination with complex service structures, there is a need to continue the shift towards greater professional
interagency coordination and collaboration (see detailed discussion below).

Third, given the likelihood of a continuation of the current trend towards flexible service provision and the development of individualised support packages for children and their families, service provision is also likely to be characterised by a greater emphasis on ensuring access to services, especially by those families most in need. It is to be hoped that any service expansion will include the provision of long-term monitoring and tailored support packages for families, particularly those with ongoing ‘chronic’ problems, such as a disability or chronic neglect. This is a serious gap in the existing family support system (Tomison 1999).

Fourth, a greater emphasis on community capacity-building, health promotion and efforts to develop resiliency should be monitored to ensure that they do not detrimentally affect efforts to reduce risk factors and to prevent social problems. The adoption of a developmental prevention approach, where the aim is to reduce risk and to promote protective factors (Tremblay & Craig 1995) would appear to offer the best way forward. A focus on resiliency without a continued focus on reducing risk factors is, in effect, only a partial solution. Effective family support requires a truly holistic approach where risk and resiliency continue to be acknowledged as interrelated, and solutions are developed to address the former and to promote the latter.

Fifth, as noted above, traditional forms of support provided by extended family and/or friends and neighbours have been decreasing (Garbarino 1995; Bittman & Pixley 2000). People’s networks of social support have shrunk considerably, with more and more people reporting that there is ‘no-one’ to whom they can turn for support in an emergency (Garbarino 1995). As further information becomes available as to the benefits (and limitations) of community participation, it will be important to maintain a balance between community and professional supports. That is, efforts to enhance children’s and families’ engagement and involvement with their wider communities, should occur together with the continued resourcing of the service sector. It is important that families who require more than informal community-based support are able to access appropriate professional assistance.

Balancing child protection and family support

Finally, perhaps the issue in the provision of family support in the twenty-first century is the effective integration of statutory child protection services within the wider family support system. The introduction of the ‘family support’ approach to child protection in Australia has enabled some child protection services to successfully re-focus their resources towards dealing with the more severe cases of child abuse and neglect (e.g. Parton & Mathews 2001). Further, the importance of working in partnership with an effective, better-resourced, non-statutory family support system has been recognised, and the services have been reintegrated more firmly into the wider family support system. However, it is apparent that at this stage the legalistic approach (forensic investigation) still continues to hold primacy in dealing with child maltreatment cases.

With a continued focus on prevention and family support (and if greater resourcing of family support services can demonstrate therapeutic ‘success’ and reduction in service demand), there is likely to be a continuation of the current de-emphasis on the government run statutory child protection response. The danger is that the critics of the ‘family support’ approach to child protection will be proved correct. That is, that the family support approach may lead to a failure to protect substantial numbers of children who are being maltreated through the adoption of a minimal intervention approach. Given that the historical pattern of change in child protection is for radical shifts driven by child abuse tragedies (e.g. Reder, Duncan & Gray 1993; Goddard 1996; Parton 1997), the danger is that the resultant policy change will swing the child protection pendulum too far. Child protection may go from a ‘family preservation’ approach to a strongly interventionist approach, thus beginning another cycle of extreme policy shifts.
DEVELOPMENTS IN CHILD PROTECTION PRACTICE

Rather than engage in a further round of dramatic policy shifts and the probable revisitation of historical approaches, it is to be hoped that policymakers will be able to withstand the fallout from any child abuse tragedies, and instead draw on the evidence base to inform a considered response. It is recommended that any change is of an incremental nature, designed to better balance and integrate child protection and wider child welfare and family support needs, rather than the sort of radical policy shift that has failed to work in the past.

One of the primary aims of the ‘family support’ approach to child protection described above was to re-balance the respective roles of statutory child protection services and family support services. Taken to its logical conclusion, the aim was to ensure that statutory intervention would no longer drive the child protection system, rather that it would be integrated as one important facet in an overall welfare or ‘needs’ assessment of the family (Dartington Social Research Unit 1995; Parton 1997). Thus, good practice and adequate child protection would emerge from adopting a wider perspective on child protection such that the underlying problems in a family that may put a child ‘at risk’, or have a detrimental effect on the child’s long-term welfare, would be addressed (Tomison 1996c). That is, it was recognised that merely conducting an investigation and applying the label ‘child abuse’ to a family would not do much to reduce the risk of further harm to children. The priority would be on supporting children and parents to reduce any risks to the child, and to keep ‘policing, surveillance and coercive interventions to a minimum’ (Parton 1997:3).

Clearly there has been a renewed focus on addressing family ills holistically, and to resource services to support children and families in order to prevent the development or recurrence of child abuse and neglect. With regard to statutory child protection services, child protection workers have been provided with a greater range of options to select from when responding to a report. These differentiated responses provide workers with more scope to tailor the assessment process to the perceived family needs and the level of risk to the child (Tomison 2002). Thus, a case that appears to be mainly about a need for general family support than the occurrence of actual child maltreatment, may receive a less intrusive assessment involving non-government family support agencies, while a serious child abuse concern continues to receive a more authoritarian response from child protection workers, at times in the company of police officers (Tomison 1996c; 2002).

The perceived cost-benefits

The benefits of these ‘new’ systems are that, in principle, families are not unduly stigmatised or traumatised by inappropriate or unnecessary investigations, and are therefore more likely to accept assistance. In addition, family problems can be comprehensively assessed and (in theory) appropriate services put in place to address them, thus preventing the development of maltreating behaviour, or reducing conditions detrimental to a child’s long-term development (Tomison 1996c).

Equally importantly, the models recognise the need for effective collaboration between child protection services and other family support agencies in order to more effectively assess family needs and to provide a response that can positively affect family wellbeing and ensure the protection of children from abuse and neglect. Such models, if appropriately resourced, enable family support services to regain prominence in preventing child maltreatment and the early detection of ‘at risk’ children, a role which many services were unable to perform substantially in the 1990s because of a lack of resources exacerbated by the high demands for services that accompanied the recession of the late-1980s and early-1990s (Tomison 1996c; Armytage, Boffa & Armitage 1998).

However, while the adoption of a ‘family support’ model of child protection can be beneficial for many children and families, it can also have potentially negative consequences. Some researchers and practitioners have raised concerns that the new
models may not adequately protect children (e.g. Tomison 1996c). Child protection departments were already being criticised by some for failing to intervene in cases where children were at risk of harm (Tomison 1996c), with the perceived failure to intervene being exacerbated by the impact of a substantial increase in the number of reports. The fear was that the child protection pendulum had already swung too far towards the preservation of families. Thus, the danger of adopting a family support approach would be that this may encourage a stronger shift to ‘family preservation’ and addressing the families’ needs as a whole, while further compromising the safety of children.

Further, if inadequate resources are put in place to enable agencies to cope with the demand for services which results from such an approach, then families, particularly families labelled as being ‘at risk’, or as having a generic welfare or family support concern, are no more likely to receive support or remediation of their problems than they would under the current ‘forensic investigation’ models of child protection (Tomison 1996c). That is, case screening and risk assessment may more effectively target protective investigations and legal intervention to those families where children are ‘at risk’ or are being maltreated. But without the resources to treat and support these families and those screened out with more generic family problems, nothing may be done to alleviate the concerns which led to a notification in the first place. This issue will be discussed in more detail below.

In addition, the interprofessional and interagency communication and coordination problems that have beset child protection systems since the modern discovery of child abuse in the 1960s (Kempe et al. 1962), may be exacerbated by a ‘family support’ model. With child protection services reducing their role as primary or coordinating agencies, family support services will have greater responsibility for case coordination (see below for a further discussion of interagency issues).

It is therefore of paramount importance that adequate means are put in place to ensure the adequate resourcing of the family support system and the development of a structure to enhance comprehensive interprofessional involvement in caseplan discussions. If not, it is likely that history will repeat itself, with cases slipping through cracks in the system or families being inadequately serviced (Tomison 1996c).

**Key Components of Child Protection Service Delivery**

In the following sections a number of inter-related key components of child protection systems that have developed (or been re-visited) over the past few years are discussed, with particular reference to their operationalisation in Australian child protection systems. These key components are: central intake systems, differentiated response models and risk assessment and interagency coordination and collaboration.

**Central Intake Systems**

One means of reducing variability in child protection decision making, particularly at intake, has been the adoption of a central intake service designed as the sole point of access for the receipt of reports of suspected child abuse and neglect. The intention is for a team of highly trained workers to make all intake decisions for a particular child protection service (in Australia, the teams usually operate an intake service for an entire State or Territory). That is, to elicit preliminary information from the notifier or reporter, to make a judgement as to whether or not the case is to be accepted for further investigation, and to then refer the case to a regional office of the State child protection team for action. Such services have been developed in order to reduce inter-regional, inter-office or inter-worker differences in decision making, and to ensure that local issues (such as resourcing) do not impact on the threshold for accepting a case. Thus, central intake services provide a means of standardising service response and increasing accountability.

Two such services that have been introduced into Australian child protection systems are described, although to date very little has been written about the development, operation and effectiveness of the services.

**South Australia**

In 1997, South Australia, through its Department for Family and Community Services, (now known as Family and Youth Services, Department of Human Services), was one of the first Australian states to develop a ‘new’ child protection system. This new approach incorporated most of the key service elements currently identified in Australian child protection systems: a central intake system, the use of structured risk assessment measures, a differential response system, and an attempt to
enhance interagency cooperation (Department for Family and Community Services 1997).

As part of the reform a central telephone intake team (CIT) of skilled and experienced social workers was established in April 1997 so that all child abuse and neglect reports from across the state would be received on a single 24-hour child abuse report telephone line. [A central Aboriginal consultation and response team – Yaitya Tirramangkotti – was also established at the same time.] Using a single 24-hour child protection phone number, the CIT was implemented partly as a means of providing easy access for notifiers, especially children and young persons. Team members utilise safety assessment and initial risk assessment instruments to ensure consistency and accountability of assessments.

**Initial evaluation**

An initial evaluation of the child protection reforms identified a number of benefits, some of which appeared to be associated, at least in part, with the introduction of the central intake team (Heatherington 1998a). First, the average rate of increase in notifications (reports), was more than twice that of the prior three years (18 per cent c/f. 8 per cent). During consultations and implementation of the central intake system, some concerns were expressed that notifiers from country and remote areas might be reluctant to phone a central telephone line in Adelaide and might prefer to use their local networks. In reality, the opposite appeared to occur (Heatherington 1998a), with the increase in notifications in country areas increasing from 5 per cent to 22 per cent.

‘In the most remote districts (more than 750 kilometres from Adelaide) the increase in notifications in the year post-CIT has been 30 per cent. Possible explanations for this significant increase in reporting from country districts include the introduction of a free call system, and the greater anonymity provided to notifiers by a central abuse report line’ (Heatherington 1998a:8).

Second, another objective of the CIT was to reduce some of the significant variation between district centres with regard to the proportion of cases they screened in and out (that is, to reduce variation in the threshold for action across the state).

‘In the twelve-month period prior to reform, the average screening-out rate was 30 per cent. However, five of the nineteen district centres in South Australia screened out less than 20 per cent of notifications whereas three screened out more than 40 per cent. Significantly, there appeared to be an association between work pressure in district centres and their screening-out practices, with the busier district centres tending to screen out the highest proportion of cases and those with the least work pressure screening out the least’ (Heatherington 1998a:8).

In the twelve months following the introduction of the central intake system, there were four observable changes to case screening practice:

- a slight increase in the overall screening-out rate (from 30 per cent to 32 per cent);
- the range of screening-out rates was significantly reduced;
- the screening-out rate no longer correlated with workload pressure. The two district centres identified at either end of the workload spectrum had, since reform, produced screening out rates of 27 per cent and 29 per cent – close to the state average (32 per cent) (Heatherington 1998a).

The introduction of the CIT, when combined with a three-tier differentiated response system, also appeared to enhance the Department’s ability to target ‘scarce investigative resources towards the most dangerous cases’ (Heatherington 1998a), increasing the number of direct, face-to-face investigations undertaken with tier 1 (‘children in danger’ – most urgent) and tier 2 cases (children at risk), and lessening the involvement with tier 3 cases (children in need – minimal protective concerns).

Unfortunately, no other evaluations have been undertaken (or have been released publicly), so firm conclusions about the effectiveness of the CIT cannot be drawn. It does appear however, that the Department has no plans to phase out the Central Intake Team, indicating a degree of satisfaction with the service.

**New South Wales**

Approximately two years ago, the NSW Department of Community Services (DoCS) introduced a major reform of child protection. Together with the introduction of new legislation (with wider definitions

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3 It should not be assumed that the use of the CIT was the only reason for the increase in notifications; service reform does not operate in a vacuum and is influenced by community education campaigns, increased public awareness of child abuse etc.
of what constitutes child maltreatment) and the use of risk assessment guides, DoCS introduced a central intake service. Like the South Australian CIT, a central telephone intake team of skilled and experienced social workers was established, with all child abuse and neglect reports from across the state being received on a single 24-hour child abuse report telephone line.

Although there has been no formal, published evaluation of the service, there is substantial anecdotal evidence about the initial impact of the introduction of the central intake service (and other child protection service reforms) from media reports (Videnieks 2002), a variety of professionals who regularly report suspected child maltreatment, and from DoCS itself. First, the then Director-General (DoCS) reported a 30 per cent increase in the number of reports received by DoCS in the first 12 months of the operation of the central intake service (there had been an expectation of a 15 per cent rise) (Niland 2002). Overall, DoCS received 107,000 calls in 2001, of which 52,000 were designated as ‘not about child abuse’ (Niland, quoted in Videnieks 2002). The remaining 55,000 cases were ‘investigated’ (although this may not have involved face-to-face contact with the child or family), with 10,000 cases being substantiated.

Noting that there had been some initial accessibility problems (caused by high demand and a limited number of staff), Niland (2002) reported that the service had achieved a level of performance such that call waiting times were now able to be kept to a minimum. This had been made possible by the recruitment of 180 additional CIT staff which was expected to ensure that the unit could then cope with the greater-than-expected service demand. In contrast, anecdotal evidence collected from a number of service providers (police, medical personnel, key non-government family support agencies) over the next six months generally indicated that access to the CIT remained difficult. Although acknowledging that there had been an improvement in service delivery, a number of professionals consistently reported call waiting times of between 60-180 minutes when trying to make a report. Further, anecdotal evidence from professionals operating in rural and remote regions of New South Wales indicated that there had been a concomitant sizeable decrease in the number of cases being accepted by DoCS for investigation or action since the introduction of the child protection reform and CIT. That is, there has been a significant rise in the threshold for taking action.

Acknowledging that this assessment should be treated with caution, a key issue in the development and use of central intake services, or any mechanism that increases the number of reports (e.g. changes to legislation; the introduction or extension to mandatory reporting; community education campaigns) is the child protection system’s ability to cope with the increased demand. As noted above, what has been evident in the 1990s has been that significant increases in demand, combined with limited or inadequate resourcing of the child protection system, has frequently led to a child protection system unable to respond effectively to children and their families and a ‘forensic investigation’ response. Thus, adequate resourcing of both statutory and wider child welfare/family support systems is a vital consideration prior to introducing any new service system.

The drive for greater accountability and uniformity in intake processes needs to be considered in light of the service’s ability to deliver an effective service response. Consideration should be in terms of both the central intake response and the state’s child protection offices’ ability to deal with increased reports, particularly when arising from regions already having difficulty in responding to local child protection concerns. Overall, merely raising the threshold for taking action (investigative or statutory intervention) has not provided a useful answer for child protection services, other service providers or ‘at risk’ and maltreating families. A key theme underlying this report therefore, is the need to ensure that there are services able to provide family support, for both ‘at risk’ and maltreating families, and to anchor the tertiary prevention (child protection) response within a wider child abuse prevention strategy.

Differentiated intake response models

Another major service change across a number of Australian state/territory child protection services (allied at times, with the development of central intake services), has been the development of differentiated response models for child protection

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4 The rise has also been attributed to the widening of the definitions of child abuse and neglect in the new NSW Children and Young Persons (Care and Protection) Act and a widening of the mandatory reporting requirements for the state (Ainsworth 2002).
intake processes. The three main models presently operating in Australia are described.

South Australia

Between April and November 1997, the South Australian Department of Human Services introduced a three-tier response system to child protection notifications, differentiating between children in immediate danger (tier 1), children at risk (tier 2), and children primarily ‘in need’ where the risk of future abuse is low, but the family is identified as perhaps failing to cope with one or more social ills or ‘stressors’ (tier 3) (Department for Family and Community Services 1997; Heatherington 1998b).

Under this system the level of risk is determined by CIT staff using a ‘safety assessment’ risk assessment checklist. For ‘children in danger’ (tier 1) ‘an immediate response is arranged, usually in conjunction with specialised police and health units. Departmental standards and quality feedback measures ensure response times are kept to a minimum, and only skilled and experienced workers investigate tier 1 cases’ (Heatherington 1998b:8).

Tier 2 children are investigated along traditional departmental lines, that is one or two workers carry out a face-to-face investigation of the child and family situation. Written outcomes of the investigation are provided to all families investigated. However, families classified as a tier 3 case do not receive a visit from child protection staff. Rather, the initial response to these cases is to contact the family (usually in writing) and invite them to a meeting to discuss their situation with a social worker. The emphasis with tier 3 cases is on assisting families to find a solution to their problems rather than investigating a reported incident.

‘Departmental and family perceptions of the reported concerns are shared and community support sought where necessary’ (Heatherington 1998b:8-9).

The evaluation of the first six months of operation indicated that the central intake and differential response systems had together led to a ‘significant improvement in the proportion of immediate (that is, within 24 hours) responses made to children in danger (tier 1), from 60 per cent in February 1996 to 85 per cent in July-December 1997’ (Heatherington 1998b:9). Little evidence is available concerning the response able to be provided to those families classified as ‘in need’ (Tier 3). However, evidence of the effectiveness of a West Australian differentiated response system may shed some light as to the impact on families.

Western Australia

In 1995, Western Australia set up New Directions, a new differentiated model of case intake, where cases were classified as either a generic ‘child concern report’ (requiring a more generic, ‘problem solving’ approach) or as a ‘child maltreatment allegation’ (Tomison 1996c). Regardless of the ‘stream’ into which a report is initially assigned, the intention of the model is that all cases undergo a full risk and needs assessment and would then receive professional supports where necessary.

The process

Under the West Australian approach, an experienced child protection worker decides at the time of receipt of a report, whether a case requires a protective assessment by the child protection team, thereby being designated as a ‘child maltreatment allegation’ (CMA), or whether it can be managed as a ‘child concern report’ (CCR) and can therefore be referred to welfare services for an assessment and the provision of services. In this model, only severe incidents of maltreatment are initially referred to the child protection team: for example, where an illegal act has been committed; where there is evidence of severe or persistent harm; or where a significant history of child maltreatment in the family exists.

The majority of cases are expected to be assessed as CCR’s and dealt with by a generic social work team. The CCR has been designed as an interim category, one that describes the assessment process undertaken, after which a case is then finally reclassified as either:

- ‘no viable departmental role’;
- ‘requires some form of family support’;
- ‘substantially resolved’; or,
- as a CMA requiring child protection involvement.

Regardless to which stream a case is assigned however, appropriate services are meant to be provided to address the families’ needs.

Evaluation

In an assessment of New Directions, Parton and Mathews (2001) identified a number of changes they

5 In Tomison (1996c) the approach is referred to as a ‘case streaming’ model, although the WA Department of Community Development prefers to classify the system as one based on ‘differentiated response’.

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considered to be evidence of the positive impact of the new differentiated response system. Analysing the WA Department of Community Development’s child protection data, they reported that the total number of reports received by the Department post-implementation (CMA’s and CCR’s), approximated the total number of reports pre-implementation. This was taken as an indication that reporting practice had not been negatively affected by the new approach.

Further, Parton and Mathews reported that the differentiated response system had enabled a better targeting of those cases rated as more severe and/or as involving high risk (especially sexual and physical abuse cases). They concluded that *New Directions* had enabled the Department to prioritise its work and to more effectively focus resources on serious child maltreatment matters despite increasing demands for service and an environment of rapid change.

In Tomison (1996c), a warning was sounded regarding the introduction of differentiated response systems, and particularly ‘streaming’ approaches, such as the Western Australian model. It was predicted that unless appropriate resources were put in place to enable agencies to cope with the demand for services, that families, particularly families classified as CCR, would be no more likely to receive support or amelioration of their problems than they would under the traditional ‘forensic investigation’ models of child protection. Analyses by both Parton and Mathews (2001) and McCallum and Eades (2001) would seem to confirm this outcome.

The analyses indicate that the *New Directions* reform has increased the threshold for both taking investigative action and for the provision of support to children and families. This has occurred despite the potential for the CCR classification to ensure comprehensive assessment and service provision for ‘at risk’ families and ‘low level’ maltreatment, that is, to prevent maltreatment. While CCR cases were reported to be comprehensively assessed (Parton & Mathews 2001), it would appear that in a substantial number of CCR’s, therapeutic or practical supports are not being provided (Parton & Mathews 2001; McCallum & Eades 2001). Parton and Mathews noted the high proportion of CCR cases where no services were provided (despite original intentions) and the relatively high rate of CCR re-referrals (27 per cent). Thus, *New Directions* has not had its intended preventative effect, rather it has become merely a more effective way to target scarce resources to those most in need.

A related consequence of *New Directions* has been a substantial decrease in the number of official child maltreatment cases recorded, as many cases have been labelled as a generic concern (CCR) rather than as a child maltreatment allegation (CMA). The former are not perceived to be child maltreatment reports by the Department and are not formally counted as notifications. Overall then, with many cases no longer recorded as child maltreatment, and a failure to increase family support resources, there is a danger that the incidence of child abuse and neglect is reduced by definition rather than by a reduction in actual maltreatment. It could therefore be argued that such a system is a cosmetic reduction of concerns which, through inaction and the failure to provide adequate support, may contribute to the development of more serious problems in some families and/or the maltreatment of children in the long term (Tomison 1996c). As McCallum and Eades note:

‘there is danger in organisations seeking to make the numbers of notifications to which they must respond less, rather than working to reduce the incidence of child abuse and neglect: the former is a re-shuffling of the cases. The latter is effective intervention’ (2001:270).

**Victoria**

An alternative to the ‘case streaming’ differentiated system applied in Western Australia, is the Enhanced Client Outcomes (ECO) differentiated response system that has been implemented in Victoria by the Department of Human Services (DHS). The aims of ECO are:

- reaffirming the importance of risk assessment as the basis of decision making in child protection and the key to discriminating between different client needs, including high risk and urgency issues;
- providing access to a range of differential response options ensuring sensitive and flexible responses to the full range of presenting problems;
- promoting interagency relationships that ensure maximum knowledge of local resources and networks and use of advanced collaborative practice;
- building on the principles of child-centred family-focused practice to ensure that the principles of partnership, strengths, sensitivity and respect underpin all transactions with families and other professional service providers.
ECO practice incorporated the principles of:
- greater attention to developing practice skills and strengthening supportive structures to enable greater linkages and collaboration between statutory child protection and other service providers;
- the articulation and ongoing development of child-centred, family-focused practice principles and strategies for use by the protective worker in their work with children, young people and their families.

Put simply, ECO provides workers with an opportunity to use a graded scale of assessment and investigation, tailoring responses to identified concerns. Thus, families that appear to be suffering some form of generalised family dysfunction, rather than a child protection concern, are provided with a less intrusive professional response. This may involve family support agency workers making an assessment, rather than having two child protection workers conduct an unannounced home visit. In many ways ECO is a formalisation of practice as it was undertaken in the 1980s (at least in Victoria – Tomison 1999), recognising the expertise of other professionals and involving them collaboratively in case assessments and caseplanning, where appropriate.

**Solution focused or strengths-based practice**

At the centre of ECO is the principle of ‘child centred, family focused practice’ which affirms the primary importance of ensuring the safety and wellbeing of children; recognises the mutual significance of the child and family to each other; and, promotes the importance of service professionals developing a solution focused or strengths based partnership with client families (De Jong & Miller 1995; Tomison, Burgell & Burgell 1998).

A focus on the positive aspects of family functioning does not imply that family problems and/or the protection of the child are forgotten under ECO. The child-centred family-focused philosophy ensures that the protection and care of the child remain paramount, while maintaining a focus on building family members’ competence and self-esteem in order to tackle protective concerns and other family issues effectively.

**ECO practice options**

The type of investigative response options available to workers under the ECO approach is dependent upon the worker’s assessment of the level of risk to the child, the urgency of the required response, the wider assessment of family functioning and strengths and by establishing the type of intervention most likely to engage the family in addressing the child and family’s needs. Overall, workers can select from any of 19 different responses which are presented in Table 1.

These options can be categorised into three broad response types designed to ensure workers have sufficient flexibility to acknowledge and respond to the individual needs of children and their families. These are *forensic/protective responses* (the traditional unannounced visit by protection workers, with or without police); *protective/community responses* (a level of collaborative work with community professionals); and *community responses* (the provision of advice or consultation to notifiers). Within each category the range of possible options ensures the flexibility to vary the response if new information or changed circumstances alter the worker’s assessment of risk to the child.

<table>
<thead>
<tr>
<th>Table 1: The ECO differentiated response options</th>
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<tbody>
<tr>
<td>1 Notifier offered advice only. No follow up calls to third parties necessary</td>
</tr>
<tr>
<td>2 Notifier referred to another agency</td>
</tr>
<tr>
<td>3 Further follow up: phone calls to other agencies/relatives – case closed</td>
</tr>
<tr>
<td>4 Further follow up, with ongoing consultancy role for child protection services but no client contact</td>
</tr>
<tr>
<td>5 Professional intake case conference, family not present</td>
</tr>
<tr>
<td>6 Case conference involving family</td>
</tr>
<tr>
<td>7 Telephone contact with parents where no visit is anticipated as necessary</td>
</tr>
<tr>
<td>8 Arranged appointment with parent/s not at their home (usually at the office)</td>
</tr>
<tr>
<td>9 Arranged appointment with child/young person with parents prior knowledge</td>
</tr>
<tr>
<td>10 Arranged appointment with child/young person without parents knowledge</td>
</tr>
<tr>
<td>11 Arranged home visit to parents with other agency or relative or notifier</td>
</tr>
<tr>
<td>12 Arranged home visit to parent/s – one protective worker</td>
</tr>
<tr>
<td>13 Arranged home visit to parent/s – two protective workers</td>
</tr>
</tbody>
</table>
Evaluation

An unpublished evaluation of the pilot implementation of ECO in two Victorian regions produced evidence that the system could produce positive changes to the intake process for protective workers, non-government service providers and the families (Tomison, Wise and Murray 1998). It involved in-depth analysis of 200 child protection cases, focused primarily on the 12 month period prior to ECO and the 12 month ECO pilot implementation period; participant feedback, collected from a sample of child protection workers, other service providers and client families; and the presentation of two case studies which highlighted issues of case management and the effect of the ECO approach on practice. Overall, despite a lack of statistically significant differences, it was apparent that the ECO pilot implementation had produced:

- an increase in the proportion of cases directly investigated within seven days in the pilot regions;
- significant increases in child protection workers’ attempts to gather detailed background information on families as a means of informing their case management decision making;
- the use of the range of differentiated response options. Staff had clearly been tailoring their responses to the perceived demands of the notified cases, utilising a range of responses. That is, there was evidence that workers had been able to adapt to the differentiated responses and had reduced the number of traditional ‘forensic investigations’ in favour of other less intrusive assessments, where possible;
- a substantial increase in the involvement of other service providers in the various stages of case practice (by DHS staff).

Feedback also indicated that the ECO approach was well received by both child protection workers and other service providers alike and effective implementation was reported to have resulted in some obvious practice benefits. When workers were familiar with ECO, there was good overlap between service provider and DHS reports of what constituted a well-handled and not well-handled case, and much commonality in delineating the principles of effective practice. Cases that responded well to the ECO approach had the following features:

- there were positive outcomes for child and family;
- the principles of child-centred family-focused work were adhered to;
- the cases were characterised by good inter-agency collaboration; and
- working partnerships between child protection services, the families and service providers were established.

Child protection workers reported that working in partnership with community professionals improved outcomes for clients, and resulted in a better managed case at all levels of investigation (including interviewing, case closure and decision making).

Conversely, child protection staff and the service providers reported that ECO was more difficult to implement when:

- families did not acknowledge protective concerns;
- families were resistant to working with child protection services;
- families did not accept services;
- families were ‘dishonest’;
- services were unavailable; and/or
- there were worker safety concerns.

However, these issues are equally applicable to child protection practice as a whole. While work should continue to reduce their impact, they were not a result of, nor necessarily caused by, the implementation of the ECO framework. It was apparent that significant changes to child protection practice and to workers’ ‘ways of seeing’ had taken place since the implementation of ECO. The challenge appeared to be one of strengthening the adoption and utilisation of the ECO approach by workers, rather than making further substantial changes to child protection practice.

Client feedback

Feedback from a small sample of client families also indicated that DHS had been quite successful in adopting the tenets of child centred family focused work and a strengths-based approach to practice
The Department subsequently undertook a more comprehensive project to gather clients' perceptions of child protection services (see Gilees, Bakos, Thomas & Moran 2001), with the intention of measuring satisfaction on an ongoing basis. Again, suggestions for improvement related to the further strengthening of workers' use of the new practice approaches and to enhance their adoption into everyday work.

It was also clear from participant feedback and case studies, that the limitations of the statutory child protection role would, at times, challenge the extent to which partnership-based practice could be achieved. Some cases, particularly those that involve significant risk of harm to the child or uncooperative caregivers, may by their nature, limit the extent to which such practice may be implemented. Such cases may require the use of statutory authority to ensure the protection and care of a child. It is therefore important that workers maintain a child centred focus, and that the promotion of family focused work takes place in a manner that does not jeopardise child (or worker) safety.

Finally, the evaluators made specific reference to the need for adequate resourcing of the larger child welfare/family support system if the practice benefits of ECO were to be truly recognised, and the need to ensure effective interagency communication and collaboration. That is, to work effectively with 'at risk' families, or those where the maltreatment is relatively 'mild', requires the availability and appropriate resourcing of coordinated support services.

In addition, it was recommended that DHS regularly monitor and review ECO practice to ensure that the use of the differentiated responses and the adoption of child-centred family-focused practice did not result, in some cases, in a minimisation of the intervention required in particular cases and as a result a minimisation of the abusive concerns. It was believed that it would only be via the regular reinforcement of ECO practice that the framework would be fully utilised, and the results for the service system and families realised.

Unfortunately, the Department’s statistical analysis of child protection data does not include an assessment of some of the outcomes ECO was specifically designed to produce. It is not possible to easily determine the nature of workers’ first contact with families (e.g. proportion of unannounced home visits); workers’ referral patterns and other interagency contact associated with cases; or elements of child centred family focused practice (e.g. proportion of families given the opportunity to invite a support person to their interview) (DHS, personal communication, 2003). Without such data it is difficult to determine whether the benefits identified in the pilot evaluation have continued, and become more or less pronounced.

The ECO system was implemented statewide in 1999, along with the new Victorian Risk Framework (see discussion below). Officially, ECO is still in place in 2003, although the 'ECO' terminology appears to have dissipated somewhat, now that the various practice elements have been operationalised in child protection practice in Victoria (DHS, personal communication, 2003). Certainly, many of the key aspects of the approach, (which could be described as ‘core competencies’) have continued to be central aspects of child protection practice. That is, workers still employ the differentiated responses to child abuse reports; there is an ongoing commitment to enhancing interagency collaboration and to child centred family focused practice; the integration of better risk assessment practices with the wider assessment of family functioning and strengths; and the adoption of a solution focused approach to working with families. The Department continues with a process of service change and refinement, as there is some recognition that the desire to reduce child abuse notifications, re-notifications to the Department, and to further enhance interagency work are significant issues that ECO-like practice changes can affect, but will not, in isolation, resolve.

In summary

Although the benefits to be gained will vary depending upon the approach utilised, the introduction of a central intake service and/or a differentiated response system do seem to provide some benefits to agencies in terms of resource targeting and prioritisation of more severe concerns. Perhaps more importantly with regard to differentiated response models, there is some evidence indicating that they can provide more scope for professional judgement at intake, by allowing workers to tailor a response to the given situation. Combined with the use of a solution-focused approach, a differentiated response system can offer a means of ensuring that all cases are responded to in a manner more likely to lead to client engagement, enhanced interagency collaboration and information sharing. Further, by explicitly working with an

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6 The Department subsequently undertook a more comprehensive project to gather clients' perceptions of child protection services (see Gileeson, Bakos, Thomas & Moran 2001), with the intention of measuring satisfaction on an ongoing basis.
adequately resourced, wider child welfare/family support system to ensure adequate assessment and supports are provided for ‘at risk’ and maltreating families, such approaches appear to offer the potential for a reduction in the level of risk in the short and longer term.

The key issue affecting the benefits that may result appears to be the underlying purpose driving such reform. Clearly, central intake and a differentiated response system may be used to better target scarce resources and to prioritise work with the most severe maltreatment concerns. If the aim is to also ensure a better response for families, then there is a need for adequate investment in the resources available to support families. Otherwise, the approach merely improves investigatory processes with limited impact on client families.

**RISK ASSESSMENT**

Some form of risk assessment guide, measure or tool, is now widely used as part of the child protection intake process in Australia, as is perhaps evident from the descriptions of the central intake and differentiated response models provided above. Along with a desire to enhance worker decision making, the need for greater accountability and a more targeted response for limited child protection resources, have clearly helped to drive the introduction of risk assessment measures. In this section the pros and cons of using such tools, commonly known as structured risk assessment measures, are discussed, and recommendations made for their use.

The investigation of the decision making of the various professionals who deal with child maltreatment cases has a history almost as long as the re-discovery of child abuse by Kempe and his colleagues (e.g. Delsordo 1963; Boehm 1964; Elmer 1966). Researchers investigating child protection decision making have usually utilised one of two alternative methods, traditionally referred to as the *statistical* and *clinical* approaches (Wiggins 1981; Ruscio 1998). The *statistical approach* commonly consists of controlled experimental and quasi-experimental studies that result in the development of a statistical decision model which identifies the factors which account for the variance (or a proportion of the variance) in making a particular decision.

It is argued that a statistical decision model provides greater accuracy (i.e. a better ‘hit rate’) and less judgement errors (i.e. ‘false positives’ and ‘false negatives’). It is not claimed that all decision errors are able to be eliminated by statistical modelling of decisions, rather that the ‘levels of accuracy are higher than we could achieve if we did not possess the risk assessment tool in question’ (Johnson 1996:14). Such experimental, logical positivist, decision modelling studies were initially used to determine the factors which influence decisions. In the 1980s and 1990s, most modelling studies have been designed to construct structured risk assessment scales designed to predict case outcomes for use in child protection practice.

In contrast, the *clinical approach*, is associated with a desire to develop causal explanations for decision making, involving ‘nothing more than a human judge evaluating available information and arriving at a decision.’ (Ruscio 1998:145). The clinical approach generally utilises qualitative-descriptive methods of data collection to describe the decision making process, such as: self-report measures; behavioural observational techniques; case tracking; and the content analysis of case records. Such methods are ecologically valid and their flexibility enables their application to a variety of research questions. However, the generalisability of their results and their ability to empirically test cause and effect relationships are hampered by their lack of experimental control (Ruscio 1998).

In an excellent conceptualisation of the realities of human decision making, Dalgleish (1997) notes that the relationships between the indicators or factors, the worker’s judgement and the actual reality of the family situation is ‘inherently probabilistic’. He argues that statistical models focus on the ecological environment (to an extent – mainly as it relates to case factors) and the reality of a family’s situation, while clinical judgement studies focus on the factors and influences affecting the decision maker, in this case, the child protection professional. The ‘irreducible uncertainty’ present in both actuarial and clinical models leads inevitably to some degree of error.

**Structured risk assessment**

The assessment of risk is intrinsic to the child protection role, beginning with Kempe et al.’s (1962) paper, which discussed the decision to return an abused child to her/his family and the inherent risks involved.

‘The physician should not be satisfied to return the child to an environment where even a

Kempe and his colleagues also anticipated a time when a: ‘better understanding of the mechanisms involved in the release of aggressive impulses [would] give us a better ability to predict the likelihood of further attack in the future’ (Kempe et al. 1962:20).

In the early 1980s research utilising statistical approaches to child abuse decision making began to shift focus away from the identification of the factors influencing decisions, to develop ‘risk assessment’ models which would enable the prediction of future risk to children (Jones 1996). In the 1990s risk assessment became the primary area for decision making research.

Risk assessment can be defined as ‘the systematic collection of information to determine the degree to which a child is likely to be abused or neglected in the future. [It also refers] … to an estimation of the likelihood that there will be an occurrence of child maltreatment in a case where maltreatment has not occurred’ (English & Pecora 1994:452).

Risk assessment has several objectives: to help child protection workers identify situations where children are at risk of maltreatment; to improve consistency in service delivery; and to help child protection services determine the appropriate priorities within their caseloads (Browne & Saqi 1988; English & Pecora 1994). The instruments which have resulted, known as structured risk assessment measures, organise information related to risk (Schene 1996). Specifically, they ‘comprise risk factors selected for assessment and forms designed to capture the procedures and calculations needed to determine risk’ (Saunders & Goddard 1998:16).

Developed at a time when economic rationalism was beginning to have a significant effect on resources while the demand for services was increasing, the introduction of structured risk assessment measures was due partly to the need for services to screen out inappropriate reports, or cases where the maltreatment was suitable for a community-based caseload without the involvement of child protection services (Wald & Woolverton 1990; Doueck English, DePanfilis & Moore 1993a; English & Pecora 1994; Parton 1996; Tomison & McGurk 1996; Saunders & Goddard 1998).

Another motivation was to improve the ability of workers to detect high risk cases prior to the child suffering some form of injury. Child death inquiries in Britain and Australia have identified errors in worker judgements, their relative inexperience, lack of knowledge of risk factors and ‘danger signals’, failures in interagency coordination and communication and a lack of ‘rigour’ and ‘consistency’ in the management of cases (Jones et al. 1987; Armytage & Reeves 1992; Howe 1992).

Similarly, in the United States child protection services had been criticised for ‘irrational decision-making, subjective and inconsistent investigations, ineffective interventions and inefficient resource allocation (Cicchinelli 1995; English 1996)’ (Saunders & Goddard 1998:21). Overall, child protection services have ‘sometimes failed to protect severely abused children and have also tended to become over-intrusive in low-risk families where inadequate parenting skills, inappropriate controls and failings rather than harmful intent are the key issues’ (Department of Family & Community Services [South Australia] 1997:8).

The adoption of structured risk assessment systems

Since 1987 at least 42 U.S. states have adopted some form of structured risk assessment system (English 1996). In most of those states, statutes governing child protection services have meant that risk assessment procedures are only allowed to be used after a child has already been defined as a substantiated case of child maltreatment (English & Pecora 1994). Risk assessment is generally used as a tool to determine the appropriate levels of service to provide to the child and family, based upon an assessment of severity of the maltreatment (English & Pecora 1994).

The speedy adoption of structured risk assessment measures by U.S. child protection services has been repeated in Australia. However, unlike in the U.S. where the use of risk measures has been somewhat restricted by legislation, some Australian state/territory child protection services have explicitly or implicitly developed screening and/or risk assessment tools for use at intake, as well as at later stages of the child protection case management process (Tomison 1996c; Department of Family & Community Services 1997; McPherson, Macnamara & Hemsworth 1997).
The efficacy and importance of structured risk assessment measures

When considering structured risk assessment systems in the context of the overall field of child protection decision making research, there are two important questions:

• Does structured risk assessment offer the means of enhancing professionals’ decision making in child protection cases?
• Is the decision making research focus on structured risk assessment systems misplaced?

When evaluating the utility of risk assessment tools, it is important to acknowledge that no decision model will be 100 per cent accurate (Dalgleish 1997), and that this has real life consequences. Hammond (1996) proposes that depending on which errors are present in a decision, that such ‘inevitable error’ will lead to ‘unavoidable injustice’ for the various stakeholders in the decision, that is, the child, the family, the worker, the worker’s team, the agency, the local community and society as a whole. ‘No matter what [system] threshold is set, someone is going to suffer injustice’ (Dalgleish 1997:10).

However, it has been generally recognised that the use of statistical or actuarial procedures to inform judgements is more accurate than the reliance on unassisted clinical judgment (Dawes et al. 1989), and that

‘a probabilistic relationship [which forms the basis of structured risk assessment measures] is more readily obtained and verified than a causal understanding, that historical truth is more accurate than narrative truth, and that the acceptance of a fixed amount of error leads to a minimal number of incorrect decisions’ (Ruscio 1998:145).

English and Pecora note that:

‘the necessity of managing high caseloads with limited resources makes it imperative that child protective service agencies develop methods to identify children who are most at risk of serious harm so that they can receive services first’ (1994:454).

In contrast, Schene (1996) contends that,

‘if we really wanted to primarily improve case decision making to advance the safety of the child and address family problems, would we have developed risk assessment as our tool?’ (1996:8).

Similarly, Wald and Woolverton caution that structured risk assessment measures should not be seen as a panacea for an ailing child protection system:

‘many agencies are adopting risk-assessment instruments in lieu of addressing fundamental problems in existing child protection systems, such as the excessive number of inexperienced or incompetent workers and the lack of adequate resources. In fact, the use of inadequately designed or researched instruments may result in poorer decisions, because workers will rely on mechanical rules and procedures instead of trying to develop greater clinical expertise’ (1990:484).

The perceived benefits

DePanfilis (1996), utilising the work of Cicchinelli (1990) and Hornby (1989), identified some of the potential benefits of risk assessment procedures. These included:

• good casework practice in operation;
• providing a base for the allocation and prioritisation of cases in risk-related groups;
• having case information readily available via the case record;
• broadening workers’ knowledge and investigation of relevant child maltreatment ‘risk’ factors; and,
• providing a basis for worker training and supervision.

In addition, because structured risk assessment measures are designed to promote consistency in worker decision making and subsequent service provision (English & Pecora 1994; Schene 1996), the instruments can reduce arbitrary case classification and management practices (Stone 1993).

Finally, risk assessment measures were developed at a time when the demand for services had increased as resource allocation remained constant or had decreased. In consequence not all children or families in need were able to be provided with the services they might require (Wald & Woolverton 1990; English & Pecora 1994; Parton 1996; Tomison & McGurk 1996; Saunders & Goddard 1998). Concomitantly, there was increasing demand for highly accountable service provision (Douceck et al. 1993a; Parton 1996). Risk assessment measures could provide ‘a pseudo-scientific, ostensibly rational basis for decision-making’ (Saunders & Goddard 1998:22).

The overall efficacy of structured risk assessment measures however, is reduced for a number of
reasons, leading Goddard et al. to conclude that overall, the
‘current conceptualisation of risk assessment at best appears to provide a crude heuristic strategy to focus the attention of workers to particular forms of information during the investigation process’ (Goddard et al. 1996:60).

**Definitional issues**

There is little unanimity in terms of defining fundamental terms in the field of child maltreatment (e.g. What is ‘maltreatment’? What is ‘risk’?), (Hutchison 1990; Zuravin 1991; Lyons, Doueck & Wodarski 1996). Being ‘at risk’ is not an objective state, but a complex, multidimensional concept that is both socially and professionally constructed and whose meaning has evolved over time (Freeman 1983; Douglas 1992; Parton 1996; Ryan 1996). It has evolved from a ‘neutral concept associated with the possibility of both positive and negative chance occurrences to a concept which threatens danger, which assumes an objectivity which legitimises its use in fields of mathematics and science, and which can be usefully applied forensically’ (Saunders & Goddard 1998:12).

There remains a clear need to develop a uniform means of quantifying the levels of risk and to establish clear parameters for the appropriate actions to be taken with each level of risk and type of maltreatment (Wald & Woolverton 1990).

**Methodological issues**

Bateson (1979) identifies one problem with the application of structured decision making systems to child protection case management. He argues that throughout history there has been a constant tension in the use of probability-based statistics to describe individual behaviour based on the behaviour of groups of individuals. Actuarial tools are derived from statistical generalisations believed to be predictive of the behaviour of a group of like individuals. In essence, it is invalid to argue that the risk to an individual child can be predicted from an analysis of variables drawn from aggregated data for groups of children with common characteristics:

‘there is a deep gulf between statements about an individual and statements about a class ... prediction from one to the other is always unsure’ (Bateson 1979:51).

Thus, in spite of some general similarities which may be evident between ‘at risk’ or maltreating families, such measures may be of limited utility in child protection work where the task is to predict the behaviour of particular parents and particular children with unique circumstances (Saunders & Goddard 1998).

Lyons et al. (1996) reviewed the published, empirical literature on 10 risk assessment models currently employed by various U.S. state child protection services, including the CARF system, the Illinois CANTS 17B and a Philadelphia derivative, the Alaska model, the Utah family assessment model, the Washington State Risk Assessment Model (WARM), the Child Wellbeing (CWBS) (Magura & Moses 1986), and the New York Child Protective Services Review Document (CPRSD). Two additional models, the Alameda County model and the Vermont model, were included in the analysis, despite their evaluations not having been completed by independent evaluators.

They focused their examination on the psychometric qualities of the risk measures, reliability and validity in particular, and the outcomes which resulted from the implementation of the risk models. Overall, despite many of the models appearing to have acceptable psychometric properties, such as internal consistency, inter-rater reliability and concurrent validity, the current level of predictive validity for the models:

‘would not allow for major dependence on them for case decision making . . . [although] the research on actuarial models, such as those used in Alaska, Alameda County and Vermont, is somewhat encouraging’ (Lyons et al. 1996:153).

Finally, Lyons et al. note that the evaluation research, published to date, on process evaluation or implementation research is ‘less than adequate’. The available evidence does, however, suggest that: risk assessment models are being imperfectly implemented; the measures are being completed after the assessment decisions have been made, merely as a means of documenting decisions, rather than as a guide to the decision making process itself; and finally, they are perceived by some workers as irrelevant to their work with both ‘at risk’ and maltreating families.

**Implementation of risk assessment tools**

Mandel, Lehman and Yuille (1995) contend that statistical models of decision making, such as
structured risk assessment systems, fail to take into account implementation issues; that is, the failure of agencies to train their workers to utilise risk factors identified by a particular statistical model, or to routinely collect data on the risk factors. Similarly, most evaluations of risk tools are outcome evaluations which fail to determine the extent to which a tool has been implemented in practice, that is, there is no process evaluation (Doueck et al. 1992). Adequate evaluation requires a focus on the degree to which a risk assessment model is being used as intended and the impact of the model on the case management process, including outcomes for families.

Failure to conduct both process and outcome evaluations may lead to what Scanlon and colleagues (Scanlon, Horst, Schmidt & Walker 1977; as cited in Doueck et al. 1992) called a Type III error – the evaluation of a program that has been inadequately implemented. Lyons et al. conclude that minimising ‘implementation problems may be as important for model development as concern about sensitivity and specificity currently is’ (1996:153).

Why are risk assessment models inadequately implemented, even under ‘unusually favourable’ conditions, such as was reported for the implementation of the CARF system? (Doueck et al. 1993b). A number of reasons have been proposed:

• there may be problems integrating the risk model into case management practice (Gleason 1984; Dalgleish 1997);
• the complicated nature of some models;
• the fact that workers have been shown to complete the measures after making their decisions, which in turn may lead the workers to perceive the measures as redundant7 (Sheets 1996); or,
• because of the perception by staff that the measures will increase their workload (Hornby & Wells 1989, as cited in Doueck et al. 1993b; English & Pecora 1994; Sheets 1996).

Dalgleish (1997) provides a concise summary of the major methodological issues surrounding and affecting the implementation and evaluation of risk assessment tools:

• conceptualisation and measurement of outcome
– there is no single set of outcomes in child protection; current actuarial measures utilise a variety of outcome measures in order to determine the weighting to be applied to various predictive factors. Hence, construct validity is currently less than optimal;  
• conceptualisation and measurement of judgement – risk is a complex concept interpreted and utilised in a variety of ways; such a concept is unlikely to be captured by a single numerical value;

One method of using a risk assessment tool is to develop a simple aggregate of risk factors – the more factors, the higher the level of risk. However, there are no clear cut-off points and factors may be intercorrelated, while others may be multiplicative for risk. Wald and Woolverton (1990) therefore conclude that this approach is ‘unjustified’.

• conceptualisation and measurement of the indicators – a specific, relevant set of indicators needs to be developed to address a particular judgement. For example, the indicators developed to inform the decision to substantiate a case will be different from those required when the decision is to remove a child from her/his family;
• representativeness of design for the estimation of weights – the weights applied to a set of indicators are optimal only for a particular outcome, a particular set of indicators and a particular sample; the weights will not generalise from the specific situation for which they are created;

As Doueck et al. concluded in their evaluation of the CARF system, generalisation ‘to other counties with a different mix of populations and different caseloads is particularly hazardous’ (1993b:465). Similarly, there is no reason to believe that the factors which predict the occurrence of child maltreatment will also predict re-abuse. McDonald and Marks (1991) noted that only half of the 88 variables commonly used to predict child maltreatment had been empirically validated, and that there is ‘virtually no research on the correlates of maltreatment recurrence for any type of maltreatment’ (Lyons et al. 1996:144).

• prospective and retrospective validation – at present some studies involve the determination of indicator weights by conducting retrospective analyses of case data, other researchers have developed prospective studies as a means of ascertaining their measure’s ability to accurately discriminate between cases (discriminant

7 Workers have been shown however, to incorporate the risk factors into their investigations and client assessments (Hornby & Wells 1989, as cited in Doueck et al. 1993; Sheets 1996).
validity). The multiple approaches further muddy attempts to compare and contrast measures, and to determine their effects on outcome.

Risk factors

Part of the appeal of risk assessment measures is that they are designed to ensure that workers give consideration to a wide range of factors in a relatively consistent manner (Corby 1996). However, the selection of risk factors is typically based on reported cases (Milner 1995) and retrospective research (e.g. archival analysis); such research is plagued by problems associated with the use of secondary data (Doueck et al. 1992; de Vaus 1995; Krysik 1997). If risk assessment is to have validity, ‘it is essential that risk factors are measured accurately’ (Wald & Woolverton 1990:490), yet it is clear that the level of accuracy required is not always forthcoming.

In addition, no checklist or model can include every possible risk factor; it is possible therefore, that a significant factor, or the significant factor for a specific case may be omitted (Saunders & Goddard 1998). Similarly, although specific factors, or the combination of a number of factors, may be important in a case, it is the interaction of factors, or ‘volatile combinations’ (Holder & Corey 1993), that may especially endanger a child. To date however, ‘nobody is able to point out which interaction of factors makes a difference’ (Wald & Woolverton 1990:495).

Finally, in addition to the various risk factors, operating in isolation or in combination, which may increase the likelihood or risk of maltreatment, unpredictable ‘triggering events’, often significant only to the maltreater (e.g. accidental breakage of crockery, a child returning home with muddy clothes), may determine a child’s safety (Pullan-Watkins & Durrant 1996).

Applying risk assessment in situ – ecological effects

A critical element frequently ignored when risk assessment is under discussion, is the effect of the decision environment on the use and implementation of the measures. Scott (1993) perceives the child protection field as operating in what has been termed by the organisational theorists Emery and Trist (1965), a ‘turbulent field’. Child protection by its very nature is ‘dominated by significant moral, emotional and socio-political turbulence’ (McPherson et al. 1997:27).

Under legislation, the aim of statutory child protection services is not merely to stop the re-abuse of children, policy dictates that the goal of intervention is to try to prevent maltreatment, while keeping families together, where possible (Wald & Woolverton 1990; Corby 1996). Thus, risk assessment, like any case management decision, is not carried out in a ‘scientific vacuum’, but within a ‘socio-legal environment which defines preferred courses of action’ (Corby 1996:23). However, because the State is ‘highly ambivalent about setting parameters for intervention into families, [the result is] fluctuating approaches and policy reversals’ (Corby 1996:14).

Thus, when a child is removed from the family, in most cases the objective is to work for child and family reunification. Risk tools must therefore be able to take account of the effect of particular treatment plans, for example, if a parent attends drug rehabilitation, what is the potential for re-abuse? The question then becomes: Under what circumstances is the risk of further maltreatment unlikely?

As Wald & Woolverton note, since

‘the availability of services, treatment, or monitoring will alter the risk posed by a given individual, a risk-assessment instrument is truly useful only if it identifies the likelihood of re-abuse given specific interventions’ (1990:491).

Statistical models fail to take into account the other systemic or organisational factors which may affect decision making, or to allow for workers’ individual differences in decision making. Even if it is assumed that risk can be objectified, individuals respond subjectively, and thus, differently to the same events (Brearley 1982). Studies of economic decision making support the view that risk taking is not fixed, but a dynamic process dependent on the context of choice and the extent of adversity (Waterhouse & Carnie 1992).

The model in Figure 1, developed from the author’s doctoral research, provides a more accurate picture of the realities of the influences on decision making. Based on an ecological framework, it takes into account the effects of systemic and professional-related factors, in interaction with aspects of the family system.

Worker effects

A potential benefit of risk assessment measures is their potential to homogenise different levels of practice expertise and qualifications and the
possibility of a reduction of the impact of worker idiosyncrasies or biases in decision making (Stone 1993). Jones and May contend that standardised procedures also ‘reduces the decision options of front-line workers, defines the boundaries of their work [and] minimises [their] discretion’ (1992:491).

Without good quality control and worker supervision, the system can be used to support potentially poor decisions (Doueck et al. 1993a). Workers, particularly the inexperienced, may be lulled into a false sense of security, believing they can reliably predict case outcomes by using risk assessment tools, and thus only focus on the checklist factors when making a case assessment (Reder, Duncan & Gray 1993). That is, such lists may constrain worker thinking, leading to a heuristical ‘check’ of the variables listed, rather than a comprehensive assessment of all case information and the worker’s own professional observations (Reder et al. 1993; Goddard 1996).

Even if it is assumed that all the significant factors for a particular case are included on the risk measure, the information still requires ordering and its significance must be recognised (Goddard 1996). As Sheets notes

‘caseworker judgment is not only a critical factor in interactive risk assessment but also in gathering the information needed to fill out the risk
instrument later ... [the] act of determining that [a] risk factor is present, or the degree to which it is present, is a sensitive assessment process involving “unstructured” but highly trained human judgment” (Sheets 1996:9).

Lyons et al. (1996), in their review of the published, empirical literature on ten risk assessment models currently in operation in various U.S. state child protection services, concluded that the results from the models’ implementations suggested that risk assessment actually demands ‘quality in education, training, and supervision, as well as vigilance on the part of administrators hoping to use it’ (Lyons et al. 1996:154). Thus, there is an obligation upon the test user to have adequate clinical and legal education before attempting to make a child abuse assessment (Monahan 1993).

Overall, there has been a concerted effort in recent times to focus much of the research investigating aspects of child protection decision making on statistical approaches, and specifically, the development and enhancement of structured risk assessment systems. It is apparent however, that there is currently insufficient information available to determine the efficacy of risk assessment tools for identifying children at risk of serious maltreatment (Wald & Woolverton 1990; Camasso & Jagannathan 1995; Lyons et al. 1996; Dalgleish 1997, Cleaver, Wattam, & Cawson 1998; Saunders & Goddard 1998).

While it is generally recognised that the use of statistical or actuarial procedures to inform clinical judgements is more accurate than the reliance on unassisted clinical judgment (Dawes et al. 1989), there has been very little actual evidence derived from the child welfare/child protection field on the extent to which statistical models offer improvements in consistency and accuracy beyond that of child protection workers’ clinical judgements. Thus, the argument that risk assessment tools (statistical models) should replace clinical judgement is a difficult one to make (Johnson 1996; Ruscio 1998). Given the limitations of applying risk measures to individual cases, workers’ professional judgement is needed to fill the gap (Saunders & Goddard 1998).

Many researchers and practitioners, although acknowledging the importance of assessing risk in child protection practice (Saunders & Goddard 1998), have therefore maintained an allegiance to clinical decision making research and the use of education and training to improve professionals’ child protection decision making rather than the use of structured decision making tools. This position is aptly summed up by Dr. Pat Cawson, Head of Child Protection Research for the NSPCC, when introducing the new NSPCC risk assessment package in the U.K. (Cleaver et al. 1998):

‘nothing can replace basic observation and attention to what children and parents say ... [however] the research also stresses the importance of agencies having adequate risk management policies and providing support to front line social workers who are dealing with complex, stressful and possibly dangerous situations’ (Cawson, personal communication 1998).

In spite of their limitations, however, the use of risk assessment systems is becoming more and more common in child protection services in the U.S., Australia and other western countries as governments and bureaucracies continue to see them as a solution when attempting to balance high caseloads, less resources and the need for service accountability (Browne & Saqi 1988; Wald & Woolverton 1990; Doueck et al. 1993a; English & Pecora 1994; Parton 1996; Tomison & McGurk 1996; Saunders & Goddard 1998). Concomitantly, workers’ clinical experience and intuition is increasingly being undermined (Saunders & Goddard 1998).

An alternative approach
Radical proponents of clinical approaches to risk assessment, that is, those who argue for a reliance on professional expertise (based on specialist training and experience), argue against the use of any checklist, or guide to risk assessment and child protection decision making. However, the realities of current child protection work are that few workers have received extensive post-qualifying training in child maltreatment and child protection research and theory. The studies that have been done suggest that workers do not rely on research and theory to make decisions.

In actuality, they appear to be suspicious of research and theory and ignore it (Preston-Shoot & Agass 1990), remain unaware of it (Stevenson 1992; Farmer & Owen 1995), or have few opportunities to acquire knowledge of it (Carew 1979; Preston-Shoot & Agass 1990; Fisher 1997). Thus, they lack the requisite information and a framework for the
organisation of such information. One approach to this issue, is to support practice experience (and the concomitant provision of supervision), with a guide to inform practice. Such guides are not meant to be used to make the decisions, but to highlight issues for consideration and to provide a framework for conceptualising and justifying a decision.

The United Kingdom experience

Although researchers in the United Kingdom have investigated various means of improving the prediction or assessment of the likelihood of future maltreatment (e.g. Greenland 1987; Browne & Saqi 1988), Britain has generally been more hesitant than either the United States or Australia in adopting structured risk assessment instruments. In 1988 the U.K. DoH introduced ‘guidelines of extraordinary detail’ (Howe 1992:501), known as the ‘Orange Book’, which was over 90 pages long and comprised of 167 questions. The Orange Book was developed to enhance the quality of assessments made by social workers and to assist in the identification and prediction of risk of future harm to a child (Howe 1992). However, the emphasis was on ensuring a thorough assessment was completed, rather than risk assessment per se.

In 1998 the NSPCC published *Assessing Risk in Child Protection* (Cleaver et al. 1998), a report of a research and development project commissioned by the DoH. The project was designed to feed results of research into risk assessment into social work practice, making it accessible to social workers, trainers and students (Cleaver et al. 1998). The resultant package includes a brief review of salient aspects of the research literature, a discussion of the findings which resulted from a study of workers’ perceptions of assessing risk (based on a series of interviews with workers), and an outline of the subsequent development and refinement of two ‘decision aids’. These were: a chart to assist with the recording of essential information at referral; and a data book to summarise some basic findings to assist with the identification of the full range of services required by the child(ren) and family. They were designed to:

‘meet the needs of less experienced workers, and to cover basic requirements, since both the research literature and the present fieldwork indicated considerable difficulties for less experienced staff in dealing with child protection and other child welfare inquiries’ (Cleaver et al. 1998:31).

Another aid, a ‘manual’ which could give specialist knowledge on topics such as parental mental illness, substance abuse, disabilities and domestic violence and their relationship to child maltreatment and child protection, was met with considerable enthusiasm, but was beyond the remit of the project (Cleaver et al. 1998).

The assumption underlying the research and the resultant package was that evidence-based practice, not the use of structured risk assessment measures, should form the basis of effective child protection and child welfare practice. Specifically, that structured risk assessment tools are no substitute for rigorous observation and assessment of the child and family, and the subsequent development of an action plan which can deal effectively with the child maltreatment concerns and other family issues which may increase the likelihood of maltreatment in the future.

Such an approach would appear to provide some of the uniformity and rigour of structured risk assessment measures, providing a useful guide to some of the salient factors (risk and protective) which may affect an assessment of risk, in conjunction with an overall clinical approach. Such a ‘collaborative path’ has been supported by Webster & Cox (1997), in a discussion of the use of risk assessment when making decisions as to the mental state or ‘dangerousness’ of particular individuals. They argue for a system where clinicians engage in practice supported by statistical evidence (e.g. risk assessment tools), where possible, but that statistical approaches are not seen as ‘almighty’ without reference to clinicians’ reality (‘the overgeneralization of research findings without due heed to case particulars is inappropriate and misleading’ [Stricker & Trierweiler 1995:997]).

‘Nomothetic material and ideographic material must be approximately balanced and alternated so as to avoid undue reliance on one kind or the other’ (Webster & Cox 1997: 1246).

Victorian Risk Framework

This reflects the view that structured assessment materials should be used as guides to practice, however they should not be limited to case-related factors only (see Cleaver et al. 1998). For example, a generic (across maltreatment types), matrix approach to risk assessment was introduced into Victorian statutory child protection services in 1997 in order to guide risk assessment (McPherson et al. 1997).
Further development led to the introduction of the Victorian Risk Framework (VRF) (Boffa & Armitage 1999; DHS 1999) -- a complex, generic (across maltreatment types) risk, safety and needs assessment guide. It was developed, in part, to provide a common conceptual framework to aid the assessment and decision making of various professionals who had some involvement in the management of cases of children at risk of child maltreatment throughout the intake phase of case practice. The hope was that this would minimise interagency threshold disputes and result in the creation of more ‘consistent decision making across workers and, with the same worker, across cases’ (McPherson et al. 1997:22).

Having implemented the VRF, anecdotal worker feedback indicated that the guide was perceived to be too complex and too comprehensive for effective use. In response, the Department worked towards reducing the number of risk factors identified in the guide – effectively reducing aspects of the framework to a smaller checklist of factors (Boffa 1999, personal communication). It is contended that this feedback may result more from general training deficiencies and some workers’ lack of child protection experience, than from problems with the guide. If anything, the VRF does not provide enough information on the realities of decision making for workers. Like many previous guides and tools, it does not attempt to raise workers’ awareness of many of the in situ (real life) factors that have been identified as affecting decision making, such as the agency’s threshold for action and resource availability (agency and systemic factors).

Overall, the development of a detailed guide, one that can supplement quality child protection training, may provide a positive outcome for child protection departments (consistency and accountability) and workers, while allowing for the complexity of child protection decision making. Such guides will be of limited utility in central intake services, given their role as service gatekeepers, where decisions are made on the basis of the information gleaned from the source of referral and a family’s prior history of child protection involvement.

It is important to note that the Department of Human Services also explored options for the training of police, sexual assault counsellors, and social workers from a variety of family support agencies in the use of the VRF framework. Further, as noted above, there was a trial implementation of the U.K. Children in Need approach (Department of Health (U.K.) 2000) within the Victorian family support system. Designed for use by service providers in cases where statutory child protection intervention was not required, one of the aims of using this more generic child and family assessment package was to enhance ‘shared understanding’ between agencies working with children and families. Trialing such approaches can be taken as further recognition of the importance of interagency and interprofessional coordination and collaboration.

**INTERAGENCY COORDINATION AND COLLABORATION**

Ensuring effective interagency and interprofessional coordination and collaboration9 has been a common theme and an ongoing, significant issue for the provision of both child protection and family support services for many years (e.g. Hallett & Birchall 1992; Morrison 1998). A coordinated response to the problem of child abuse and neglect can produce:

- more effective interventions;
- greater efficiency in the use of resources;
- improved service delivery by the avoidance of duplication and overlap between existing services;
- the minimisation of gaps or discontinuity of services;
- clarification of agency or professional roles and responsibilities in ‘frontier problems’ and demarcation disputes; and,
- the delivery of comprehensive services (Hallett & Birchall 1992; Morrison 1998).

Overall, the generally accepted objectives of a coordinated child protection response are to achieve: a comprehensive perspective in case assessment; comprehensive case plans or interventions; support and consultation for the workers involved in child protection; and the avoidance of duplication or gaps in service delivery (Hallett & Birchall 1992).

However, as Reid noted in 1969, interagency coordination is not a natural state of affairs and does not result merely from good intentions. While there would appear to be overall agreement that coordination in child protection (and family support) is a necessary and valuable practice, effective

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8 Victoria has not, however, ruled out the development of a structured risk tool in the future.

9 Interagency coordination can be defined as ‘different agencies working together at an organisational level’, while interprofessional collaboration is ‘committed individuals from different disciplines working together’ (Morrison 1998:6).
coordination is difficult to achieve (e.g. Jones et al. 1987; Morrison 1998). The desire for a coordinated response to child protection is often ‘asserted, rather than demonstrated, and [may be] taken to be self-evident’ (Hallett & Birchall 1992:18).

Conversely, service coordination problems, especially where many services are involved, have often been cited in the literature as leading to less than optimal case management (Jones et al. 1987; Hallett & Birchall 1992; Morrison 1998; Tomison 1999). There is the potential for children and families to miss out on services, or to become victims of duplicated services or incompatible treatments, potentially causing the child and family more distress (Hallett & Birchall 1992). Poor coordination and cooperation have also been mentioned as contributing factors in a number of child abuse death inquiries (e.g. Goddard & Hiller 1992; Reder, Duncan & Gray 1993).

Inaccurate information, the failure to receive relevant case information, interagency disputes and/or ignorance of the role of other professionals involved in a case’s management, all reduce the ability of professionals to make informed decisions when dealing with suspected or substantiated child maltreatment cases. For these reasons many social scientists have argued for a clearly structured ‘teamwork’ approach to child abuse case management (e.g. Jones et al. 1987; Tomison 1999), and stressed the importance of the participating services being coordinated by a designated key worker and/or agency.

The mechanisms of coordination

There is the potential for agencies to develop a large variety of inter-organisational (or interprofessional) links for the purpose of coordinated service delivery. These may range from low-key, unstructured, informal links between workers from different agencies, to the formalised interrelationships which may occur with agencies or professions in (and between) particular organisational networks, to highly formalised, centralised coordination structures (Challis et al. 1988; Hallett & Birchall 1992).

The formal structures or mechanisms that commonly facilitate interagency and interprofessional coordination are referral protocols, case conferencing, and the development of multidisciplinary teams. In Australia, formal referral protocols between statutory agencies, and mandatory reporting legislation (Goddard et al. 1996; Tomison 1999) are perhaps the primary formal means of communication in most states and territories. In addition, although not mandated as they are in the United Kingdom, case conferencing is also a significant means of interagency coordination and communication in Australia.

However, a number of authors have highlighted the important role that informal professional relationships and communication paths can play in combination with formal child protection structures (e.g. Challis et al. 1988; Morrison 1998; Tomison 1999). Although an over-reliance on informal communication methods and the circumventing of formal coordination and communication mechanisms may lead to the variety of interagency communication problems identified above, strong informal linkages operating in conjunction with more formal communication structures appear to lead to a more effective interagency network (Morrison 1998; Tomison 1999). Thus, ‘to be effective, interagency and interprofessional communication and collaboration should be based on formal structures, such as referral protocols, case conferencing procedures and the placement of substantiated cases onto a central register. The underlying formal structure can then be supplemented or enhanced by the development of informal links or ‘working relationships’ (Tomison 1999:353).

Interagency work in Australia

In the Australian Audit (Tomison & Poole 2000), service providers involved in approximately one-quarter (450) of the 1814 programs could be said to be working collaboratively or in partnership with another agency. These partnerships generally involved a generic family support agency working with another, more specialist agency (for example, a drug rehabilitation service). However, in general, the partnerships involved only limited liaison between the agencies in order to refer cases and/or to share knowledge as a means of enhancing their service’s response to particular groups of client families. Most of these arrangements did not appear to constitute cross-sectoral working arrangements.

For example, the providers of health education and a variety of universal, community development programs appeared to recognise and attempt to address a number of social ills and/or to promote general health and wellbeing. In general, these programs were not truly cross-sectoral in that they did not involve the pooling of shared resources or the
collaborative development of programs by services from a variety of sectors. Given that most prevention work has traditionally been done by agencies (or sectors) in isolation, focusing primarily on addressing one form of violence or social ill (Rayner 1994), the lack of a truly cross-sectoral response is perhaps not entirely surprising.

**Australian programs**

In order to create an environment that enhances cross-sectoral, interagency or multidisciplinary work, some Australian states and territories have adopted some form of joint investigation or formal multidisciplinary teams approach to assessment and case planning. Some of the more important interagency structures (with most having a basis in family support rather than purely forensic investigation) are described here.

**Suspected Child Abuse and Neglect (SCAN) Teams – Queensland**

SCAN teams were developed in 1980 via the then Queensland Coordinating Committee on Child Abuse, in order to provide a formal mechanism to coordinate the activities of various government departments’ responses to child maltreatment. They have been described as a ‘best practice’ model for the investigation, management, treatment and prevention of child abuse and neglect (Cameron, Roylance & Reilly 1999).

The statewide system of SCAN teams is designed to ensure an effective, coordinated, multidisciplinary response to notifications of suspected child maltreatment, particularly by the three government departments with statutory responsibility for child protection in Queensland (Department of Families; Queensland Police Service; Queensland Health), although a number of the teams have also permanently co-opted members from the education and mental health sectors.

SCAN teams are predominantly involved with the investigation and management phases of the child protection process, although they may be consulted about any aspect of child protection work. SCAN teams undertake to provide ‘an interagency forum for case discussion and planning to ensure:

- the safety of the child;
- that assistance is available to the family and child;
- that intervention is effective and coordinated’.

(Cameron, Roylance & Reilly 1999:8)

The teams also provide a forum for formulating recommendations for action, including the actions to be undertaken by the three statutory departments; and have a review role such that the effectiveness of the SCAN team recommendations made are assessed in terms of meeting the needs of the child and family (Cameron, Roylance & Reilly 1999). In 1996–97, SCAN teams discussed approximately half of all substantiated child maltreatment cases in Queensland (one in six of all notifications received) (Cameron, Roylance & Reilly 1999).

The SCAN teams do not, however, have a formal role in monitoring or sanctioning the actions of the statutory departments; rather, the focus is on case planning and case coordination. The team determines the best course of action for each case via consensus, but individual agencies retain the statutory and/or professional responsibility for their own actions. Each agency does, however, have an obligation to report back on the outcomes of the actions taken. Further, if an agency decides not to implement a team plan, they are expected to refer the matter back to the SCAN team for further deliberation (Cameron, Roylance & Reilly 1999).

Why is the model effective?

- the SCAN teams have a focus on the holistic management of cases, not just the investigation process;
- they ensure information is shared between agencies in an effective manner;
- they are a professional forum, allowing all participants to voice their concerns and to hear others’ perspectives;
- each member is informed of the views and plans of other members;
- each participant agency retains its statutory obligations and powers.

The teams also play a key role in identifying regional education and training needs, and initiating activities to meet those needs.

**Joint Investigation Response Teams (JIRT) – New South Wales**

Given the difficulties of coordinating interagency or interprofessional work for separate agencies and/or individual professionals, there have been some attempts to develop an integrated, co-located multidisciplinary team. Many such attempts have focused on the creation of a combined child protection/police team for child protection.
investigations – the aim being to have all relevant, reported cases jointly assessed at intake by a social worker and a police officer. Such schemes have been operating in a number of jurisdictions overseas (e.g. in Scotland, Bowman 1992) and is reported to work well (McCarthy 1995). One such teams approach is currently being run successfully in New South Wales – the Joint Investigation Response Teams (JIRT) (Cosier & Fitzgerald 1999).

Since an initial pilot project begun in 1994/95, the NSW Department of Community Services and the NSW Police Service have implemented a statewide network of JIRT teams. These multi-agency investigation teams made up of DoCS child protection workers and police officers are jointly responsible for the ‘investigation and management of serious child abuse notifications which might constitute a criminal offence’ (Cosier & Fitzgerald 1999:935), (generally physical and sexual abuse). JIRT teams are co-located in premises separate from both police and DoCS offices and adopt a child-focused philosophy. The teams are jointly managed by a senior child protection worker (DoCS Assistant Manager) and a police sergeant. Once a referral is received, a police officer and child protection worker are assigned to the case.

The core business of JIRT is the investigative interview10, where the child protection worker and police officer jointly interview the child (the primary interviewer role is determined by a number of factors, but typically it goes to the person who is best able to establish rapport with the child). Following the interview and other initial investigation tasks, the JIRT staff have a case debriefing with the Team Leaders. This session provides an opportunity for any differences of opinion to be raised and resolved, for Team Leaders to provide feedback and support to their staff, and for a plan of further action to be developed. If legal action is planned, the police member initiates criminal proceedings, and the DoCS worker handles any protective intervention through the Children’s Court. Following investigation however, the case is referred back to DoCS and/or the police service for follow-up.

The benefits which have resulted from such an approach include a reduction in the emotional trauma experienced by victims and the eliciting of higher quality case information, resulting in more effective investigations. This in turn has enhanced the decision making process and enabled a higher degree of quality in planned interventions and a large increase in the number of prosecutions carried out. There has also been a higher degree of satisfaction by child protection workers, the police members and other agencies as to the protective and criminal casework that has been carried out, which has led to better interagency cooperation and the active support of the unit in its investigations (Bowman 1992; Cosier & Fitzgerald 1999). As Cosier and Fitzgerald note:

‘we have found that one of the significant advantages of joint work is being able to utilise the most appropriate and optimal forms of intervention from either police or DoCS to provide protection or to ensure safety and wellbeing of the child. Police are able to apply for apprehended violence orders, lay charges and request bail conditions to protect a child and to remove an offender from the home is a major step forward ... In our experience the joint investigative process provides a timely, coordinated and comprehensive service for children and their families and produces significantly better outcomes’ (1999:946).

Cosier and Fitzgerald also highlight some of the issues that have needed to be resolved in order to ensure JIRT has been effective. The development of a ‘shared understanding’, that is, recognition and acceptance of other professional’s roles, duties and values has been vital. To ensure the units are effective, case decisions are always made jointly by police and DoCS staff. In addition, JIRT members are required to participate in joint training to ensure the development of the skills required for the team and to facilitate shared understanding. The units also have a conflict resolution policy in place to ensure interprofessional disputes are able to be resolved in an effective manner.

New South Wales area child protection committees

A number of attempts have been made in various Australian jurisdictions (with and without government mandate) to promote interagency coordination and collaboration via the development of interagency area committees operated via government agencies or non-government professional forums.

New South Wales currently has the strongest legislated interagency coordination mechanisms. For more than a decade the NSW Department of

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10 Prior to conducting the investigation both DoCS and Police databases are searched to elicit any previous history of statutory involvement.
Community Services, which has the statutory responsibility for child protection, has been required to consult at the highest levels with the Police, Education and Health Departments and peak family support and child welfare bodies when developing policies, contemplating changes to service delivery, in order to develop effective, coordinated cross-sectoral case practice (Tomison & Wise 1999).

In 1985, the government created the NSW Child Protection Council to coordinate the Government’s child protection response. In addition to leading (or being the vehicle for) much of the senior interdepartmental contact, the Council also had responsibility for the establishment of formal interagency guidelines (updated regularly) and for developing and supporting a series of regional interagency Area Child Protection Committees, which were set up across the state. The NSW Child Protection Council provided information, training and support to local agencies and professionals via the Area Committees. These Committees became a key mechanism for imparting knowledge and training, and for the identification of local issues or needs that the Council then attempted to respond to.

Through enactment of the Children and Young Persons (Care and Protection) Act 1998, the NSW Government legislated for strengthened interagency partnerships, developing a series of clauses specifying the mutual obligation of the government departments in responding to child abuse and neglect. The Act explicitly states that Health, Education, the Police Service and the non-government sector all share the responsibility for child protection and are expected to share some of the burden of responding to maltreating families.


Strengthening Families – Victoria

The Department of Human Services Victoria has created a service that provides another perspective on both case planning and case coordination for ‘at risk’ families and/or those where there are ‘minimal’ protective concerns. It highlights the coordinated ‘wrap-around’ service model, where a key worker or designated service acts as a case coordinator and service broker, supervising and purchasing supports for a multi-service case plan. As Karp notes:

‘the coordinator’s role is multifaceted: marshalling resources, developing a mutually agreed-upon interagency plan, ensuring coordination across agencies, and being ready when and if crises or problems arise’ (1996:300–301)

The Strengthening Families program, initially piloted as the ‘Brimbank Family Outreach Service’ (Tomison, Burgell & Burgell 1998), was designed to provide support and advice to ‘at risk’ families not currently identified as maltreating. The aim of the program was to prevent these families from becoming abusive or neglectful, and thus becoming clients of statutory child protection services. In order to achieve this, the Outreach Service team engaged with identified ‘at risk’ families. They would then provide case planning, service brokerage and interagency coordination functions for the client family within a defined network of local family support services.

That is, child protection services or other professionals would refer ‘at risk’ families to the Outreach Service team. Using strengths-based approaches, a worker would then approach the family and seek to engage them in developing solutions for their practical and/or therapeutic needs. Having developed a case plan, the worker would then purchase and coordinate service delivery by local agencies.

In an evaluation of the pilot program, Tomison, Burgell and Burgell (1998) found that the Outreach Team did appear to enhance professional attempts to engage with, and address, the needs of ‘at risk’ families. It was reported by a range of service providers that the service had generally enhanced interagency relationships. Specifically, the Team had improved case record keeping and information sharing between agencies, while reducing service duplication and the number of inappropriate reports received by local child protection agencies. Further, the staff were able to develop and provide effective support for these client families, decreasing the probability of the families becoming abusive (at least
in the short term) and entering the statutory child protection system. The individualised, coordinated case plans were perceived by other service providers, and the families themselves, as being effective.

IN CONCLUSION
Despite the development of a range of new service models, agencies across the western world still struggle to meet the demands of the complex and difficult job that is child protection. The significant increase in child abuse reports that have beset child protection services since the early 1990s, has resulted in a range of new service developments designed to enable services to better target the statutory response to those families where there is serious risk or actual harm to a child.

It was noted earlier that the ‘new’ ‘family support’ models of child protection practice that were developed in the 1990s, were really a revisiting or recapitulation of solutions previously tried and tested. Rather than continue to develop ‘new’ versions of child protection case management systems, perhaps what is needed is greater recognition that the crux of effective child protection work is an adequately supported workforce, trained on a set of (clearly articulated) child protection ‘core competencies’, such as those identified under the Victorian ECO approach.

As noted previously, the historical pattern of change in child protection is for radical shifts driven by child abuse tragedies (e.g. Reder, Duncan & Gray 1993; Goddard 1996). Rather than engage in a further round of dramatic policy and practice changes, it is noted that an investment in core child protection skills, such as risk assessment, interagency collaboration, and working effectively with children and families, along with the means to effectively monitor service provision, may provide a better return for governments, agencies, and most importantly children and their families, in the longer term.

Interagency coordination and collaboration
It is also apparent that for child protection interventions to be effective, it is vital that effort be put into developing clear, coordinated interagency and interprofessional practice. Unfortunately, effective interagency practice is difficult to achieve, particularly when the number of professionals or agencies involved is high. Regional coordinating mechanisms, such as the regional or area children’s services plans proposed in the U.K. Audit Commission report (1994), is one model worth exploring further.

On the ground, the joint team approach appears to be a promising development that has the potential to reduce the chances of coordination and communication problems arising. To date, such teams have generally been developed as a police-child protection response, and the evidence of their effectiveness is still quite limited. It would therefore be useful to further develop the team concept by developing a co-located, permanent multidisciplinary structure for a larger, more diverse group of professionals. A joint team for both investigation and subsequent professional intervention (even if only in the case planning and service brokerage phase such as the SCAN Team and Strengthening Families models) may be a more effective way of working, and lead to better outcomes for children and their families.

In the absence of such teams, legislating for interdepartmental collaboration, in conjunction with formal and informal opportunities for workers to develop a ‘shared understanding’ of key issues and the different professional ways of working, would appear to be desirable. Such work should be (and usually is) supplemented with formal, mandated, mechanisms of case conferencing and/or referral protocols to ensure a degree of interagency work on a case-by-case basis. In the following sections the provision of child protection services for rural-remote and Indigenous communities is explored.
Best practice responses and solutions to Indigenous family violence are difficult to find due to a dearth of programs and the lack of documented evaluations about the effectiveness of programs. The many reports on the problems within Indigenous communities conclude that the general failure to find solutions is exacerbated by a significant lack of resources, an ongoing paternalistic approach towards Indigenous people and a reluctance to address the problem. The latter being due to issues such as Indigenous peoples’ mistrust of the government and government uncertainty about what should be done. A number of broad principles for programs are repeatedly identified in the literature. They include the need for major policy change which gives power and decision-making back to the Indigenous community, together with financial resources adequate to make a change and professional support to the community.

**TERMINOLOGY**

Within Australian Indigenous communities, ‘family violence’ is commonly used as a broad term, encompassing all forms of violence between members of a kinship group or the immediate community. Concomitantly, abuse of Indigenous children, including sexual abuse, is generally viewed as a community issue, rather than within the narrower nuclear family context used in the non-Indigenous community.

The term “family violence” has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms, including child abuse and neglect, rather than taking a focus on a particular form of intra-familial violence. Family violence is widely seen as the term that best encompasses the various forms of violence that may take place between family members. It is the most inclusive term, and is capable of encompassing changing ideas about what “family” means in late 20th century Australia’ (DVIRC 1998:36).

The term is perceived as most accurately describing ‘how violence reverberates through the entire family or community’ (DVIRC 1998:13); it allows for the range of family members who may perpetrate violence and a wide conception of violence; and ‘it is not dependent, to the same extent as the term “domestic violence” on a clear delineation between private and public spheres, which are more blurred for indigenous than for non-indigenous people’ (DVIRC 1998:13).

In addition, there is a preference in Indigenous communities for issues of violence to be seen as a community issue that takes into account intergenerational issues and not to be seen as a ‘woman’s issue’ (DVIRC 1998). Second, popular or mainstream conceptualisations of violence are often rejected by Indigenous communities as a result of the perception that western definitions are not sensitive to the culture and traditions of indigenous Australians (IINA Torres Strait Islander Corporation Research and Resource Centre 1996; Secretariat of the National Aboriginal and Islander Child Care [SNAICC 1996]; Bagshaw et al. 1999).

Third, Indigenous community groups often indicate a preference for programs that take an holistic approach to addressing issues of violence, loss of cultural identity, substance abuse, and specifically address the needs and rights of indigenous women and children (National Crime Prevention 1999a). Finally, there is a preference for identifying and discussing ways of defining violence in Indigenous communities that do not alienate perpetrators and/or victims/survivors (Bagshaw et al. 1999).

**HISTORY OF CONTACT BETWEEN THE INDIGENOUS POPULATION AND WHITE SETTLEMENT**

The history of contact between the Indigenous population and white settlement is documented in the report, ‘Bringing them Home’ (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997), which reveals the subjugation of the Indigenous population from the first white settlements.

There is a marked difference between the history of child protection of Indigenous children and non-Indigenous children (Jackson 2001). Early in the
white settlement of the colony Indigenous people were regarded as ‘savages’ to be controlled and separated from the European community (Jackson 2001). While it is unclear when the separation of children from parents began, the practice had become clear by the second half of the nineteenth century when legislation was passed which allowed removal of Aboriginal children from their families and their re-location to institutions and missions.

From 1915 to the 1930s, Indigenous people were forcibly re-settled into ‘native settlements’ (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997:105). However, from the age of 14 years, children of mixed descent were being sent away from the settlements to work, particularly on pastoral stations. First documentation of the sexual abuse of female Indigenous young people appears to have occurred at this point, as it was recorded that ‘a large proportion of the young women returned pregnant’ (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997:108). In the 1950s, Indigenous children were removed for ‘education’ reasons, as well as for ‘neglect’. From the 1960s the policy changed to one of ‘integration’, which then moved to ‘self-management’ (Jackson 2001). The Aboriginal Child Placement Principle which states that Indigenous children in out-of-home care should be placed with an Indigenous family, became policy in 1985.

**VIOLENCE IN INDIGENOUS COMMUNITIES**

Accurate statistics about the incidence of family violence in Aboriginal communities are scarce (Bolger 1991). Although the statistics that are available are imperfect, ‘they are sufficient to demonstrate that the occurrence of violence in Indigenous communities and among Indigenous people ‘is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole’ (Memmott, Stacy, Chambers & Keys 2001:6). O’Donoghue (2001) illustrates the extent of the problem of family violence, noting that many Indigenous children are growing up in communities where violence has become ‘a normal and ordinary part of life’ (O’Donoghue 2001:15).

Ferrante and colleagues (1996) suggest that Aboriginal women living in rural and remote areas are one and a half times more likely to be a victim of domestic violence than those living in metropolitan areas and 45 times more likely to be a victim of domestic violence than non-Aboriginal women. Further, available data from the Northern Territory indicate that there are around 6000 incidents of assault on Indigenous women in the Northern Territory per year. That is, approximately one-third of the Northern Territory’s Indigenous female population is assaulted each year. Weapons are reported to be used in around 50–60 per cent of Indigenous attacks between spouses (Memmott et al. 2001).

There would appear to be a clear need for more extensive and consistent assessment of the nature and extent of violence in Aboriginal communities. However, Hatty (1988, cited in Bolger 1991:23) suggests that ‘we should give up our preoccupation with the incidence of domestic violence’ as there will always be a dark or hidden figure of crime of this type. Rather than attempting to develop a precise estimate of the extent of violence in Indigenous communities, she argues that time and resources would be better spent focusing on the nature, structure, history and dynamics of such violence (Memmott et al. 2001).

**Child abuse and neglect**

There is little information available on the prevalence of child abuse in Australia generally, or for Aboriginal and Torres Strait Islander children specifically. The most reliable statistics available are the national child protection statistics that have been collated by the Australian Institute of Health and Welfare (AIHW) since 1990. These statistics suggest that the number of child protection notifications in Australia is increasing every year, with 137,938 notifications being made in 2001/02, 30,473 of these being cases substantiated or confirmed as child abuse (AIHW 2003). The statistics also reveal that Aboriginal and Torres Strait Islander children are significantly over-represented in the protection and care system of all states and territories (AIHW 2003). This trend has been evident each year since the first collation in 1990.

Since 1996–97, the rates of Indigenous and Torres Strait Islander children where abuse has been substantiated has increased in all states except Tasmania. In all states, cases involving Aboriginal children are more likely to be substantiated than cases involving other children. The total number of Aboriginal and Torres Strait Islander children subject to substantiations in Australia for the 2001/02 period was 3254. Aboriginal and Torres Strait Islander children comprise 2.7 per cent of children in Australia, yet constitute 20 per cent of those placed...
in out-of-home care (Cunneen & Libesman 2000). As of June 2002, there were 4199 Aboriginal children in out of home care.

While Cunneen and Libesman (2000) believe that accurate information is not available for the numbers of Indigenous children placed with non-Indigenous families, Ah Kee and Tilbury (1999) reported that slightly more Indigenous children are placed at home or with relatives (50.2 per cent) compared with non-Indigenous children (33.3 per cent). Indigenous children are also slightly less likely to be in residential accommodation than non-Indigenous children. However, 24.2 per cent of placements of Indigenous children in Queensland, were with non-Indigenous foster parents (Ah Kee & Tilbury 1999).

The failure to report child maltreatment

It should be noted that the AIHW statistics only deal with cases of child abuse which have been reported to authorities and thus, are an underestimate of the incidence of child abuse across the nation. The failure to report and record the abuse and neglect of Indigenous children is said to be due to a number of reasons. It has been suggested that incidents of sexual and physical abuse of Aboriginal children are often not being reported to authorities ‘due to lack of assistance from police or fear of reprisals, or shame’ (Robertson 2000:101). Other factors identified include a fear of being shamed and experiencing racism, and a fear of reprisal from the perpetrator in small, closed communities, or pay-back from relatives, as well as fear by some of the police response (Robertson 2000; Aboriginal Women’s Task Force and the Aboriginal Justice Council 1995).

Further, many Indigenous communities are located in rural or remote areas of Australia where surveillance and contact with child health or welfare professionals are at a minimum. There has also been some concern that government agencies have been reluctant to intervene in Aboriginal communities for fear of reprisals from the community and media and therefore ‘relied upon cultural politics to justify inability to intervene’ (Robertson 2000:91).

Some people perceive a need to protect the perpetrator because of the high number of Indigenous deaths in custody (O’Donoghue 2001). Fitzgerald (2001) writes that this is a realistic fear, particularly in Cape York communities where a death in custody would be seen as the woman’s (victim’s) fault. There may be no official to report to and/or no means of reporting in remote communities without public transport or private vehicles (Fitzgerald 2001; Aboriginal Women’s Task Force and the Aboriginal Justice Council 1995).

Past inaction associated with reports reduces confidence that appropriate action will be taken (Greer 1992; Robertson 2000). Inaction may be due to authorities being fearful of their own safety because of the high general levels of violence in the community and/or a fear of retaliation for action they may take (Memmott et al. 2001). It may be due to an experience of stress and burnout associated with too few resources and too much work (Stanley & Goddard 2002; Memmott et al. 2001). Indigenous workers may have particular problems when actions are taken against an offender. They are likely to live and work in the same community, the person may be a family member or a Community Elder (Cunneen & Libesman 2002), or from the same language or clan group, thus there is the potential for a conflict of interest (Richard Munt, personal communication, 2003).

With regard to child sexual abuse, once a report is made, there may be a number of reasons why the substantiation rate of sexual abuse is lower for Indigenous, than non-Indigenous children. It is possible that child protection authorities and other professions there to protect the child are confused about the right response, particularly in the legacy of the, ‘stolen generation’ when many Indigenous children were removed from their family and community. It is also possible that practitioners are overwhelmed by the size, complexity and number of problems associated with Indigenous communities. Problems created by a lack of resources, such as in relation to the Aboriginal and Torres Strait Islander Child Placement Principle11, may create uncertainty about what is best for an Indigenous child – remaining with some level of risk, or facing the adverse impact of cultural dislocation.

In short, none of the submissions from Indigenous communities to the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (HREOC 1997) saw interventions from ‘welfare departments as an effective way of dealing with Indigenous child protection needs’ (Cunneen & Libesman 2002: 21).

11 This Principle, adopted by all states, says that an Indigenous child who has to be removed from home should be placed elsewhere according to the following priority: firstly with a family member, secondly with a community member, and thirdly with an Indigenous family.
THE CAUSES OF FAMILY VIOLENCE AND CHILD ABUSE IN INDIGENOUS COMMUNITIES

As in non-Indigenous communities, it is commonly believed that child abuse and neglect in Indigenous communities are caused by a multitude of factors (Belsky 1980; Memmott et al. 2001). However, as noted earlier, the Indigenous perspective usually places considerably more emphasis on the impact of the wider community and societal causal factors.

It should be noted that a comparison between the two bodies of literature (non-Indigenous and Indigenous) reveals a marked difference in the ‘ways of knowing’. Academic discourse in Australia has been rightly criticised as constructing a Westernised perspective of Indigenous reality and as presenting racially biased constructions of the ‘truth’ (Foley 2003). Although Indigenous communities are culturally and geographically diverse, Foley (2003:50) argues that an ‘Indigenous Standpoint’ can be reached.

Non-Indigenous knowledge is generally reported after (and only if) it has been acquired by a highly structured and defined process of knowledge gathering, via the ‘research method’. In contrast (and despite some public perceptions), an Indigenous perspective is rarely recorded in the academic literature. Further, much Indigenous knowledge is based on personal accounts and stories, a method which has Indigenous cultural integrity. Evidence of the validity of particular perspectives for Indigenous communities is achieved by the passing of information or stories – that is, their repeated sharing and confirmation by many people. Indeed, Indigenous perspectives can be seen as similar to the qualitative methodologies increasingly being used by some non-Indigenous researchers.

Despite the differences in gaining knowledge, it should be noted that there are strong parallels between the two bodies of literature. For example, Tomison (2000a) reports on research which has found that adults (particularly males) who were physically abused while an adolescent and/or who witnessed domestic violence, were more likely to be involved in marital aggression themselves (Straus, Gelles & Steinmetz 1980; Rodgers 1994). Aboriginal writers and commentators also make this link (for example Hazelhurst 1994).

Causal factors

Cunneen & Libesman (2000) point out that there are a range of factors which make Aboriginal and Torres Strait Islander families more susceptible to becoming involved with both child protection services and juvenile justice services (see Stanley, Tomison & Pocock 2003 for further information). These factors include the high levels of poverty, unemployment, homelessness, ill health and substance abuse found in Indigenous communities, much of which arises from previous government policy of assimilation, as well as their experience of racism, dispossession and marginalisation (Cunneen & Libesman 2000). As noted above, many Indigenous communities are also plagued with extremely high levels of sexual and physical violence (Tomison 2000a).

Garbarino (1995) identified a series of factors including high crime rates, poverty, unemployment, poor housing and an under-resourced education system, that may be presumed to lead to an increased potential for abusive or neglectful behaviour in families, or higher incidences of other social ills. Aboriginal and Torres Strait Islander people are disadvantaged across a range of socio-economic measures, and are more likely than non-Indigenous Australians to live in a community with inadequate and poorly maintained infrastructure, and to be in poorer health.

Socioeconomic disadvantage

A report on the health and welfare of Indigenous Australians, documents that inadequate and poorly maintained infrastructure is a major problem for some Indigenous communities, particularly those in rural and remote areas (Edwards & Madden 2001). For example, one third of community-owned or managed permanent houses in discrete Indigenous communities (over 14,500 dwellings) were found to need major repairs or demolition (Australian Housing Survey 1999, reported in Edwards & Madden 2001). In addition, the quality of drinking water is poor and provisions for grey water are inadequate in many intact Indigenous communities.

Indigenous people continue to suffer from higher levels of ill health than the rest of the Australian population, as well as being more likely to smoke, consume alcohol at hazardous levels (binge-drinking), and be obese. Life expectancy is lower for Indigenous people, being 56 years for Indigenous males compared to 76 for non-Indigenous males, and 63 years for Indigenous females compared to 82 years for non-Indigenous females (Edwards & Madden 2001). Overall, some Indigenous communities have been described as suffering from ‘dysfunctional community syndrome’ (Memmott et
al. 2001). That is, they suffer from a ‘toxic’ environment which, together with geographical and social isolation, is associated with the break-up of families (Garbarino and Abramowitz 1992). At times this syndrome becomes a self-perpetuating process in Indigenous communities.

Child maltreatment is disproportionately reported among poor families and, particularly in the case of neglect, is concentrated among the poorest of the poor (Wolock & Horowitz 1984). Thus, socio-economic disadvantage is closely entwined with family violence, being both a cause of child abuse, in the traditional sense and, it is argued, a form of child abuse and neglect in itself. For example, the boundary between the socio-economic disadvantage experienced by many Indigenous people and personal culpability for child neglect is neither understood or defined (Pocock 2003).

Robertson (2000) highlights the impact of socio-economic disadvantage on female heads of households, who often care for large numbers of children (which may in itself be due to family violence) and forced to live in derelict houses that cannot be adequately locked to prevent external intruders entering the house and assaulting residents (children or adults). To what extent should a caregiver be held accountable for abuse or neglect under such circumstances? Clearly, there needs to be some recognition (and attempts to resolve) the environmental conditions affecting a caregiver’s ability to adequately care for her children.

The past influencing the present

Cunneen and Libesman report on the findings from the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (NISATSIC) (Human Rights and Equal Opportunity Commission [HREOC] 1997). This Inquiry found that the past forced separation of Indigenous children from their families and communities has resulted in a loss of parenting skills, as well a range of other pervasive adverse impacts (HREOC 1997). This impact includes unresolved grief and loss, depression, violence, behavioural problems and mental illness. These issues also impact on parenting ability and in turn increase the likelihood of the involvement of child protection services.

Intergenerational transmission of violence

Hunter (1990) makes the connection between the greater access to alcohol in the 1970s and an increase in Indigenous violence, particularly increases in female homicide, suicide, para-suicide and self-mutilation in the 1980s. He notes that the children and young people who currently engage in self-destructive behaviour are the children of the generation who were young adults at the time of rapid change in the 1970s.

They are the first generation to have grown up in environments with normative heavy drinking and significant family violence. Reflecting the intergenerational transmission of behaviour, Indigenous children in some communities are now using alcohol at a very early age (Robertson 2000). Further, the inhalation of solvents (paints, glues and petroleum products) has become widespread in some Aboriginal communities (Moore 2002).

Robertson notes that ‘having been socialised into a culture of alcohol, substance abuse, violence and anarchy, the crimes committed by some (of the current generation) offenders reflect those witnessed or experienced as a child’ (Robertson 2000:31).

Overseas models for child protection in Indigenous communities

Given that many overseas indigenous peoples are also struggling with the aftermath of colonisation, overseas child protection models trialed in other indigenous communities may provide possible solutions. However, while there is some literature available in regard to overseas models of child protection used with Indigenous communities, this literature is small and difficult to access. The National Child Protection Clearinghouse is investigating the identification and acquisition of this material, which will then be made available via the Clearinghouse library collection.

Pellatt (1991) provides an overview of the position of child protection in relation to Indigenous communities in many countries. Although the information is somewhat dated, Pellatt records an overall world trend towards less intrusive child protection practice. She notes that Indigenous communities in Australia, Canada and the U.S. are all seeking legislative change. Sweeney (1995) gives some information on models of child protection services in Canada, New Zealand and the United States where part or all protective responsibilities have been transferred to the Indigenous population. Cunneen & Libesman (2002) also provide a useful summary of international trends. For this report, innovations in practice for Canadian First Nations peoples will be highlighted.
Canada

Hill (2000) provides an overview of Canada’s First Nation tribes’ history since colonisation by Europeans, a history that is remarkably similar to that of Australia’s Indigenous peoples. It includes a period of the forced removal of children from their families (a ‘stolen generation’), and the continued high rates of children’s removal on child protection grounds (four times higher than the wider community). Despite anecdotal evidence of some Aboriginal (First Nation) communities in Canada overcoming significant social dysfunction and enhancing the health and wellbeing of children and families, the development of healthy communities has not yet become the dominant pattern.

Since the late 1970s, there have been attempts to develop child protection and family support services run by (and for) the First Nations peoples. Hill (2000) outlines some key issues for consideration when developing services for the protection of children in Aboriginal communities. Underlying this approach was recognition of the ‘cycle of poverty and dependency perpetuated by the very services designed to resolve the social ills of First Nations communities …[and that] First Nations people [have] had to become active participants in the resolution of social problems that impacted them’ (Hill 2000:163).

Subsequently, Aboriginal foster care programs and child protection services – staffed and run by the Indigenous community and with statutory authority – were provided in a way that recognised the cultural integrity of the people. The new services were developed under the auspices of the non-Indigenous child protection agency, but were not a unit of that Department. Underpinning the service development was the following:

• recognition of the need for formal training and professional education for Aboriginal workers;
• adoption of a ‘least intrusive’ approach to child protection work (unless over-ridden by risk of harm) and a greater emphasis placed on seeking to work with extended family as an alternative to placement, thereby maintaining the child within the family and cultural community. ‘However, accepting these new opportunities also required First Nations to embrace the legal system in situations where involuntary interventions were necessary to protect a child’ (Hill 2000:166);
• recognition of collective Aboriginal rights – if court intervention is necessary for the protection of a child, the child’s tribe is entitled to be notified and has the right to send a representative as a third party to the court proceedings.

In addition, a variety of family support programs were developed, particularly culturally-appropriate parent education programs for Indigenous parents, and the development of ancillary services, such as an Indigenous cooperative day nursery. It is interesting to note that the development of all these services, including the statutory services, was not an easy process. In fact it was characterised as ‘confictual’:

‘at every step … there emerged political clashes, formal and informal, for decision making power’ (Hill 2000:166).

While the implementation of such a model is not easy, it has also not necessarily led to significant improvements in Canadian First Nation communities’ health and wellbeing and/or a reduction in violence. Although providing an example of how to move forward with more effective services, Hill’s model has some serious ‘gaps’.

It does not seem to address issues of how to place a child within their Indigenous community if the community is beset by familial violence, substance abuse and other social problems. Nor does it provide a solution to the non-Indigenous statutory authority’s (or Aboriginal authority’s) reluctance to intervene with Aboriginal families, which may leave children in serious harm. Finally, it does not address the issue of effective prevention and/or community development to minimise the removal of children and violence in the first place.

Yet many of the tenets of the approach described by Hill have now been embraced by Indigenous groups and agencies (and to an extent, by government departments) in Australia. However, a statutory child protection service controlled and run by the Indigenous community has not been trialed yet.

ARGUING FOR A RADICAL POLICY CHANGE IN AUSTRALIA

Aboriginal and Torres Strait Islander communities have a clear preference for change strategies that do not require the perpetrators of violence to leave the family (Blagg 2000), and have a similar preference for strategies where children are not removed from their community. Yet Indigenous child welfare policy is still based on the premise that the government should decide what is best for Indigenous people (Sweeney 1995).
Sweeney draws on the report, *Learning from the Past*, which was commissioned by the NSW Department of Community Services and prepared by the Gungil Jindibah Centre at Southern Cross University (undated). He notes that the report states that the legacy of the past is still overshadowing present intentions in relation to Indigenous policy. Similarly, it is argued that a legacy of past mistakes is currently producing a reluctance to intervene by statutory child protection staff/departments when an Indigenous child is at risk of harm.

There appears to be a fear of the community’s reactions and confusion about what action (or inaction) is in the best interests of Indigenous children. This conclusion is supported by a recent review of out-of-home care services for Victoria’s Aboriginal children and young people (Practice Leadership Unit 2000) (and highlighted in a number of media articles). The review identified a practice of minimisation of statutory involvements by DHS in cases where intervention was/is required to avoid significant harm to Aboriginal children.

Moving forward

In a similar vein to Canadian developments, the NISATSIC Inquiry recommended that new legislation be enacted, based on self-determination by Indigenous people, where far greater control over matters affecting young people is given to the Indigenous community (HREOC 1997; Cunneen & Libesman 2000)12. Further, that the Australian Government establish negotiations that would allow Indigenous people to formulate and negotiate an agreement, leading to legislation, on measures best suited to their needs. The Inquiry also recommended that legislation set out minimum standards as a basis for future developments in relation to Indigenous children. The Australian government has responded that such legislative change is a state/territory responsibility; there has also been no indication that state/territory governments have moved towards law reform in order to transfer power to Indigenous communities (Cunneen & Libesman 2000).

Similarly, the authors of the *Learning from the Past* report recommended that State policies focus more on developing collaboration and empowerment strategies for Indigenous peoples. Further, it was recommended that counselling services and measures to reunify Indigenous families should be undertaken by independent Indigenous organisations, with the statutory child protection service limiting their role to funding and referral only (Sweeney 1995). However, Sweeney believes that such recommendations do not go far enough, and fail to adequately reflect the information contained in the report. He believes that control and responsibility for Indigenous child welfare and child protection needs to be given to the Indigenous communities themselves. He doubts whether the system is capable of real change without this process.

Cunneen & Libesman (2000) have also argued for a complete revision of child protection services in relation to Indigenous Australians. They report that not one submission from an Indigenous organisation to the NISATSIC Inquiry found the current interventions from child protection/welfare departments to be an effective response to their child protection needs. The general model of operation of child protection services, based on ‘individualising’ and ‘pathologising’ a particular family, is culturally suited to white Australian culture, not Indigenous culture (Cunneen & Libesman 2002).

Yet there have been some attempts to advance Indigenous self-determination and empowerment, and to better acknowledge culture. For example, the Yaitya Tirramangkotti unit operating within the South Australian Department of Human Services is a central Aboriginal child protection consultation and response team. Staffed by Aboriginal people, Yaitya Tirrimangkotti makes sure that everything is done to involve Aboriginal families and help them care for their children in ways that are culturally appropriate (Tomison & Poole 2000). In general, however, most of the efforts to date have tended to be tokenistic. Thus, although an Indigenous child protection worker may be employed, there are still interventions from other non-Indigenous professionals and organisations. In general, the key decision-making still remains with non-Indigenous officials.

Litwin (1997) notes that the NSW Department of Community Services has taken measures directed at advancing self-determination and acknowledging Indigenous culture. These have included: recruiting Indigenous field officers and policy advisers, funding Indigenous organisations, and establishing the Aboriginal Child Placement Principle within child

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12 It should be noted however, that a major problem in relation to this recommendation may be the difficulty in locating (or developing) an Indigenous agency to undertake the task of protection in each major community.
protection legislation (Litwin 1997). These policies are based on the principles of self-determination and empowerment. However, she argues that the over-representation of Indigenous children in the out-of-home care system can be taken as a demonstration that these policies have not led to particularly successful outcomes.

Litwin (1997) also notes the paradox of child welfare bureaucracies providing a service to Indigenous peoples when they have contributed to the need for these services in the first place. She points out that Indigenous communities do not have a tradition of active involvement in child welfare policy, with their response, based on past history, being one of suspicion and resistance. Thus the administration of the self-determination policy has required an ever-increasing level of government intervention. Further, there has never been a precise definition of ‘self-determination’ and what this means in practice. For example, how is it to be negotiated? What are the constraints that may limit autonomy? How can competing interests be resolved?

Litwin argues that the power imbalance between Indigenous communities and welfare bureaucracies is ‘overwhelming’ (1997:331). Thus, even the attempt to make child welfare bureaucracies more attuned to Indigenous needs, will be swamped by non-Indigenous culture and processes. Not only is it unrealistic to believe that the few Indigenous employees will be able to positively influence departmental policy and practice, but these workers are faced with the conflict that they are working within a child welfare system which:

‘has been implicated in the ongoing generation of profound social and cultural trauma for Indigenous Australians’ (Litwin 1997:334).

Finally, Litwin (1997) contends that there has never been an attempt by child welfare to understand the nature of the differences between the Indigenous and non-Indigenous concepts of child care. Without these major issues being addressed, and a determination of where the Indigenous culture is expected to fit in with the bureaucratic child welfare culture, ‘institutionalised racism’ will continue (1997:337).

**Service development and delivery**

The literature offers a number of ‘best practice’ suggestions for intervention into family violence in Indigenous communities (Stanley, Tomison & Pocock 2003). It is commonly reported that effective intervention into family violence needs to address both the past traumas and present situational problems and health disadvantages of Indigenous communities. Almost without exception the literature notes the need for inclusion/participation of the local community. Commentators provide a range of similar broad principles as a basis for all service provision in the Indigenous community. However, while there has been a lot of criticism of existing intervention models into family violence (Blagg 2000), few fully developed alternative models have been produced for Australian communities.

Similarly, and building on Sweeney (1995), Blagg (2000) provides a summary of what appear to be core tenets that should be considered when planning services:

- participation
- ownership/self-determination
- infrastructure (training and education)
- support services needed to support child protection function.

Blagg (2000) notes that the literature supports models of intervention that:

- are tailored to meet the needs of specific localities;
- are based on community development principles of empowerment;
- are linked to initiatives on health, alcohol abuse and similar problems in an holistic manner;
- employ local people where feasible;
- respect traditional law and customs where appropriate;
- employ a multidisciplinary approach;
- focus on partnership between agencies and community groups;
- add value to existing community structures where possible;
- place greater stress on the need to work with men; and
- place more emphasis on intervention that maintains family relationships and healing.

With specific regard to statutory child protection roles, SNAICC recommended the use of inclusive, participative processes to engage with Indigenous communities. It was noted that this should include

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13 With regard to developing a participatory approach, the guide ‘Working with Indigenous Australians: A Handbook for Psychologists’ (Dudgeon, Garvey & Pickett 2000) provides some useful information and approaches to working with Aboriginal communities.
the development of Elder Councils that could make a contribution to policymaking, resource provision, program development and service delivery14.

Kurduju Committee

The Kurduju Committee, developed by the combined communities of Ali-Curung, Lajamanu and Yuendumu Law and Justice Committees in the Northern Territory provide one example of how such partnerships may be enacted (Kurduju Committee Report 2001). Men and women from the Ali-Curung, Lajamanu and Yuendumu communities have been working together to look at a range of law and justice issues that affect those communities15. Their first report looked at the issue of family violence (predominantly domestic violence), and focused on the operation of safe houses, night patrols and Aboriginal dispute resolution processes.

Developed through the services of the former Office of Aboriginal Development, the Aboriginal Law and Justice Strategy was initially implemented in Ali-Curung in 1996, and in Lajamanu in 1999. The Strategy takes a whole-of-community and whole-of-government approach to assisting communities to address issues identified via a law and justice planning process (Kurduju Committee Report 2001). Each community develops a community law and justice community to act as a focal point for addressing law and justice issues. Ali-Curung (and later Lajamanu) has successfully modelled the Kurduju structure for the Yuendumu community.

In addition, the committees can act as an interface with the law and justice system (that is, working together with non-Indigenous agencies to develop culturally appropriate, workable solutions to issues like family violence. The Committee also plays a role in victim/offender conferencing; makes recommendations to the Court; assists in the development and management of diversionary programs; reports to local Councils on trends in law and justice issues; facilitates community dispute resolution; and maintains positive relationships with the police, correctional services and the Court system (Kurduju Committee Report 2001). The model is very much of ‘local solutions for local problems’, where the community has strong representation and ownership of any developments.

Service coordination

As with the non-Indigenous responses to family violence and family support, effective interagency coordination and collaboration are identified as key aspects of effective service provision. In the Aboriginal and Torres Strait Islander Women’s Task Force on Violence Report, the need for the inter-linking of services to address the multiple forms of violence in the communities, and the need for a flexible service delivery approach is clearly noted (Robertson 2000). Further, that multi-service delivery centres must be established to provide a coordinated service for alcohol and drug addiction, family violence, sexual assault, grief counselling, advocacy for women, child counselling and support groups for men (Robertson 2000).

Prevention not just protection

Finally, it is contended that the development of prevention services is a vital part of a total package of responses, rather than being seen as ‘either/or’ services. One has only to observe the recent history of child protection in Australia to conclude that statutory intervention without a wider network of family support and preventative services is highly unlikely to produce positive outcomes for children, families and communities (Tomison 2002). In the Proposed Plan of Action for the Prevention of Child Abuse and Neglect in Aboriginal Communities, by SNAICC (1996), a number of approaches/ components flesh out some of Blagg’s (2000) key issues for child abuse prevention and child protection.

SNAICC noted that to effectively address the multi-faceted dysfunction or problems plaguing many Aboriginal communities, and the need to develop and support Aboriginal welfare/support services operating within the communities, such as Aboriginal Infant Welfare services they advocated establishing a community-controlled Aboriginal children and family resource centre to gather information and develop training and education resources. The importance of a strong training program for Aboriginals already working as volunteers or community-based professionals (e.g. in Aboriginal Child Care Agencies), and the need to identify services already

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14 However, it should also be noted that elder groups or community councils have the potential to facilitate or to hinder efforts to create less violent, more positive communities. There is anecdotal evidence that some male elders, in particular, have hindered violence prevention initiatives because of their own involvement in family violence.

15 The Kurduju Committee is reported to be the only group from remote communities [in NT] currently ‘researching, documenting and implementing initiatives to address issues such as family violence’ (Kurduju Committee Report 2001:8).
having positive impact with the communities and to fund them to expand and professionalise are clearly identified throughout the proposed plan.

**Alternative Care: The Aboriginal and Torres Strait Islander Child Placement Principle**

The widespread shift to family-based out-of-home care for non-Indigenous communities (Tomison 2001) has been repeated in Indigenous communities, particularly after the acknowledgement of the damage caused by the widespread removal of Indigenous children as part of the ‘Stolen Generation’ (HREOC 1997). The Aboriginal and Torres Strait Islander Child Placement Principle has now been adopted by all states and territories as a cornerstone of Indigenous child welfare policy (Ah Kee & Tilbury 1999). This principle sets out the right for Indigenous children to be brought up in their own family. Where that is not possible, it gives guidance for alternative placements and continued family contact, and requirements for consultation with Indigenous agencies. Further, in New South Wales and Western Australia, child protection service protocols require that Aboriginal children are placed with an Aboriginal family (Ainsworth & Maluccio 1998).

The de-institutionalisation of Aboriginal and Torres Strait Islander children who are in need of out-of-home care has been further assisted by the development of Aboriginal and Islander Child Care Agencies who have played a leading advocacy and service provision role since the 1970s. Although there are approximately 30 agencies currently operating across Australia, the number of agencies has remained virtually static since the mid-1980s. Most of these are relatively small agencies with few staff and a role focused primarily on placing Indigenous children who have already been removed from home by State child welfare authorities. Many Indigenous communities, particularly those in New South Wales, Western Australia and the Northern Territory, and/or those located in rural and remote areas, have little or no access to agencies to assist them with parenting, family support or dealing with child protection issues and authorities. However, behind the successes of the past two decades lies the ongoing failure to reduce the over-representation of Indigenous children in the care and protection system of each State and Territory (HREOC 1997; Cadd 2001; AIHW 2003).

Ah Kee and Tilbury (1999) believe that, despite a concerted effort to try and make the principle work in Queensland over a 15 year period, there has been little real improvement in outcomes for Indigenous children in care. They describe the steps that have been taken, such as research, training, and the use of Indigenous community workers to work alongside front-line staff. There has also been the development of a Child Protection Reform Strategy, which was developed in conjunction with Indigenous agencies.

Ah Kee and Tilbury (1999) also outline some of the reasons for the limited progress. These include: a lack of constant reinforcement in relation to the Placement Principle; tensions between the child protection department and Indigenous agencies; the lack of evaluation and research; and particularly, a persistent lack of funding. With regard to the latter, about 10 per cent of alternative care funding goes into Indigenous agencies, whereas 25 per cent of children in alternative care are Indigenous (Ah Kee and Tilbury 1999).

Further, highlighting other issues affecting the ability to ‘work together’ on issues of out-of-home care for Indigenous children, it was noted in the recent Victorian statewide review of out-of-home care services for Aboriginal children and young people, that:

‘Aboriginal workers remain concerned about the placement of Aboriginal children with non-Indigenous families. The reasons for this relate to the small number of Aboriginal foster carers available, the difficulties child protection workers have in locating family members able to care for Aboriginal children and young people, and to some extent, requests from parents to have their child/ren placed with non-Indigenous families’ (Practice Leadership Unit, 2000:48).

**In conclusion**

It would appear that the legacy of past practices is still impacting on both Indigenous peoples and present governments’ policy and practice associated with responding to Indigenous child welfare and child protection issues. Unfortunately, many of the well-intentioned policies, such as the use of Indigenous officers in child protection services, appear to have only resulted in superficial changes, rather than fundamental change. Many commentators have argued that the control of child protection services and other child welfare should be given to the Indigenous community. There are overseas precedents for this approach, although their effectiveness needs further examination. It is also apparent that many of the tenets underlying what
may be ‘successful’ overseas approaches are well-known to both Australian Indigenous and non-Indigenous services, but the implementation of the new approaches has been a highly politicised, difficult process that is unlikely to proceed quickly.

Rural-remote communities
The ‘tyranny of distance’ produces a number of issues specific to rural and remote communities that impact on general service provision, and child protection and child abuse prevention in particular. First, rural and remote communities generally have limited access to health, welfare, education and support services, and the people are, by definition, geographically isolated. Second, in some communities, ensuring the confidentiality of service provision may be a greater issue than is the case in more populated urban areas.

Social isolation and social connectedness
Social isolation, which is clearly exacerbated by geographical isolation and a lack of connectedness or social supports, may have very real effects on community members’ quality of life and ability to cope with stressors. Non-involvement in the community, (being disconnected) can have serious social consequences such as alienation, loneliness, low self-esteem, boredom, intolerance of others, lack of motivation, and may negatively impact on family functioning or impair child development (Fegan & Bowes 1998).

Numerous studies have shown that the absence of social support and a lack of involvement in social networks is associated with a greater risk of child maltreatment, and in particular, child neglect (e.g. Wolock & Horowitz 1984; Drotar 1992; Vinson, Baldry & Hargreaves 1996; Chalk & King 1998). Among other things, adequate social support, via the professional system or informal social networks can provide parents and families with respite care, advice on parenting practices, skills acquisition, information and emotional support (Tomison & Wise 1999).

The U.S. National Commission on Children (1991) concluded that enhancing a sense of community and invigorating informal systems of social support for children and families should be a primary goal of social policies at all levels of government. This was greeted with less enthusiasm by government leaders who had worked with neighbourhood development programs in the 1960s, in that it appeared to be a return to a policy, planning and resource allocation model that had been judged to be unsuccessful (Wilson & Ward 1997). However, the ‘failure’ of these earlier approaches may not have been due to flaws in the overall concept. Such values underpin the shift to a community capacity-building or ‘strengthening families’ approach outlined above, that has been widely implemented across Australia.

Service delivery issues
Access to services in rural and remote areas is often hampered by: a lack of available services; a lack of transport (Breton 1985); and families’ fear of the stigma attached to being identified using family support services. With regard to the latter, Breton (1985) identified the need to locate preventive or family support services near other facilities so that members of the community do not feel stigmatised when walking into the agency. The child and family centres or ‘one stop shop’ model is an extension of this concept, where family support or specialist anti-violence services are located with more generic services. This model has been well-received in rural communities (Tomison & Poole 2000).

With regard to the statutory child protection response, as Ryan (1997) notes, child protection staff in rural Australia (where they are present) are often asked to deal with complex child protection issues in an environment where medical, legal and social work professionals lack experience in dealing with child abuse and neglect (Ryan 1997). However, in many remote communities, workers often have to contend with professional isolation, a range of service gaps in the local community (at times including an absence of a regular police and statutory child protection presence), and thus, the necessity of undertaking roles or functions they would not usually perform.

For example, in very small professional networks it is not uncommon for teachers and nursing staff to fulfil much more significant roles in child protection, the prevention of other family violence, and other social concerns. For governments and policymakers, the issues are therefore not just about the use of resources to better serve remote communities, but also about how to support existing professionals to provide an effective service in communities that may be suffering from significant social problems. As Jacobson has noted:

‘marginalised by distance and small numbers, rural human service workers face the challenge of adapting urban service models that support
dominant theories and social problems definitions to fit local realities ... [However] this “shrink to fit” approach ... falls short of adequately addressing the factors that complicate work in rural areas and has not proven to be effective’ (Jacobson 2002:738).

Rather, as Schorr notes, the most successful programs ‘grow deep roots in the community ... [and] cannot be imposed from without’ (1997:7).

As was noted above, it is now recognised that when dealing with Indigenous communities there is a need to develop tailored, community-owned solutions rather than impose externally-developed plans. This is also the case with non-Indigenous rural and remote communities. Given the lack of professional infrastructure and limited resources, whatever support system is developed for remote communities needs to be accepted by the people and tailored to meet their needs. In this section an attempt is made to highlight innovations in professional support and service provision in rural and remote communities, based on the premise that effective support must, by definition, be tailored to local needs.

Working together in remote areas

Much has been made already of the potential for the development of informal collaborative relationships between different agencies and professions for enhancing (or hindering) child protection and family support work (e.g. Tomison 1999). It is not uncommon in smaller rural networks for informal collaborative arrangements to result in a degree of role-blurring (Hallett & Birchall 1992; Tomison 1999), such that particular professions take on the role of other professions in order to facilitate an (hopefully) effective response for families.

In regions where there is not a permanent child protection presence, and very little other service provision, governments may wish to formally recognise the child protection and family support work done by community-based professionals, such as medical staff, teachers or police officers. Such formal recognition should involve the provision of education, training and support to enable these workers to provide an initial response to protective concerns, with access to advice, supervision and a ‘backup’ professional response from regional expert teams, as required. For example, Foreman (1996) reported that health professionals in rural New South Wales identified a dearth of appropriately-qualified workers in the Macquarie region. In response, some were reportedly willing to undergo specialist training (in addition to lobbying for funding of new specialist positions) in order to boost the region’s capacity to deal with child maltreatment concerns. There are some programs already in operation in Australia and overseas that are worth consideration and adaptation for other rural-remote areas.

Baker (2000) presents an overview of the Workers with Families Project which operated from July to December 1999 in Toowoomba, Queensland and surrounding areas, with funding from the Department of Family and Community Services as a child abuse prevention pilot project. The project set out to explore the possibilities for partnership between a specialist child protection agency and rural family support workers with the goal of extending effective early intervention responses to families where there were protective concerns (‘at risk’ families). Acknowledging the isolation faced by many rural workers in their professional practice, the project explored a number of strategies (depending on local needs). These included: the development of mentoring relationships; professional case supervision; peer supervision and support; collaborative casework practices; and training programs (individualised support plans). Participating workers received both face-to-face and telephone support and debriefing. It was concluded via:

‘the [action research] evaluation of the project ... that supporting rural workers in this flexible individualised manner has the potential to significantly expand local capacity to respond to the needs of vulnerable and at-risk families’ (Baker 2000:23).

Crocker (1996) describes an innovative, community-based response by child protection teams in rural Newfoundland and Labrador, Canada. Like the Northern Territory, the regions host small populations spread over a significant geographical area. The communities were described as small and hampered by substantial gaps in support services. Child maltreatment issues (whose existence was often denied by the community) was strongly intertwined with poor socioeconomic conditions. The communities were also characterised by a strong sense of family rights (and the right to privacy) which is common in rural areas (Sigurdson & Jones 1982, as cited in Crocker 1996). Further, the communities generally mistrusted the professionals who were working in their towns as they were generally not local people.
In Newfoundland and Labrador, a range of local or regional multidisciplinary child protection teams had developed by the end of the 1980s. Traditionally, these teams were designed to enable a group of professionals dealing with specific cases of child abuse to run case conferences. However, over time it became apparent that the existing team structures and functions were no longer working. There were issues in the teams around confidentiality and accountability. Some professionals involved in the teams were inappropriately being made privy to confidential information on families where they had no professional need to know. There were concerns that the ability to keep families’ issues confidential had been eroded, a serious issue in rural communities where information can often travel very quickly through the population (Crocker 1996; Jacobson 2002). Overall, the existing team structures appeared to be atrophying, with some teams closing down entirely (Crocker 1996). Thus, there was a need for a new approach, one tailored for the local communities and their particular issues.

First, the teams shifted focus mainly on prevention through public education and awareness, advocacy, and professional development. Many of the child protection teams have developed a two-tiered service model where the first tier of the team includes community representatives who participate in the preventative activities listed above. The second tier is composed only of professionals dealing directly with the cases of child abuse, who are brought together to hold case conferences on a ‘need to know’ basis (in order to reduce the risks of breaches of children’s and families’ confidentiality).

The expansion of the teams to include community members, had a number of positive benefits for the teams. First, it strengthened the local community’s trust of the professionals providing services. Second, the expanded membership ensured continuity of the team’s community development and prevention activities, even when some professionals left the community. Overall, as Crocker notes:

‘the experience of child protection teams in this province demonstrates that by working together, rural [and remote] professionals and community people can develop appropriate responses to child abuse without depending on direction from government or any other agencies’ (1996:210).

Overcoming distance

Two Australian programs (identified in the national audit of prevention programs – Tomison & Poole 2000) provide some examples of visiting prevention programs that may be effective in targeting small, remote populations, who have a wide variety of needs.

Mobile Services for Rural and Remote Families and Children, National Association of Mobile Services for Rural and Remote Families and Children Inc., Wodonga (Vic.).

Mobile Services support children and their families living in rural, remote and isolated regions of Australia and those living in disadvantaged urban communities. Priority of access is given where needs are highest, including children at risk of abuse and neglect. There are approximately 135 Mobile Services operating in Australia. The Mobile Children’s Service in Albury–Wodonga works with children’s health and welfare services to allow the development of a comprehensive, integrated approach to children’s wellbeing.

In rural and remote areas, Mobiles deliver information, resources and qualified staff. They are often the first and only point of contact, intervention and referral for families, particularly in crisis situations. The National Association aims to: represent and support Mobile Services providing for rural and remote families; facilitate networking; provide information exchange/resources; facilitate regular training; advocate for Mobile and other atypical services; promote the Association; relieve poverty, disadvantage and isolation suffered by children on the basis of need.

Contact – Project for Isolated Children, Contact Inc. (NSW).

Contact Inc. is founded on the belief that strong families and strong communities are crucial to maintaining a cohesive, healthy and compassionate society. Isolation can undermine the confidence and resilience of individuals, their families and communities, and when this happens, young children are particularly vulnerable. Since 1979, the Commonwealth Children’s Services Program has

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16 One of the first community memberships was filled by local First Nations people. It was recognised that effective change could not take place without the indigenous peoples feeling able to contribute with an element of ownership and self-determination (Crocker 1996).
provided funding for the Contact Project to alleviate the negative effects of isolation on young children, and those who care for them. The Contact Project aims to help families find support so they will be better able to meet the needs of children in their care. The project also intends to stimulate interest in the wellbeing of young isolated children by improving community awareness of the needs of children.

Contact has developed flexible service and community development strategies designed to combat isolation while supporting the emergence of community resilience. Contact acts as catalyst and advocate to support local initiatives. Contact has an outreach component with staff making field trips to a large number or rural and remote areas throughout the year, to discuss issues and needs in person, and link people to the most useful support or resource. Outreach processes are complimented by promotional strategies, telephone calls and the mailing out of Contact’s reference materials. Contact provides information on issues such as child development, discipline, self esteem, community initiatives and resources, antenatal and postnatal information, and activities for children.

In contrast, the rapid growth in information technology has opened up a whole new way of bridging distance via the use of the internet, email communication, and teleconferencing to facilitate families’ access to specialist services (such as obstetric consultations and testing with urban-based specialists via videoconferencing) as well as interprofessional communication, training and support.

A teleconference service set up by the Child Protection Unit at the New Children’s Hospital in Sydney offers access to the Unit’s experienced professionals and works closely with the rural welfare and support services involved with cases (Ryan 1997). Child protection workers can gain access to a panel of experts, if necessary brought together at short notice, to discuss a case via teleconferencing. While many calls are able to be addressed via simple discussion, some more complex cases are referred to the Unit’s intake meeting for further discussion. If the Unit accepts the case, further information is requested, and a panel is selected to undertake further work with the case. External experts, such as senior child protection staff, psychologists or legal practitioners may be brought in, as required. Following a teleconference, the Coordinator of the service drafts a report (and recommendations for action) which is then forwarded to the conference participants. Where necessary, the Coordinator is also able to give evidence in Court proceedings (Ryan 1997).

In order to ensure the continuity of care for children, the referring rural child protection workers are encouraged to involve local family support staff, given their role in providing counselling and support to the child and family. The teleconferencing system also has a use as a case follow up system for the hospital. Hospital staff may contact rural workers to check on children identified as being ‘at risk’ by the hospital who have subsequently returned home to a rural area of the state. As information technology improves, it is hoped that videoconferencing will become the primary means of communication for these consultations, enabling a more personalised response to be developed (Ryan 1997).

Conclusion

At present, there is a dearth of literature reporting on effective child protection and family support practice in rural and remote communities. However, as is being recognised by governments and service providers with respect to Indigenous communities, what is apparent is the need to engage in partnership with remote communities in order to identify priorities and to develop flexible solutions suited to the local environment.

Service ‘gaps’ in health and family support services mean that often whichever professionals and community workers are available ‘on the ground’ will have to pick up some of the work associated with preventing and responding to child maltreatment. Consideration should therefore be given to formally recognising and supporting this work, as a means of enhancing services for children and families. A key aspect of such a response is to develop training and support structures for workers. Developments in information technology are already providing new and effective ways to support professional supervision and consultation by enhancing professionals’ ability to communicate quickly and effectively over long distances.

In the final chapter consideration is given to how governments, service providers and the research community can work together to create a better knowledge base with which to inform child protection and family support policy and practice.
EVIDENCE-BASED PRACTICE IN CHILD PROTECTION: HOW DO WE BETTER INFORM PRACTICE?

Does the current western approach to child protection work? How do we know? What is good practice in child protection? In this section, the aim is to explore the means by which evidence-based practice may be embraced to better inform practice.

**Evidence-based practice** can be defined as:

‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals’ (Sackett, Richardson, Rosenberg & Haynes 1997:2).

More specifically, it involves:

‘integrating individual practice expertise with the best available external evidence from systematic research as well as considering the values and expectations of clients’ (Gambrill 1999:346).

The 1960s heralded not only the modern ‘re-discovery’ of child abuse via Kempe and colleagues’ work on the ‘battered child’ syndrome (Kempe et al. 1962), but also the first empirical (or experimental) tests of the effectiveness of health and welfare programs. This heralded the dawn of the program evaluation era, and with it, the expectation that public sector programs should be able to objectively and scientifically demonstrate program success and client satisfaction (Rist 1997).

This shift has eventuated partly as a consequence of a growing focus on demonstrating service cost-effectiveness and cost efficiency (Rees 1994; Cooper 1997), and ongoing concerns regarding the social cost of poorly performing programs (Weiss 1988; Stevens 1999). The validity of the latter has been demonstrated with respect to child abuse and neglect, by the continuing toll of child maltreatment deaths (Stevens 1999), high rates of re-abuse and repeated child maltreatment reports to statutory child protection services, and the continuing high incidence of child maltreatment in the community.

Curtis (1997) argues that it is the ‘the seductive appeal of absolute certainty’ thought to result from the use of quantitative, economically-focused performance criteria that has led to the domination of ‘scientific’ or experimental evaluation methods, an appeal that has been strengthened by the absence of other viable alternatives. Thus, in the 1990s, following a trend evident across a variety of fields including medicine, welfare, and education, there was a growing shift to adopting an ‘evidence-based approach’ to child protection practice. Based on the view that ‘formal rationality of practice based on scientific methods can produce a more effective and economically accountable means of social service’ (Webb 2001:60), the intention is to make policy and practice decisions informed by a critical appraisal of the best evidence available rather than merely ‘accepting famous ideas just because they are famous’ (Sheldon 2001:803).

**SIMPLY THE BEST? – RANDOMISED CONTROL TRIALS**

Empirical evaluation can be defined as involving the conduct of a ‘true experiment’ (Fink & McCloskey 1990). This requires pre- and post-test comparisons of matched control (‘no treatment’) and experimental (‘treatment’) samples. Overall, the intention is to evaluate with large sample sizes over time, enhancing the potential for future replication.

Of all experimental approaches, it is randomised control trials (RCTs) that are considered to be the ‘gold standard’ or best practice research (Fink & McCloskey 1990; Smith 1999). Such designs involve the random allocation of participants to either an experimental group or a control group, enabling the researcher to overcome a variety of potential sources of bias and provide the best chance of determining an unbiased estimate of the effect of participation in a particular program (Chalk & King 1998).

Unfortunately, many have taken evidence-based practice to mean:

‘that practice should be based upon the evidence of randomised control trials alone, and that all other practice is either not evidence-based or of a lower quality ... This narrow approach, whilst not one envisaged by the original proponents of evidence-based medicine (Sackett et al. 1996), is a common misunderstanding of the paradigm’ (Ramchandani, Joughin & Zwi 2001:60).
In actuality:

‘the phrase evidence-based practice (EBP) draws attention to the kind of evidence needed to rigorously test different kinds of practice-related claims. What is needed to critically appraise data regarding a question depends on what kind of question it is (e.g. question concerning effectiveness, validity of a measure, predictive accuracy of a risk assessment measure) (Gambrill 1999:344).

Thus, although generally grounded in controlled, experimental studies, this does not mean that only RCT research should be accepted as valid. Rather, the development and use of the evidence base involves developing as complete a picture as is possible, critically assessing the most reliable and valid information available. RCTs can therefore be seen as an important, (but not the only), component of a research base. Because as Lewis notes:

‘there are problems in trying to apply (RCTs) … to social interventions, as many such interventions are not amenable to research designs involving RCTs’ (Lewis 1998:136).

Despite its ability to demonstrate clear cause and effect relationships with regard to program or practice outcomes, a randomised control design (RCT) or even quasi-experimental approaches are often not possible in situ (in the real world context), or even desirable in every instance. First, they are not particularly sensitive to local and contextual factors that may affect practice and professional decision making (e.g. Webb 2001). Second, only a small proportion of published research – even in medicine, the home of the RCT – is able to be based on RCTs as it is often too difficult and too expensive (in terms of time and money) to be utilised.

It is important therefore, to recognise that there are a variety of research methods that can provide a degree of experimental control, reliability and validity. The trick is to tailor the methods to the research question being investigated and any situational constraints. For those reasons the use of a multiple methods (or triangulation) approach is advocated. Combining quantitative and qualitative methods, and not necessarily excluding RCTs, this approach can provide a better understanding of applied social phenomena, such as child maltreatment and child protection work (Lewis 1998; Tomison 2000b).

Developing a Comprehensive Picture

What is also required when creating an evidence base is the development of a comprehensive picture of what works. Research should consist of a hierarchy of steps that builds to a comprehensive evaluation of policy and practice, not merely a measure of outcome or ‘success’ which does not tell us why a particular initiative is successful. A research program is therefore the equivalent of a basic program evaluation model, and should include the following stages in order to fully assess an issue (Tomison 2000b):

Baseline (or input) stage: where the question to be addressed is documented; aims, objectives etc. reported; and the development of the program or initiative described.

Process (also known as implementation or formative evaluation): The extent to which a program or initiative is operating as intended via the assessment of ongoing program elements and the extent to which the target population is being served. That is, how the program is achieved, any modifications undertaken, which program elements have led to a successful outcome.

Outcome (impact): The extent to which a program or intervention affects participants on a set of specified outcomes, variables or elements; the effect on clients, workers, and wider society. Outcome studies are often the focus of research where a primary aim is to demonstrate success to funding bodies.

Overall, to develop an evidence-base requires an investment in a research base that supports comprehensive investigation and evaluation. Determining why something works is just as important as determining whether it works at all.

However, Lewis contends that to develop a truly comprehensive assessment regarding a particular issue, undertaking input and process analyses in combination with impact/outcome assessments, is only part of the process. It is also important to give consideration to what types of information can be incorporated into the assessment. Lewis contends that a wide range of information should be drawn upon, in addition to research data, such as ‘experiential knowledge, common sense, practice wisdom, user perspectives – rather than simply statistical correlations, important though these can be’ (Lewis 1998:136).
HOW CAN A GREATER INVESTMENT IN RESEARCH AND THE EVIDENCE-BASED APPROACH BE FACILITATED?

Taking as a ‘given’ the general disparity between the levels of funding available and the need for research in this field, other issues require addressing if both the conduct and use of research are to be facilitated.

Governments

First, as noted above, substantial changes to policy and practice in child protection systems have often been implemented without careful, evidence-based consideration of the effectiveness of existing systems, or proof that the new initiative will have a significant, positive impact. This tendency has been exacerbated by the crisis-led approach to development in child protection.

Child deaths and regular adverse media coverage on a variety of aspects of child protection practice (leading many workers and services to feel that when making decisions or taking action they are ‘damned if they do, damned if they don’t’) have helped to create a climate where it is, at times, more important to be seen to be making some form of response to alleviate concerns rather than taking the time to plan a considered response (so-called ‘policy by media’, Goddard and Saunders 2001). As a result, changes to policy and practice have often not resulted from the careful consideration of evidence-based practice.

Further, the absence of strong research knowledge has hampered attempts to make considered strategic decisions. In order to minimise the tendency of ‘quick fixes’, child protection departments require the resources (time and funds) that will enable them to develop a research plan able to adequately assess service limitations and the implications of advocated policy and practice changes. This will require a cessation in ‘innovation-led’ policymaking (the desire to be seen to be taking action and adopting new approaches) and the common practice of only funding pilot programs of limited duration. Such policies impact negatively on the ability to adequately assess trial programs and to determine their efficacy (Tomison 2000b).

However, addressing such issues leads to a catch-22 situation. Research evidence is required to provide an alternative to crisis-led, ‘quick fix’ or innovation-led policymaking. Yet to obtain that evidence requires the development of a body of knowledge that can only eventuate if governments and/or departments invest in programs and research with timelines that allow adequate assessment and a slower approach to the implementation of changes to practice. Making that investment appears to be more likely when departments are not in crisis and governments do not have to make quick responses to child protection scandals.

Uniformity

Even allowing for some regional or statewide differences in populations, community needs and service infrastructures, the challenges and solutions facing the different child protection sectors are remarkably similar. Thus it should be that research findings are also, to a large extent, generalisable.

Generalisability would be further enhanced by the state/territory child protection services moving to adopt uniform definitions of maltreatment, case outcomes and data collection processes (although this would require legislative changes). In recent years, despite attempts by the Australian Institute of Health and Welfare and Standing Committee of Community Services and Income Security Administrators (SCCSISA 1998) to develop uniform data definitions that would enable the collection of uniform community services data from across the country, child protection systems appear to be becoming more divergent in their approaches, such as the introduction of the New Directions ‘case streaming’ model in Western Australia (Tomison 1996c). Such trends have hampered the generalisability of research investigating child protection systems and will reduce (to an extent) the value of any national research plan of action.

Cross-sectoral collaboration

Child maltreatment is a complex phenomenon that may reflect the degree of underlying social problems in a family, community or society (Melton & Flood 1994). The adequate prevention of child maltreatment requires that an holistic approach be adopted in order to address what are often multiproblem, disadvantaged, dysfunctional families. It has been demonstrated that attempts focusing primarily on remediating a single family problem are often not as effective as approaches that utilise a multivariate, holistic approach. Such programs target the influence of constellations of family factors and/or problems, often working in collaboration with other services (Tomison 1996b; Durlak 1998).
There are clear associations between a variety of social ills and child abuse and neglect. There are similarities between the risk and protective factors underpinning the development of a range of social ills. Over time, a high degree of congruence has developed between the prevention of the various forms of violence and/or social ills, in terms of the priorities and strategies for action that have been proposed and undertaken. Clearly therefore, the prevention of child maltreatment and other social ills, and the enhancement of the professional systems would be facilitated by greater cross-sectoral collaboration and coordination from government, researchers and non-government agencies from policy-level linkages down to the enhancement of relationships between sectors and agencies at the service provision level. In research terms, this could be facilitated by the development of a cross-sectoral research group (see below).

Agency and departmental issues

In order for statutory child protection services and non-government child welfare and family support agencies to make the most of research opportunities, to develop an evidence base and/or evidence-based practice, a number of issues should be addressed, some of which are discussed below.

• The first step must be the development of a research culture, where research is valued across an organisation or department and where the pursuit of research by internal and external parties is encouraged and facilitated. [This does not preclude negotiation regarding the projects undertaken, the methods used or the dissemination of results.]

• Second, a culture of evidence-based practice should be developed. Staff should be trained in the process of evidence-based practice. That is, to identify an answerable question and the information needed to answer the question; to (efficiently) track down the best evidence available; to critically appraise the evidence for validity and usefulness; to apply the results; and then to assess or evaluate the outcome (Gambrill 1999).

• Third, departments must make the most of the information that is already being collected and stored, ensuring adequate record-keeping and data management. That is, facilitating the research process by enhancing information sources and encouraging analysis by internal staff with research expertise and/or by external research bodies. Significant data quality issues currently hamper attempts to assess child protection practice.

To achieve these steps, a number of ‘agency’ issues need to be addressed.

Agency defensiveness

Parton (1985) described defensive practice as professional and agency self-protection, where child protection professionals are not prepared to take risks in case management or decision making for fear that they may make an error and subsequently be vilified or sued. This may lead to an inflexibility with respect to child protection investigation, or the minimisation of abusive concerns; either practice may in turn create harm for children and families (Satyamurti 1981; Jones 1991; Hallett & Birchall 1992).

Certainly, the regular criticism of child protection departments in the media (and to be fair, often in research publications) has led, at times, to a highly defensive stance by workers and department managements. This has translated into a reluctance to expose departments to further criticism via research unless it (and the dissemination of findings) is able to be entirely controlled by the department. It is becoming common for research to be contracted on the basis that a department has full intellectual ownership of the work and veto rights over dissemination and publication of the results.

Restrictions on intellectual property is a major issue for research bodies who, if they cannot publish the results of research they undertake, are unable to justify the time and academic resources expended. For those relatively few studies that are being undertaken, or that are proposed, the ‘ownership’ issue is beginning to seriously impact on what can be undertaken and achieved. First, a body of evidence is not seeing the light of day, in some cases even where the results are predominantly positive. Thus, the ability to learn from these studies – in research and practice terms – is substantially reduced. Second, overly restrictive contract terms means that researchers will be deterred from applying to undertake contracts. The withdrawal of such research expertise has the potential, over time, to affect the quality of the research that is able to be produced.

There is a clear need for a change in the ways in which research is undertaken – whether it be
independent or contract research undertaken for a department or agency. Despite the risks of (once again) having practice errors or flaws in service delivery systems being highlighted, departments require research to inform practice. Admittedly, this needs to be undertaken in a manner that does not merely ‘catastrophise’ the system, but provides a balanced picture, creates learning and provides a means of enhancing or guiding policy and practice development. It must also be done in such a way as to enable researchers to disseminate their work within the department and the wider child protection field. The issue of partnerships in research is discussed further, below (see Researchers below).

Developing a culture of evidence-based practice

There is a need to develop a research-friendly culture within child protection departments, such that research is valued as a means of better understanding child maltreatment and of determining the most effective professional responses. Research has indicated however that child protection workers generally fail to keep up with research knowledge and instead rely on ‘practice wisdom’ as the main means of informing their practice (e.g. Gambrill 1999). While practice wisdom is a vital component of an agency’s knowledge, at times some sections of the child protection and/or family support sectors appear to operate under the assumption that their views and experience, in isolation, provide an accurate, comprehensive assessment of practice that can adequately inform changes to service delivery. That is, there appears to be a feeling that ‘we think this is what’s happening – therefore it is’.

Such attitudes can lead research to be perceived as a waste of valuable resources that will, at best, merely confirm practice wisdom. Thus, the costs of participating or undertaking research are not seen as being offset by a significant increase in knowledge. Hence, overcoming agency defensiveness and developing an agency culture where research and evidenced-based practice is valued should be key features of corporate planning.

In addition, training programs are required that can teach workers’ the value of using research to inform practice. Specifically, such courses will need to teach the process of evidence-based practice: identifying a question and the information required; knowing the information that is required to answer the question; the critical review and assimilation of information; and the ability to determine the implications for practice. Workers will also need to be educated on how to access and use the information resources of specialist research agencies (e.g. National Child Protection Clearinghouse) and academic libraries to supplement their knowledge (Ramchandani et al. 2001).

As an indication that researchers and practitioners are recognising the need to train staff in evidence-based practice techniques. Darlington & Osmond (2001) reported on their recent development of the Using Knowledge in Practice (UKIP) project. This system is designed to assist child protection workers to make better use of research-based knowledge in making practice decisions. The project was piloted with the Queensland Department of Families, Youth and Community Care in 2001.

Research/Training unit

In addition to a general promotion of an evidence-based approach, a key feature of the shift to a research culture should be the development and empowerment of agency staff in research roles. That is, utilising staff experience, practice wisdom, and awareness of agency culture in combination with research expertise in order to facilitate the conduct (internal and external) and adoption of research knowledge. [The latter may incorporate the development of worker training programs.]

 Appropriately trained staff provide an in-house expertise or capacity to conduct rigorous research, enable agencies to conduct highly sensitive research while avoiding issues of client confidentiality (e.g. legal responsibility to keep client information within the department) and/or enable research ownership in circumstances where a department may not wish to publicise any results.

The development of specialist in-house expertise is also vital as a means of ensuring that when research is done, particularly research involving external researchers, it is based on accurate information about the department, agency culture and practices. It is contended that researchers produce more balanced findings if they seek out, or are able to obtain practitioners’ interpretations of the findings. An internal research cadre is best placed to provide

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17 The latter term was picked up while the author was working with a child protection manager. She defined the term, in child protection vernacular, as presenting the most negative or pessimistic perspective when describing the child protection system.
an insider’s view of the results, or to ensure practitioners are able to provide their interpretation of the data. Thus, such staff could assist in bridging the research-practice gap, such that external experts’ research benefit from the interpretation and assistance of those ‘at the coalface’, thus increasing their ecological validity.

Importantly this would also enable academic and practice concepts to be more accurately translated, ensuring a better understanding of practice and ensuring that research findings are produced in a form that encourages adoption or use by practitioners. It would also minimise the publication of ill-considered conclusions that merely result in the scapegoating of practitioners.

**Utilisation and dissemination**

Knowledge has to be available if it is to be used. Once research is completed it is vital that the results are used and disseminated widely so as to inform practice. This can be facilitated in a number of ways. First, agencies should encourage researchers (internal and external) to produce academic publications. This provides status for the research and also contributes to the dissemination of knowledge to the field from a source that is considered reputable (that is, books, refereed journals etc.).

Second, it is vital that the research is translated for practice. Researchers have an obligation to assist internal ‘experts’ to use research findings to develop material or training programs as a means of disseminating the research findings effectively through the child protection system – that is, to contribute to practice wisdom. It would be particularly beneficial if researchers devoted time to developing research syntheses or meta-evaluations – rigorous reviews designed to encapsulate knowledge of a particular issue and presented in a form enabling easy access and comprehension by practitioners and policymakers (Gambrill 1999).

Unfortunately, although many researchers would be pleased to work more effectively with child protection agencies, particularly if it became a condition of access to information, it is currently the case that very few researchers are requested to develop practice materials or to provide seminars or training sessions for practitioners or policymakers.

Overall then, as part of any research undertaking, it is strongly recommended that a publication/dissemination plan be developed (allowing the agency a period of confidential review of the results prior to publication or use). This should incorporate both academic and professional practice publications (including meta-analyses if practicable) and training schedules.

In summary, it is recommended that child protection and/or family support agencies should:

- send the message to staff that research is important – which requires the development of a professional culture that values research and the evidence-based approach;
- bridge the research-practice divide by investing in internal research ‘experts’;
- promote collaboration and partnerships with researchers, whether a project be an independent or a contracted study;
- ensure researchers have the advice and/or resources to overcome issues of language and culture to ensure the resultant message is adopted by target audiences (practice and research);
- negotiate confidentiality, ownership and dissemination of the research. The growing trend of refusing to allow the release of research findings is currently having a negative impact on the research that is being undertaken and the sharing of information as to what works; and,
- develop effective methods of internal (and external) dissemination of research findings. At times, it appears that much of the research that child protection departments do undertake or facilitate does offer benefits for practitioners, but is under-utilised. What is required is use of research/training ‘experts’ to work in collaboration with the researchers to produce materials tailored for the needs of the workers.

**Researchers**

It is generally acknowledged that child protection work is exceedingly difficult and that no matter what decision is made, a child protection worker is liable to have that decision criticised by other professionals, the media and wider community. It should also be acknowledged that child protection work is typically not done under ideal situations – workers must contend with involuntary, uncooperative and/or hostile clients, a lack of resources, high workloads etc. (e.g. Tomison 1999). Thus, when investigating aspects of child protection practice it is often the case that the focus is on...
understanding practice and identifying elements of the system that may benefit from alternative approaches. That is, the research is often focused on identifying less than optimal performance (and hopefully offering some solutions).

While researchers should not cease to document the realities of practice – ‘warts and all’ – it is apparent that a proportion of the research that is produced is perceived by workers as merely scapegoating them, offering what they perceive to be a biased representation of their experience. Although this may be the case in some instances, most researchers are genuinely attempting to develop as accurate a picture as possible of the realities of child protection practice. As was noted above, it is argued that some of the so-called ‘bias’ or perceptions that research is not an accurate depiction of practice, is based in a failure (or a lack of opportunity) to adequately incorporate workers’ or the agency’s perspective. That is, it represents a failure to take into account agency cultural issues and the language of practice. This emphasises the importance of an ‘action research’ approach, where researchers have access to practitioners’ perspectives on aspects of practice and/or their interpretation of the research findings.

The identification of service deficits or areas requiring improvement provide vital data for researchers if they are to ensure their findings are utilised and translated into practice. Yet it is important that a problem focus or ‘catastrophising’ does not become the primary means of information-sharing. The way results are presented – balancing negative and positive aspects of practice, ensuring that the language used, and the understanding of what has occurred, is congruent with workers’ perspectives – will improve the utility of the research. Although a researcher may maintain a different interpretation of the findings, giving workers a voice is important for ensuring that the results are perceived as balanced and objective. It facilitates the acceptance and use of research findings in child protection systems and ensures that the researcher is able to make the most of the collected data. The tension inherent in such a process however, is avoiding being too influenced by practitioner views such that important findings are minimised or inappropriately modified merely to avoid conflict.

Overall, to conduct research with the child protection departments requires entering into an agreement based on mutual trust. From the researcher’s perspective, the benefits of engaging in a collaboration relate to: enhanced access to the field; ensuring the most accurate depiction of child protection practice; and thus ensuring the work is a valuable addition to the research and practice fields. The only possible downside is that rather than being more balanced, the research process and interpretation of the results may become too influenced by agencies or practitioners such that important, less positive findings are minimised. With care however, the potential benefits of getting the support/advice and wisdom of the system’s ‘insiders’ far outweigh the risks.

Research partnerships

In the past year at least two national associations of researchers have been developed to create a national agenda for research on children and more specifically, an agenda for research on the out-of-home care system (the latter being discussed at this conference). A sub-committee of one of these committees, or another national body, is required to focus specifically on research investigating child protection practice. Such a group, perhaps linked in with the Australian Research Council, should also include government policy makers and non-government service provider representatives.

The group would be able to regularly advise on new developments in child protection-related research and practice. More importantly, the group should be charged with the development of a national research strategy. Such a framework or ‘master plan’ would work to ensure uniformity of purpose, clarity of mission, and enable large-scale cross-sectoral research initiatives (with pooled funding), while also forming a base for sector-specific interventions. The group would also ensure communication was maintained between the various sectors and states, and enable the sharing of new research and lessons from practice.

Overall

Although making some useful contributions to child protection knowledge, Australia is currently failing to adequately invest in developing a child protection research base. However, there are some promising signs of change – greater recognition of the benefits arising from adopting an evidence-based approach, and some recognition of the need to create better research-practice partnerships in order to get the most from the research that is undertaken. In creating further opportunities for change it is contended that the three principles for conducting
and using research – from the perspectives of both researcher and practitioner – should be:

- **Educate** (on evidence-based practice)
- **Evaluate** (critical appraisal of the data and investment in ongoing research investigations)
- **Disseminate** (informing the field using both academic and practice-oriented material).
CONCLUSION:
CHILD PROTECTION AND FAMILY SUPPORT IN THE 21ST CENTURY

Acknowledging the realities of current child protection practice, this report has provided an overview of some of the issues in the identification, assessment and management of suspected child maltreatment cases in Australia. It is contended that the restructuring of Australian child protection systems – based predominantly on the U.K. experience and Messages from Research in the mid-1990s – has focused on enhancing case screening or gatekeeping, with a predominant focus on addressing ‘significant harm’. However, there has also been recognition of the need to adequately address wider family support needs as a means of preventing the occurrence (and recurrence) of child abuse and neglect.

For the most part, most policy changes have been translated into attempts to develop better identification and assessment practices, and the development of new risk assessment tools or guides. Few child protection systems, including the U.K. Social Service Departments (Parton 1997) have enacted policies to develop better partnerships between workers and families, or to ensure all families are actually assisted to remedy their problems, whether they be child protection matters, or generalised family dysfunction.

It could be argued that the role of statutory child protection services is only to deal with families where there are significant issues of child maltreatment or a risk of maltreatment. Concomitantly, generalised family support needs are therefore seen as the responsibility of the child welfare and family support system. While such a demarcation may be appropriate, the substantial increase in the number of reports to child protection services experienced across the nation (and the western world) in the past decade has seen the bulk of the resources for family support and child welfare allocated to the child protection system at the expense of child abuse prevention and wider family support. As a result, many ‘at risk’ families, or those with more general social problems have struggled to obtain assistance through either system.

The question that should then be asked is: Is there a point in assessing risk more effectively? if as Corby has noted, ‘the resources needed to achieve risk reduction are not available’ 1996:27).

Most children at severe risk of maltreatment, or who are being seriously maltreated, are already known to statutory agencies. Child protection gatekeeping procedures, while perceived as still (inappropriately) allowing in cases where there are minimal maltreatment concerns, are generally quite successful at identifying children at serious risk. For example, taking the worst case outcome, while the death of a child at the hands of a caregiver may indicate a failure of professionals to adequately assess the level of danger to a child at a particular time, (often associated with caseplanning and interagency communication problems), the vast majority of child deaths are known to statutory child protection services.

It is therefore concluded that for changes to identification and assessment processes to have meaning for children and their families, there must be a change in the conceptualisation of the roles of child protection and the wider child welfare and family support systems. Focusing on minor adjustments to the threshold for statutory action and enhanced accountability without adequately resourcing the child protection and wider family support systems will significantly reduce any possible benefits for children and families who are identified by the professional system, particularly those with generic welfare concerns. Thus, child protection ‘success’ clearly rests more with the provision of adequate family supports to ‘at risk’ and maltreating families than changes to intake assessment.

The ‘system’ must therefore be conceptualised as a prevention-protection ‘continuum of action’, where regardless of the level of protective concerns, children and families receive some form of support to alleviate their concerns. The threshold for action can then be seen as less important than ensuring the protection of children within a process of family support, of true child-centred family-focused work.
Governments and child protection departments have recognised the need to address the needs of ‘at risk’ families, (e.g. Western Australia’s *New Directions*), but the reality is that greater investment is required to ensure that there is a significant secondary prevention impact. (At the same time, it is recognised that providing support to Indigenous and remote populations, where there are relatively few professional supports, raises significant service provision issues.)

Such a framework will only result if governments and departmental management teams recognise the importance of preventing social ills, particularly child maltreatment and the social and economic benefits that can result. Under such an approach, identification and assessment, while important, truly no longer drive the child protection system, but maintain an important position in a model where remedying dysfunction is given primacy. Although it is unlikely that this framework will be adopted in the short-term, it is proposed that the ‘continuum of action’ be retained as a benchmark against which future re-structuring and innovation in practice are measured. What then for the future?

**Future Directions**

In the coming decades it can be expected that the adequate provision of family support will remain a driving force in the prevention of child maltreatment. It is likely that further evidence will be produced of the social and economic benefits of early intervention and family support services, leading to a continued focus on prevention, and in particular, an expansion of the family support services.

There is likely to be increased emphasis on ensuring greater accessibility to services, especially by those families most in need; and that the range of services available will be increased to better cater for children and families. It is hoped that any such expansion will include the provision of long-term monitoring and support options for families, particularly those with ongoing ‘chronic’ problems, as this is a serious gap in the existing family support system (Tomison 2001; 2002).

Continued efforts to strengthen and expand family support services should also lead to a much stronger (and highly valued) role for the non-government sector. In many ways this can be considered a reclamation of the prominent role held by such agencies for much of the nineteenth and twentieth centuries (Tomison 2001). Should the preventative approach prove successful, there is likely to be a gradual de-emphasis on the government-run statutory child protection response. Much like the ideal proposed by proponents of the current ‘family support’ child protection models, only a small number of families – families that health surveillance, early intervention and family support services are unable to help – will receive a child protection response. In many ways such a system could look much like it did before the rise of statutory child protection agencies in the 1970s. Such a utopian system may also lead to greater attention being placed on addressing the structural forces impacting on families.
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CURRENT ISSUES IN CHILD PROTECTION POLICY AND PRACTICE

Northern Territory Department of Health and Community Services