

nsw commission for
children & young people

Submission to the Special Commission of Inquiry into Child Protection Services in NSW

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**Think Child,
Think Family,
Think Community**

From a child protection system
to a system for protecting children

Introduction

Child protection cannot be separated from policies to improve children's lives as a whole.

UK Green Paper "Every Child Matters", 2003

Every child has the right to feel loved and supported within the family and the community and to participate fully in the richness of life. We must support our youngest citizens in their pursuit of such goals with strong public policy and ample resources. Australia has both the material and intellectual wealth to achieve this, but we must focus and integrate our efforts and harness the political will to improve the lives of our children.

The Special Commission of Inquiry into Child Protection Services in NSW (the Special Commission) was born from a concern to protect children from the abuse and neglect which shadows some young lives. To address this concern we must take a broader view, and one that is based on worldwide understanding and experience in the field of child well-being.

It is widely accepted today that children will be better protected from abuse and neglect, and their development and well-being promoted, if we build 'a system for protecting children' so they grow and develop rather than focus narrowly on 'the statutory child protection system'. It is as unrealistic to expect the NSW Department of Community Services (DoCS) to prevent child abuse and neglect as it is to expect public hospitals to prevent illness, or prisons to prevent crime. Remedial services are an important but ultimately a small part of "growing up our children to be healthy and happy".

By overloading our statutory child protection agency with the responsibility to prevent *and* assess all *possible* cases of child abuse and neglect, we have diminished its capacity to perform its core and unique functions. These functions are to bring before a court those cases where statutory intervention is necessary to protect a child and to fulfil the role of *in loco parentis* for children who are admitted to State care. The broader responsibilities must be addressed by a far wider group, which includes state, not-for-profit, community and family organisations and services.

Organising Principles

Organising principles enable us to order information and make sense of the world. They help us to incorporate new information and to set priorities. Such principles are especially valuable when designing systems to address complex challenges.

The following Organising Principles need to be at the heart of a system for protecting children:

1. **Develop legislation, policies and services for children from a child centred view so that they reflect children's needs and experiences.** This will result in more effective policies and services and it will protect the rights of children to take part in decisions which affect their lives, as set out in the UN Convention on the Rights of the Child.
2. **Promote children's well-being based on research, on our experience of the most effective strategies and of the key services necessary for promoting such well-being.** Strategies to reduce key risk factors such as parental alcohol and drug misuse and domestic violence at a population level are central to this, as are strategies to strengthen universal child health and education services to reach all families and to provide additional support to vulnerable children. This requires a major commitment to a sustained research and development strategy and a sophisticated approach to translating research into policy and practice, listening to the experience of those involved, and scaling up effective innovation across the State.
3. **Integrate all responses to vulnerable children and young people.** Every agency receiving public funding should provide a door to access the full range of services needed by each child. Every agency needs to answer the questions: What can I do to support this vulnerable child? And what can other agencies do to support this child? Services should also understand that when they are seeing an adult in difficulty they may also be seeing a child who is in need of help.

4. **Develop the workforce and value the contribution made by people in their professional role.** Long term strategies are needed to build a work force that can meet the broad range of children's needs. Child protection workers need to be valued in the community and their status and conditions of work improved. All relevant government and non-government organisations need to transform the prevailing culture of 'shifting risk' to one of 'sharing risk'.
5. **Meet the needs of children and young people for whom the State is *in loco parentis*.** The State must provide stable and emotionally secure care and meet the physical and mental health, educational and recreational needs for the children and young people for whom it is morally and legally responsible. The responsibility for this is not that of DoCS alone. All health, social care and education services should give priority to children in State care.

Specific Recommendations

The following specific recommendations are based on the above principles and the supporting analysis which follows. They also build on the extensive reform effort currently underway in DoCS.

Tackling disadvantage

Children are harmed by poverty, domestic violence, and parental alcohol and drug abuse, and mental illness. The extent of these problems needs to be reduced at a population level if children are to do well.

1. The NSW Government should seek to place on the COAG agenda the development of specific national frameworks aimed at reducing disadvantage to children caused by poverty, domestic violence, parental alcohol misuse and illicit substance use, and parental mental illness.

Strengthening supports around all vulnerable children and young people

Supporting all vulnerable children promotes their well-being and reduces demand on the statutory child protection system. This should be at the family, community and government level. All levels of governments have a role to play.

2. The NSW Government should encourage the Commonwealth Government to meet its responsibilities to vulnerable children and young people by:
 - Developing a large, comprehensive and ongoing program of public education regarding those specific parental behaviours which represent a risk to the well-being of children using evidence-informed health promotion and social marketing approaches, supported by services to respond to the demand this may generate
 - Giving first priority for placements to disadvantaged children in its Priority Access Guidelines for Children's Services
 - Creating employment opportunities, housing and community infrastructure in Aboriginal communities
- Extending the COPMI (Children of Parents with a Mental Illness) initiative to alcohol and drug treatment services
- Expanding the role of Centrelink to identify from within their existing clients those families where children and young people are vulnerable and provide a comprehensive case work and referral service to meet their needs
- Expanding Family Relationship Centres to respond to a wider range of family conflict issues including those arising in kinship care
- Expanding the Reconnect service system for young people in serious conflict with their family including the development of independent living skills if they are unable to return home
- Increasing the current allowance to young people leaving care to support their transition to independent living
- Reviewing the Youth Allowance rate.

 3. NSW Health should offer a home visit by a child and family health nurse to every family with a new baby. Where the child and family health nurse forms the judgement that the family could benefit from additional support, they should be offered a free, sustained nurse home visiting service until the child is two years of age.

Health at work for Aboriginal mothers and babies

The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) was funded by NSW Health to improve the health of Aboriginal mothers and their babies. The AMIHS provided care to 689 women in 2003 and 2004 with about one in four being less than 20 years of age.

The evaluation of the strategy in 2005 found improvements in the number of Aboriginal women attending their first antenatal visit before 20 weeks and also reductions in peri-natal morbidity and mortality rates. It also found that Aboriginal women were very satisfied with the program. Aboriginal women reported that home visiting, the inclusion of an Aboriginal Health Worker and Aboriginal Health Education Officer in the team and reminders about and transport to antenatal appointments were the most important aspects of the AMIHS.

Integrating services to children

Vulnerable children should have the full range of their needs met regardless of which agency door they enter first. And when seeing an adult, services need to remember there may be a child behind that adult who requires support.

4. Drug, alcohol, mental health, disability and housing services should develop and trial an intake process that identifies those adult clients who are parents and then develops an intervention plan that also meets the needs of the adult client's children.
5. Transfer the service delivery aspects of the Early Intervention Program (Brighter Futures) from DoCS to the health and non-government sector, with established criteria for vulnerability and entry to the program. This should be the first step in implementing integrated services for children at the local level. Other existing investment in DoCS, Health and Education should be transitioned into an integrated framework within three years.
6. Specifically address the needs of children and young people, including better integration of criminal and support services and the removal of the offender not the child in violent situations in the Framework on Family and Domestic Violence (being developed under the NSW State Plan).

Providing early support for vulnerable children and families

The Benevolent Society delivers the DoCS-funded Brighter Futures program in eight regions across NSW, including both metropolitan and rural areas.

The Benevolent Society takes a whole-of-community approach to finding solutions. They work collaboratively with existing services and communities and seek to attract employees who have the skills and experience to engage families over the long-term.

In Moree, for example, The Benevolent Society established the Brighter Futures service in mid 2007. Although new to the area, they were successful in forming a relationship with a well-known local grazier who has provided a centrally located building cost-free for them to run the service from. The local Aboriginal grandmothers group, The Granimators, who run a breakfast program for children, also use the building regularly and The Benevolent Society is providing them with fundraising support.

With more than 17% of the Moree population of Aboriginal or Torres Strait Islander descent, The Benevolent Society sought to employ experienced Aboriginal workers to engage local families and has been successful in recruiting a team of six employees, of whom four are Aboriginal including the Team Leader.

The Benevolent Society has formed a relationship with the Kamilaroi Midwifery Service and is supporting their Aboriginal Young Mothers Support Group, which is an arts project. They have also partnered with Moree Family Support Service to jointly run a mobile support playgroup in the more isolated Aboriginal communities of Pallamallawa, Garah, Ashley and Mehi Crescent.

Although only being part of the Moree community for the past 12 months, The Benevolent Society is now seen as an integral part of the service system. Feedback from the Aboriginal community is that the Centre is seen as a neutral community access point that everyone is happy to go to regardless of which Aboriginal community they come from.

Mandatory Reporting Pathways

Steps need to be taken immediately to reduce demand on the overloaded DoCS child protection response and to improve its capacity to perform its unique functions.

7. Except where there is evidence of significant harm to a child or immediate safety concerns, major groups of mandated notifiers (police, health, education and NGO services) should have the option to report concerns to a Child Protection Consultant within their own organisation. Such a consultation should be deemed to satisfy mandatory reporting requirements.

The purpose of the consultation would be to determine if the case was one that required a child protection investigation and, if so, this should be directly referred to DoCS. Where a case was not reported to DoCS, or if DoCS decides not to investigate the matter, then an appropriate case plan should be developed by the agency (or Consultant) to reduce the child's vulnerability. This case plan should be based on a Common Assessment Framework which will need to be developed.

Child Protection Consultants should be registered by DoCS, have appropriate qualifications and experience, and be given training in child protection assessment.

Consultations should be recorded and accessed, with appropriate privacy restrictions, by DoCS staff and all registered Child Protection Consultants in NSW.

Members of the general public and those service providers who do not belong to a major notifier group and who have concerns about a child should continue to use the existing centralised intake system.

This system including the Common Assessment Framework should be trialled in at least one urban and one rural high need area. The evaluation should compare the outcomes for children, the efficiency of such a process and the changes in inter-agency relationships. If successful, this model should be scaled up across NSW and consideration given to extending the use of the Common Assessment framework to all relevant services encountering vulnerable children.

Working with families to protect children: Family Group Conferences in NSW

Several family group conferences or family decision-making pilots were conducted in different areas of NSW. The first was carried out in Western Sydney by Burnside, with DoCS. Family Group Conferences bring family members together after considerable preparation and discuss how DoCS concerns and "bottom line" can be met by the family and other services. The "bottom line" may be, for example, that the child cannot live at home while the parents drug use results in neglectful conditions for the children. Beyond or above the "bottom line," the family is encouraged to make their own decisions.

The evaluation found very strong support among family members (81%) and especially among DoCS staff (100%) for an independent facilitator. Family members commented positively on the benefits of "clearing the air" about family conflict, on being open about the problems the parents were facing, and finding out about available services. A number of times parents would have preferred to have had this information earlier. They also wanted access to such a process before DoCS intervention became necessary. A very recent review of family group conferences in Australia concluded that "while conferences have had an impact on practice, they have not yet become part of mainstream practice in most of Australia" (p 16) and are quite different here from the original New Zealand model. Cashmore & Kiely, 2008; Harris, 2008.

Strengthening the response to abused and neglected children

Services should be provided to abused children and young people and their families so that the risk surrounding the child is reduced and they can remain with their families, if appropriate.

8. The Children's Court should be headed by a judge, and appeals from the Children's Court should be heard by specialist District Court judges with appropriate knowledge.
9. DoCS should develop and evaluate the use of different models of Alternative Dispute Resolution (ADR) at different stages of the process as provided for in the legislative framework that are able to gather appropriate information and to involve key people in a respectful way to develop creative and fitting solutions for caring for and keeping children and young people safe.
10. All allocated cases should have a secondary risk of harm assessment completed within 28 days and an agreed case plan developed that is supervised and monitored at set times or milestones by the managing Community Service Centre.
11. Tools, resources and training should be provided to all DoCS caseworkers on assessing and monitoring parental capacity to change so that decisions regarding children's safety are informed by parent's actual behaviour.
12. Re-model KIDS (the DoCS casework Information Technology system) so that it provides immediate reports of the child's and family history and patterns of care for DoCS caseworkers.
13. Resource allocation models for DoCS should be based on providing an intensive casework service to those children who are assessed as being at significant risk but who are not removed from their families. This should include intensive family preservation services to assist families to achieve a safe reunification for the child and to prevent future removal where possible. These casework services should be delivered by staff from DoCS, Health and NGOs.

The NEWPIN program

UnitingCare Burnside's NEWPIN program (New Parent Infant Network) works with families under stress, and offers intensive parenting programs, therapeutic support groups and individual counselling to teach parents how to become better parents.

Burnside operates three NEWPIN programs in local communities. Two are for mothers, at Doonside and Bidwill, and one is for fathers, also at Bidwill. NEWPIN centres can be used by up to 25 families at any one time and members commit to attending at least twice a week. Most families are involved in the program for around 12–18 months.

Evaluations of NEWPIN programs, in Australia and overseas, have found that involvement in NEWPIN improved self-esteem, self confidence and social isolation of women with young families experiencing disadvantage.

14. Review NSW Health PANOC (Physical Abuse and Neglect of Children) services to improve alignment between them and DoCS including referral pathways, response times, information exchange and continuity of caseworker.
15. Provide additional funding to expand the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities* particularly in relation to
 - developing services for children and young people with sexualised behaviours and for juvenile sex offenders
 - expanding forensic services to western NSW possibly through Aboriginal medical services
 - engaging the community in responding to child abuse and neglect
 - providing services to assist communities, families and people heal from the legacy of abuse, neglect and separations
 - the Department of Aboriginal Affairs supporting the implementation and monitoring of the Plan.

Supporting children in out of home care

Children who are removed from their families because of abuse or neglect need the State to provide for them so they develop and grow with the same opportunities as children who live with their parents. Providing stable care, broadening the service models to include professional foster care, retaining authorised carers and increasing their allowance and increasing the NGO's role are important aspects of this.

16. Children under State guardianship should have priority access to all government services including child and adolescent mental health, dental, and remedial educational support services. All children entering care on final orders should have a comprehensive assessment of their health, developmental status and educational needs. Particular focus should be on priority access to specialist services that address severe behavioural problems which threaten the placements of children in foster care.

The KARI Clinic partnership for Aboriginal foster children

KARI Clinic is a partnership between KARI Aboriginal Resources Inc, South Western Sydney Area Health Service and Metro-South West region of DoCS. It is a pilot program that provides comprehensive health assessment for children entering foster care.

Through the work of the KARI Clinic children are getting documented evidence of their health status. Health assessments and reports are providing children with a medical history that they can take with them as they move on. The KARI clinic is also seen as a positive and stabilising experience for the children.

For foster carers the KARI clinic provides an opportunity to talk to professionals about the health concerns of their foster children and an opportunity to be more involved in their foster child's life. It is seen as providing information and guidance to foster carers in their role as carers through improving their confidence and knowledge.

The KARI Clinic also improves communication and relationships between key partners- KARI, Health and DoCS. Through the Clinic's creation, these partner agencies have acknowledged the importance of giving priority to the health of vulnerable Aboriginal children in out-of-home care.

Another of the reported benefits of the partnership is that agencies are starting to recognise the work of the Clinic as core business. Agencies are also better able to access many children who would usually slip through the cracks in the health system. Health staff reported learning more about out-of-home care and there is now greater prioritisation of the health needs of Aboriginal foster children.

17. Use and evaluate the tools and resources developed by the NSW Commission for Children and Young People, Department of Community Services and the Children's Guardian for the participation of children and young people in case planning and decision-making.
18. Designate a teacher in each school where there is a child in out-of-home care to be the out-of-home care mentor. Their role would be to support and monitor the progress of all children in out-of-home care and to develop the school's capacity to provide children in out of home care with positive experiences. The teaching load should be adjusted to allow for this extra responsibility.
19. Develop training and information packages for carers (including kinship carers) and caseworkers on the education system, the importance of education for children in care, and on ways to support children's educational progress. Develop more specialised training and information packages for principals and

teachers on the care and protection system, the effects of trauma, abuse and neglect on children's development, the importance of education for children in care and strategies to engage children in their education.

Build the workforce

No system for promoting children's well-being, reducing children's vulnerability and protecting those who are abused or neglected can succeed without attracting, retaining, and developing the knowledge and skills of the workforce.

20. The NSW Government should seek to place on the COAG agenda the urgent need for a COAG led workforce development strategy for human services workers. It should address financial and other barriers to tertiary study, remuneration, training and development needs and Aboriginal staffing levels. Post-qualifying university child protection courses should be government subsidised.

DoCS builds its workforce through professional supervision and support

The importance for child protection organisations of providing formal, regular professional supervision to its staff is widely recognised. 'Service quality and positive service outcomes' are linked to how well workers are managed, supervised and supported within the organisation. (Farmer & Owen, 1995; Brown & Bourne, 1996; Glisson & Hemmelgarn, 1998; Morrison, 2001).

In recognition of this, DoCS introduced a Professional Supervision Strategy which is now in its second year of implementation. It aims to increase staff capacity to deliver high quality supervision to frontline caseworkers. The strategy consists of a four day training program and monthly practice groups to support the transfer of learning to the workplace. The strategy was reviewed and showed that the percentage of managers who reported to be confident in their supervision practice increases over time. This confidence has been sustained to the 12 month stage of the review.

Building the evidence base

The child protection knowledge base needs to be deliberately built over time and actively translated into policy, service design and practice if we are to ultimately provide for the well-being of all our children. The research agenda currently developed by DoCS is a start but needs to be fully implemented, including the delayed longitudinal study of vulnerable children.

21. Implement the longitudinal study or tracking studies of children entering the system as a means of providing critical knowledge about children's paths into and around the systems, including the services they receive and the longer-term outcomes. This study should develop and trial data linkage between DoCS, Health, Department of Education and Training, Department of Ageing, Disability and Home Care, Police and Department of Juvenile Justice as part of the study.
22. Improve data collection and make better use of existing data including establishing a database for the Children's Court that facilitates reporting of the profile and outcomes of Children's Court matters and by making public the Children's Guardian audit reports.

Data transparency

Understanding what happens when children and their families enter the child protection and out-of-home care systems helps develop a better system. There are figures available on the input side. However, there is little information available about the outputs, and more importantly the outcomes for these children. On the input side for example, DoCS' figures indicate that in 2005–06:

- *9,185 children and young people were involved in actual harm reports*
- *3,771 children and young people were involved in risk of harm reports*
- *3,681 entered care during this period.*

However on the output side there is little information.

For example:

- *How many children are involved in intensive family preservation services?*
- *What orders are sought and obtained?*
- *How many children are placed on supervisory orders?*
- *What are the conditions associated with these orders?*
- *What services do children and families receive prior to and following their return home?*
- *How many children return to care within 3, 6 and 12 months of entering care? Why?*
- *Most importantly, are children who enter out-of-home care 'better off' than comparable children who do not? Under what circumstances? Over what period of time?*

Some of these questions should be able to be answered by reference to the KIDS system but some can only be answered by tracking children through the system in a properly conducted longitudinal study or series of studies which DoCS has committed to.

23. Extend the reporting time for the Ombudsman's report into reviewable deaths to every three years with a focus on deaths from child abuse and neglect and children who die in suspicious circumstances, with annual reporting on progress of recommendations.
24. All recommendations resulting from the Special Commission should be supported and informed by appropriate evaluations and research.
27. Develop a new Priority Delivery Plan via a participatory process which includes children and young people, experts in relevant fields, community members and service providers. Include ongoing monitoring and review mechanisms involving these stakeholders at state and regional level.
28. Give responsibility for implementing the Priority Delivery Plan in each region and for arranging and supporting regional stakeholder monitoring and review mechanisms to Regional Co-ordination Management Groups.

Implementing

Building on and mainstreaming the reform effort by placing implementation within existing planning and monitoring systems heightens the chance of reform succeeding. A legal framework to enable this to happen needs to be implemented. Major restructuring of departments will divert time, effort and energy away from the current momentum for reform and improvement and should not be undertaken at this time.

25. Prioritise infants under 1 and Indigenous children and young people in implementing the recommendations.
26. Include the implementation of the Special Commission's recommendations in the NSW State Plan, replacing the current priority F7, (Reduce rates of child abuse and neglect) and its associated Priority Delivery Plan. The Premier should be the lead Minister and the Department of Premier and Cabinet the lead agency. Implementation should be overseen by the Premier's Delivery Unit and the Human Services and Justice Chief Executive Officers' Forum, with accountability to the State Plan Performance Committee of Cabinet and regular public performance reports against the detailed delivery plan.
29. Review other State Plan priorities and incorporate the Special Commission's recommendations in their delivery plans, particularly those relating to these goals: *keeping people safe; building harmonious communities; healthy communities; students fulfil their potential; strengthening Aboriginal communities; opportunity and support for the most vulnerable; and early intervention to tackle disadvantage.*
30. Lock-in the resources from the beginning, with implementation of new models started in some areas, modified by experience and then rolled-out to all parts of the state. Implementation should not proceed as a series of "pilot" activities which are funded on a short-term basis, then evaluated and made subject to a decision about whether resources will be made available recurrently.

The Alcazar Centre in Windale: a child abuse prevention success

Windale, in the New South Wales Lake Macquarie region, was originally established as a suburb by the New South Wales Department of Housing. In 1999, Jesuit Social Services rated Windale as the most socially disadvantaged community in New South Wales. A comprehensive three-year community renewal process improved the situation.

Proving that preventing child abuse is possible, Windale moved from the worst one per cent in terms of child protection notifications in New South Wales in 1999 to the best 25 per cent in 2003. Windale achieved this outcome primarily through the establishment of a community centre attached to the local primary school. The community centre – known as the Alcazar Centre – was led by a community committee with broad representation. Programs initiated by the Centre included:

- *parenting classes*
- *staged introduction of preschool-aged children to schools*
- *joint exercise and sociability groups for isolated mothers*
- *an Aboriginal health service and community nursing*
- *provision of academic extension opportunities for talented youngsters*
- *relocation of some families by the Department of Housing's to make schools more accessible*
- *involving fathers in various contributions to the life of the school and a general increased involvement by parents in school life*
- *a Shop Smart nutrition program*
- *improved street lighting, enabling safe travel at night, and a Windale 'welcome' landmark, building community pride*
- *sponsorship of school and sporting needs by local businesses.*

Over time, Windale Primary School became a hub of the community, later being used as a blueprint for the Schools as Community Centres initiative across New South Wales. The Alcazar Centre was given an Award for Excellence by the Director General of the NSW Department of Education and Training.

A Success for Children

The Windale community demonstrated that reducing and preventing child abuse and neglect is possible. Because the 'causes' of abuse and neglect are complex and diverse, the solutions can be different to what we might expect. The positive community-based initiatives at Windale had a butterfly effect: small or seemingly insignificant steps ultimately made a significant difference to the children of Windale.

Funding stops

Unfortunately funding for this project was allocated for only three years and has now stopped. Thus a proven success has been a victim of the policy of short-term funding for 'pilot' projects. It suffered from the lack of strong and realistic policies to ensure long-term support of vulnerable communities.

From "Practical child abuse and neglect prevention", article by Adam Blakester, in Child Abuse Prevention Newsletter, vol. 14 no. 2 Winter 2006.

SUPPORTING ANALYSIS

Historical Background

Child abuse and neglect are not new problems but until the late 19th century this was deemed beyond the domain of the State except in extreme cases that were treated as criminal matters. The State did assume some responsibility for destitute and abandoned children, assisted by churches and charitable organisations. But as social attitudes changed, the State gradually assumed greater powers to remove severely neglected or mistreated children from their families. Some children were returned to their families but many remained in foster care or institutional care throughout their childhood.

In the second half of the 20th century, the expectation increased that the State would intervene to protect children from maltreatment, and to identify and respond to situations which might be harmful to the child. Knowledge of child development grew, and significantly, the child came to be seen as a holder of human rights and a psychological being. A greater range of parental behaviour was regarded as potentially harmful to children, and as requiring State intervention and protection. In the 1980s, the hitherto hidden problem of child sexual abuse emerged from years of taboo. There was an increased willingness to discuss the problem and to report this and other forms of child abuse.

By the early 21st century the definition of child abuse and neglect had become very broad; including physical, sexual and emotional abuse, and acts of omission and commission that previously would not have been seen as child abuse, let alone have justified State intervention (e.g. harsh physical discipline, exposing children to domestic violence, leaving children in the care of older children). It is interesting to note that while violent physical and sexual abuse attracts the greatest media coverage in this country, the majority of substantiated child abuse cases in Australia today involve neglect and emotional abuse.

The reasons for the admission of children to State care have also changed in the past fifty years. In the post-war years, about half of the children in State care had suffered from “parental neglect”, while the remainder showed “uncontrollable behaviour” or came from families affected by divorce, “illness, death or affliction” (Tierney, 1963). Homelessness and poverty affecting large families was a significant factor in the neglect of children. By the 1970s improved birth control and more generous income security for single parent families reduced the impact of these factors. Meanwhile, parental substance dependence, reflecting the increased use of drugs in modern society, has become a far more common reason for children coming into State care.

There is, however, recognition that the ‘rescue’ of children by the State, by removing them from their parents and communities, especially within Aboriginal communities, is not a simple or unproblematic solution. The concern that children might be harmed by the very system that intends and is expected to protect them is not new, and has been spelt out in harrowing reports about such harm in Australia and elsewhere (e.g. *Systems abuse: Problems and Solutions*, Cashmore, Dolby & Brennan, 1994; *The Forgotten Australians*, Senate Report, 2004).

The findings of research about the effectiveness of foster care and the outcomes for children in foster care and other forms of care compared with children remaining at home are mixed. On the one hand, children and young people in several studies have later indicated that they were better off in care than remaining at home. The results of a number of studies have suggested that this is the case if the children are in stable care (Barber & Delfabbro, 2004; Davidson-Arad et al, 2003). Other studies, however, have found that going into care fails to have a remedial effect for many children and may in fact have adverse outcomes (Doyle, 2007; Lawrence, Carlson & Egeland, 2006).

The inherent dilemma for the State is how to protect vulnerable children while avoiding inflicting further harm. In the absence of valid and reliable risk assessment instruments and because it is such a rare event, it is not possible to predict which children are likely to suffer fatal assaults. Thus no child protection system can prevent the deaths or serious injury of all children, just as no mental health system can prevent all suicides. This is an uncomfortable reality and difficult for the community to understand when looking, with the benefit of hindsight, at the circumstances surrounding a child's death.

The challenge is to develop a system which can protect children from serious harm without causing further psychological injury with 'the cure', or by unnecessarily removing children from their families. Statutory child protection services thus inevitably walk a tightrope between over and under-intervention. Choosing the right intervention is as complex as it is critical to the child's life, both now and in the future.

Child Abuse and Neglect – A Complex Problem

It is now well accepted that child maltreatment (abuse and neglect) is a complex problem and requires a broad range of interventions. But there is no doubt that with the right combination of policies and services, and with proper resourcing, we can improve the lives of vulnerable children and young people. As an illustration of a serious social problem that has been very successfully tackled in Australia over the past few decades, consider the problem of road injury and death. Here, a broad range of evidence-based strategies from different disciplines were implemented. Services and interventions were delivered through different sectors and developed in an integrated way.

As well as improving emergency medical services for those injured on the roads, legislation was introduced relating to compulsory seat belts, drink driving and probationary driver's licence restrictions. Strong law enforcement made sure the legislation was effective; sustained and well-resourced public education campaigns made sure everyone knew what was happening. On the hardware side, there was an investment in better road design and improved safety features in cars. And above all, these measures were underpinned by continuing, rigorous research. Drink driving has been a particular success story with a major shift in community attitudes and behaviours achieved in a relatively short period of time.

Child abuse and neglect is a more complex social problem than road trauma, given its problematic measurement and definition, its multiplicity of causes, and the potential for well-intentioned statutory interventions in the lives of children and families to harm as well as to help. However, both social problems share the need for multiple, well-integrated strategies which are sustained over a long period of time and which are underpinned by strong research. Nothing less than such an approach is needed to successfully address child abuse and neglect.

Media coverage of child abuse

Media coverage of child protection is a double-edged sword – it has increased community awareness of child abuse and neglect, and at times led to greater resources being allocated to child protection services. At the same time, it has led to the politicisation of child protection and the adoption of policies which are not based on evidence. It has contributed also to creating a defensive and fearful climate where some services and professionals are reluctant to work with vulnerable children and their families, seeing their responsibility as limited to reporting to DoCS.

Mass media coverage struggles to convey the complexity and inherent dilemmas in child protection decision-making. This can leave those working in the field feeling scape-goated and denigrated, and may be one factor driving well-qualified and experienced professional staff from the field.

The way in which publicity surrounding child deaths is dealt with needs to be carefully examined. It should be accountable and transparent in relation to the findings of inquiries but should not further weaken the service system. Different models of inquiring into and reporting on child maltreatment related deaths should also be investigated. Annual reporting which does not lead to new information or which does not allow for enough time for change to be implemented or measured can also demoralise staff and inadvertently weaken the service system.

Adopting a “root cause analysis” model such as that operating in the fields of health and industrial safety would shift the focus from the last link in a chain of events to a broader view of the problems and of the multiple potential points of intervention. A longer reporting schedule (over several years) would help to bring a wider perspective.

No child protection system has yet been developed which can prevent all the deaths and injuries caused by child abuse and neglect. The best that can be achieved is to minimise the numbers. To expect a child protection system to do otherwise is to set it up for failure and therefore to increase the risk that children will be harmed.

Child Abuse: A media Issue

In a newspaper article last year DoCS was roundly criticized for its handling of child deaths. Unfortunately the article was not an example of balanced reporting, but used provocative language and misinterpreted the facts.

On the basis of figures from the NSW Ombudsman’s reports into child deaths, the article argued that children “known to DoCS” had died at a rate of more than nine per month since December 2002, comparing this with “just 18 deaths last financial year in Victoria”. “Known to DoCS” is used as shorthand to cover one group of the children whose deaths are required by law to be reviewed by the Ombudsman. Being “known to DoCS” is also a signal of disadvantage. For most children in this group, their deaths were not directly attributable to abuse or neglect.

The figures quoted in the article – nine deaths per month – were incorrect. Within the last reportable period of one year (2006–07), 16 children “known to DoCS” died as a result of abuse and neglect, and 15 in suspicious circumstances; 50 children “known to DoCS” died as a result of other causes that were not “suspicious” such as cancers, genetic abnormalities, respiratory diseases, motor vehicle accidents or SIDS. The correct figures are of course much closer to the Victorian equivalent.

The Current Crisis in Child Protection Services

The increasing numbers of reports/ notifications¹

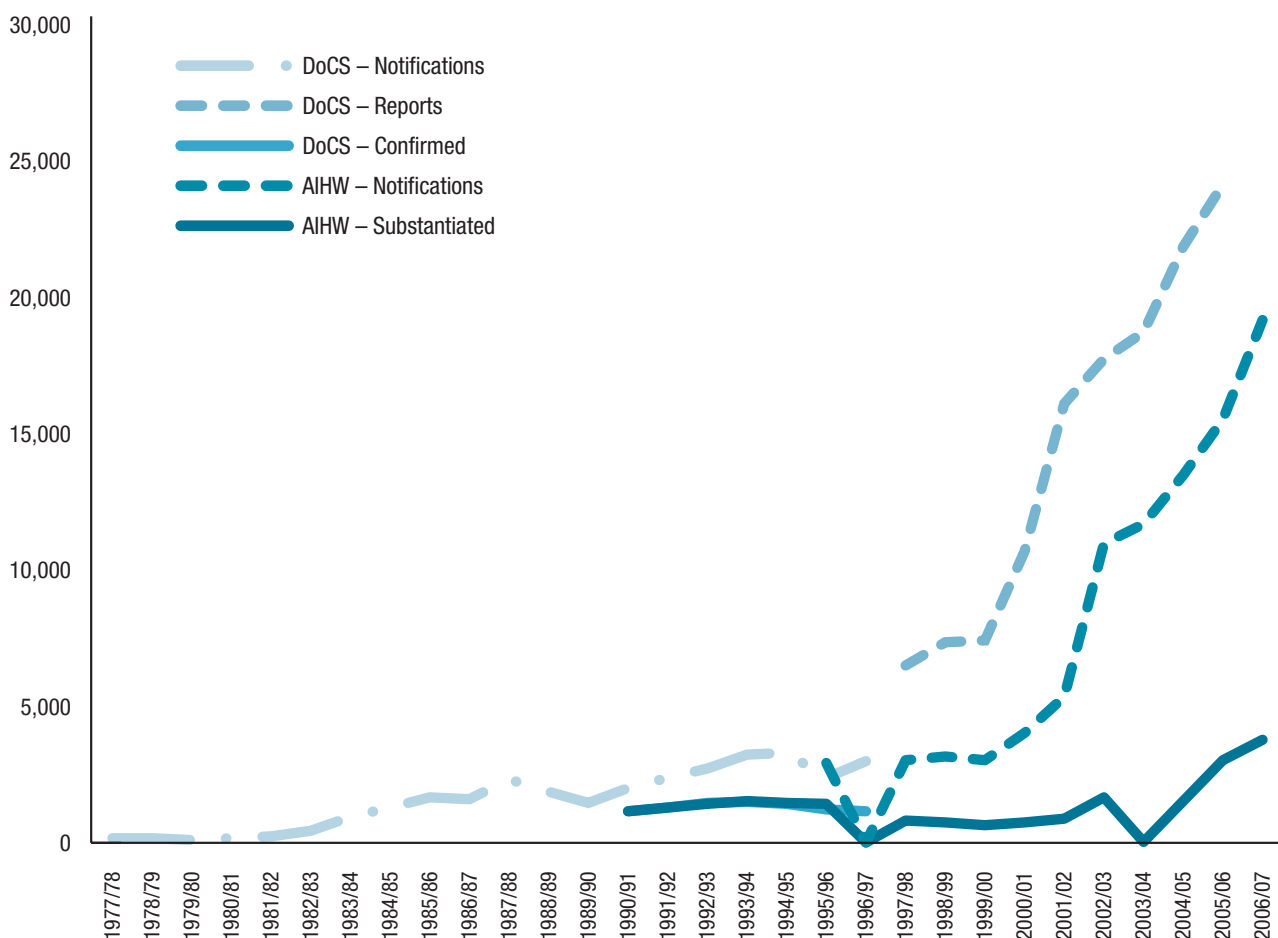
The number of reports to the NSW Department of Community Services in relation to child protection has shown a very marked increase over the last decade, particularly in the last five years. Figure 1 shows the steep increase, using both the DoCS data and the Australian Institute of Health and Welfare (AIHW) figures based on the DoCS data. The Australian Institute of Health and Welfare collates national figures for reported child abuse and neglect, based on information supplied by the states and territories; the AIHW uses an agreed

general definition of abuse and neglect to take into account the significant differences between the States in relation to their legislation, policy and practice.

As Figure 1 shows, the AIHW figures for NSW have been substantially less than those produced by DoCS since 1997–98 – at times less than half or a third. The main reason for the difference is that the AIHW definition of a notification includes “reports made to an authorised department by persons or other bodies making allegations of child abuse or neglect, child maltreatment or harm to a child”. It specifically excludes “reports regarding wider concerns about children or families which are classified as child concern reports”.

Figure 1: Notifications and reports (DoCS, 2007 and AIHW, 2008)

NSW Reports and Notifications 1977–2007



¹ The terms are both used here because New South Wales DoCS data refers to ‘reports’ based on the terminology in the Act whereas the Australian Institute of Health and Welfare uses the term ‘notification’ across all jurisdictions.

The number of **children** involved in these reports/notifications is considerably less than the number of **reports** on both sets of figures; on average, according to the DoCS 2005–06 annual statistics, DoCS receives about 2.1 reports per child. The AIHW figures are similar: 1.9 reports per child (189,928 reports in relation to 99,949 children).²

There is no analysis, however, on the frequency distribution of reports or on re-notification rates. And this raises a number of questions whose answers have policy and practice implications. For example, do a high proportion of reports relate to only one child who is not reported again or to several children within the same family or household? Do a relatively small number of households account for a relatively high proportion of reports? In relation to re-reporting, how quickly do reporters make another report related to the same child? On anecdotal evidence, one reason for repeated or further reports may be that those making reports are expecting some form of response or action, and in concern or frustration make further reports if they receive no feedback to spur some action. To what extent do further reports come from the same

or different reporters? Are either or both of these forms of duplicate reports an indication of higher risk? And a higher likelihood of any follow-up or ‘determination’?

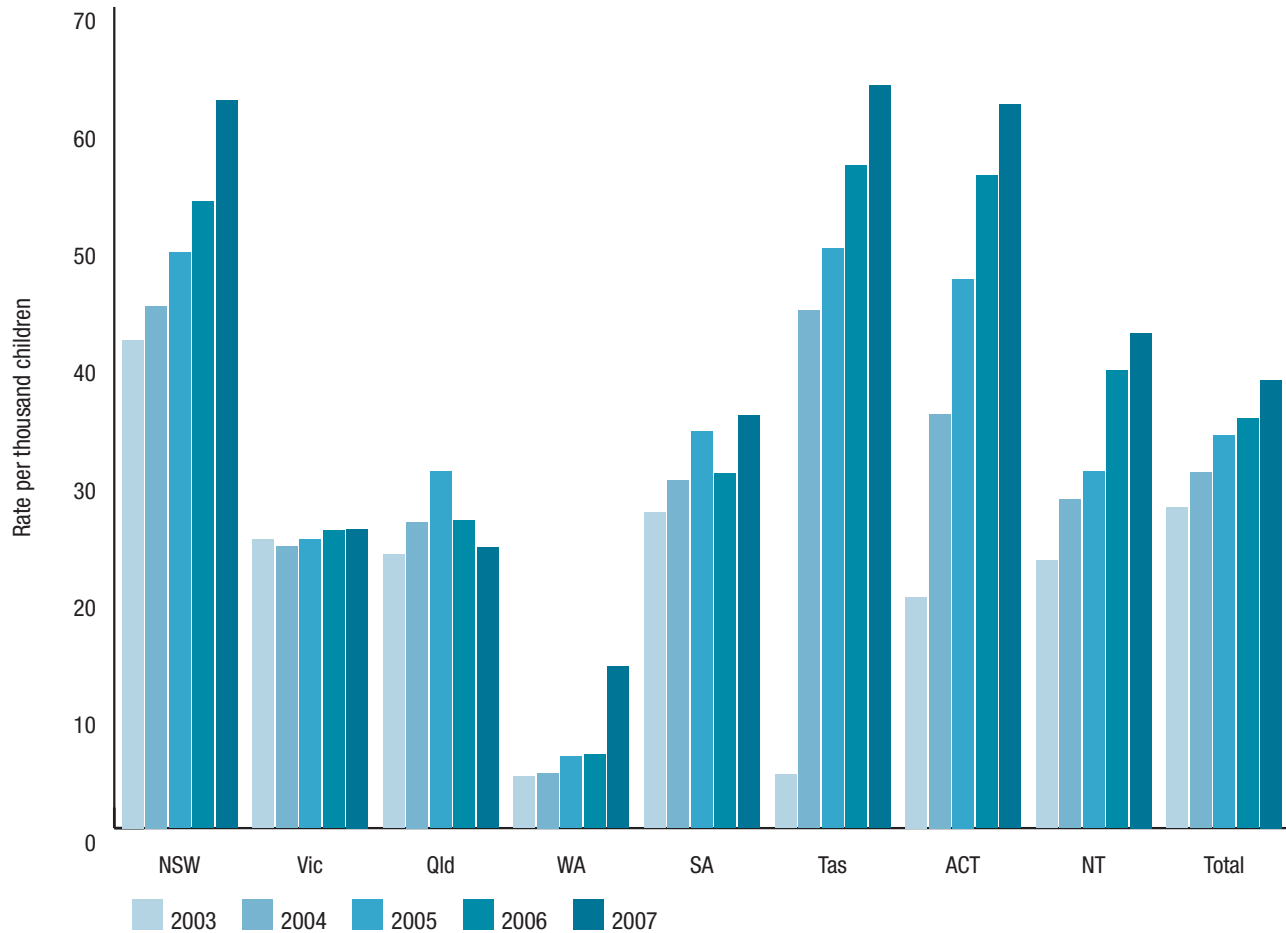
The trends in **notification rates per 1000 children** in NSW and the other states and territories are shown in Figure 2 using the data published by the AIHW. Any comparisons over time and across jurisdictions need to take into account the differing definitions, legislation and policy, and assessment systems used in the various jurisdictions. Queensland, for example, now includes as notifications only those cases deemed to require an investigation whereas in NSW 39.4% of notifications were not ‘investigated’ by DoCS but dealt with by other means (such as referral to police, referral to family services or provision of advice). As the AIHW (2008) points out, “the data are basically a measure of the activity of the departments responsible for child protection and as such are sensitive to changes in child protection legislation and departmental policies, practices, resources and data systems” (p. 26).

² According to the AIHW counting rules, a notification can involve only one child; where it is claimed that two children have been abused or neglected, this is counted as two notifications, even if the children are from one family. Where there is more than one notification about the same ‘event’, this is counted as only one notification. Where there is more than one notification between 1 July 2005 and 30 June 2006, but relating to different events (for instance, a different type of abuse or neglect or a different person believed responsible for the abuse or neglect), these notifications should be counted as separate notifications.

Figure 2: Rates of children who were the subject of a notification by State and year (AIHW, 2008)

Rates of children who were the subject of a notification 2002–2003 to 2006–2007

(age 0–17 years)



The rates were calculated using the numbers of children notified for each state and territory and dividing by the number of children aged 1 to 17 in the population.

Most jurisdictions – with the exception of Victoria, South Australia, and Queensland³ – have experienced dramatic increases in notifications. Those in which the increases have been most marked tend to have certain policy features in common such as: broad mandatory reporting

legislation; broad definitions of ‘abuse and neglect associated with risk of harm’; centralised intake systems; and laws or policies requiring police to notify statutory child protection services of all family violence cases in which there are children.

³ The drop in Queensland is probably a result of the change in definition of ‘notification’ so that it includes only those cases deemed to require an investigation.

Policy features of the NSW system

- **Broad mandatory reporting legislation:** the aim of the mandatory reporting provisions in the *Children and Young Persons (Care and Protection Act) 1998* was to regularise and clarify the situation whereby different groups of professionals and workers had different requirements for notifying different types of abuse, some by law (medical practitioners), some by regulation or departmental policy or ministerial directive: the proposal that all those working professionally with children (or young people) should be required to report was strongly supported during the review process and the 2002 Inquiry found strong support for mandatory reporting.⁴

In addition, the *NSW Children and Young Persons (Care and Protection) Act 1998* increased the penalty for mandatory reporters who fail to report a child in need of protection to \$22,000 (200 penalty points). In the absence of any evaluation of the Act or reliable research, the extent to which this may have encouraged defensive reporting is unknown.

- **Broad definitions of ‘abuse and neglect associated with risk of harm’:** Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* sets out five sets of circumstances in which current concerns relating to children’s safety, welfare and well-being indicate that the child is at risk of harm: the Legislative Review report referred to ‘serious’ risk of harm and children ‘in need of protection’.⁵ Different criteria apply elsewhere that include ‘serious’ risk and ‘significant harm’.

The inclusion of exposure to domestic violence as one of the criteria for children being at risk of ‘serious physical or psychological harm’ was based on research indicating the harm to children as the result of such exposure.

- **Legislation and policies requiring police to notify DoCS of domestic violence cases where children were members of the household:** Police are the single biggest category of mandatory reporters in NSW, contributing about a third of all reports. These are presumably primarily in relation to domestic violence call-outs. While section 23(d) of the *Children and Young Persons (Care and Protection) Act 1998* refers to the risk of “serious physical or psychological harm” as a result of exposure to domestic violence incidents, the police response has been to report all domestic violence incidents on the basis that police are not well equipped to assess the “risk of serious physical or psychological harm”.
- **Centralised intake systems:** the requirement for the Department of Community Services to record all reports (s. 28 of the *Children and Young Persons (Care and Protection) Act 1998*) coincided with the commencement of the Helpline in December 2000; prior to this, calls from mandatory notifiers and the public were taken at local Community Service Centres, and some calls were not treated as notifications, some were noted in local files,⁶ and some were recorded on the centralised intake systems.

⁴ *Review of the Children (Care and Protection) Act 1987: Recommendations for Law Reform*, p. 22-23; Standing Committee on Social Issues, Legislative Council, *Final Report on Child Protection Services Dec 2002* (Parliamentary Paper Number 408), NSW Parliament.

⁵ The 1987 Act referred only to a child under the age of 16 years who (a) has been or is in danger of being, abused, or (b) is a child in need of care, defined under s. 10 as a child (a) for whom adequate provision is not being made, or is likely not to be made for the child’s care; or (b) who is being, or is likely to be, abused, or where (c) there is a substantial and presently irretrievable breakdown in the relationship between the child and one or more of the child’s parents.

⁶ This was identified as a problem in various child death inquiries when families moved from one area to another and there was no central recording or transfer of such information.

- **The provision for children, young people, and parents to request assistance (S 20 – 21):** The aim of these sections was to clarify the responsibility of DoCS for early intervention and provide an avenue for children, young people and families in need to seek help without having to be notified or reported via the child protection route. It is unclear how many such requests there have been and how they have been dealt with by the Helpline. It may have added to the conflation of ‘children in need’ with those who have been abused or neglected.
- **Media coverage:** The launch of the new Act and the Helpline were broadly publicised with promotion of the “HELP” aspect of the new legislation. It is unclear what effect this publicity had but New Zealand research has indicated a clear link between media coverage of child deaths and increases in the volume of reports (Mansell, 2006).

How these notifications/reports are dealt with

Reports or notifications are dealt with in several ways. In NSW, according to AIHW figures, about 60% are investigated with ‘more detailed information’ sought and an assessment made by DoCS about the harm or degree of harm to the child and his or her protective needs.⁷ NSW investigated a higher proportion of reports/notifications than any other State,⁸ with just under 40% dealt with ‘by other means’ such as ‘the

provision of advice or referral to services’.⁹ In Victoria, South Australia and Tasmania, around 70% of notifications/reports are dealt with by other means.

Of the 92,729 finalised investigations carried out by DoCS in 2006–07, 40% were “substantiated”. According to the AIHW definition, this means that it has been “concluded after investigation that [there was reasonable cause to believe] that the child has been, is being or is likely to be abused, neglected or otherwise harmed” (AIHW, 2008, p. 3, p. 96). This level of substantiations is comparable with some other States (WA, SA and ACT) but considerably lower than Victoria (64.8%).

It is clear then (see Figure 1) that only a relatively small proportion of reports are substantiated. Using the AIHW figures (which exclude multiple notifications for the same event and are more comparable with other States), notifications/reports were substantiated for only 13.8% of the **children** reported/notified in NSW during 2006–07 (AIHW, 2008, p. 25).¹⁰ The figures for the other states and territories range from 10.8% for Tasmania, to 21.8% for Victoria, and 30.4% for Queensland.¹¹

What is unclear is how this varies by reporter, although it is very likely that the large number of reports made by police are less likely to be substantiated than for other reporters (see Table 1).

⁷ AIHW (2008), p. 15. According to the AIHW definition, “an investigation includes the sighting or interviewing of the subject child where it is practical to do so” (p. 15).

⁸ The 1998 Act loosened the obligation under the 1987 Act for all ‘notifications’ to be ‘investigated’, allowing the Department to determine whether or not a report needed further investigation (s. 30(a)) and allowing the Department to take no further action if, on the basis of the information provided, it is considered that there is insufficient reason to believe that the child or young person is at risk of harm (s. 30 (b)).

⁹ AIHW (2008), p. 16: the standardised definition of ‘dealt with by other means’.

¹⁰ The numbers of children for whom a report/notification was substantiated are quite similar in both the AIHW and DoCS figures: in 2005–6, for example, 12,627 children were the subject of a substantiated notification according to AIHW figures compared with 12,956 who were determined to be at risk of harm (3,771) or to have suffered actual harm (9,185) associated with abuse or neglect according to the DoCS figures.

¹¹ The high figure for Queensland reflects the fact that Queensland now defines “notifications” as only those cases deemed to require an investigation. These figures are also interim figures due to be revised in 2008.

Table 1: Source of reports for period 2005–06 – substantiation rate unknown (DoCS, 2007, and AIHW, 2007)

Source of report	% of reports [DoCS]	% of finalised * investigations [AIHW]
Police	33.4	26.6
Medical/health	16.1	20.3
School /child care	13.1	14.6
NGO	7.1	7.8
Other mandatory reporters	5.8	
Mandatory reporters	75.6	
Family	14.9	13.6
Friend/neighbour	3.1	3.6
Non-Mandatory reporters	24.4	

Lack of information on the services for reported children

While the figures focus on the number of reports coming in and the way they are processed (investigated, dealt with by other means, further assessment), there is little information available on the critical issue of what services vulnerable children and their families are receiving in the wake of reporting. How many children who were the subject of reports that were “dealt with by other means” received services that assisted them or their families and met their needs? Likewise, how many children whose reports were substantiated received services? How effective were these in meeting their needs? How many in each group came back into the child protection system via a further report? These questions are largely unanswered.

Unsubstantiated reports

One reason for the high proportion of unsubstantiated reports is the very significant gap between the legal threshold of suspicion for mandated notifiers to make a report to DoCS, and the threshold for DoCS initiating statutory intervention. Although the aim was to pick up early concerns about children, this gap imposes very heavy demands on DoCS to identify and respond appropriately to children in serious jeopardy; being overstretched results in superficial assessment and premature case closure. The design of the KIDS

system also makes it difficult for caseworkers to get a clear picture quickly, of the pattern of reports and cumulative risk of harm when there is a series of reports that, separately, may not appear serious.

The gap in these two thresholds also causes enormous strain between the very organisations that need to collaborate if children are to be protected. Notifiers struggle to get cases through the ‘gate’ of child protection services – and there is some evidence that they re-notify in frustration when they see no response. On the other side of the ‘gate’, the priority of child protection workers has to be to identify and respond to the most ‘at risk’ cases which require statutory intervention.

While most of the families notified to DoCS are struggling and providing poor quality parenting, the concerns may not be such to justify statutory investigation or intervention. These families and children typically receive little or no assistance and many of the children are subsequently renotified, with opportunities for preventive intervention having been missed. This was well illustrated in the wake of the sudden increase in notifications in after 2000, when the number of DoCS referrals to family support services in NSW actually declined (Fitzgerald, 2002).

The capacity to make effective referrals is compromised when the overriding priority is to assess quickly and close the case in order to find the next one which justifies seeking a court order. It also results in ‘goal displacement’, with the mass screening of socially disadvantaged families to

identify a very small minority where a threshold for statutory intervention is reached, displacing the core statutory roles of bringing serious cases before the court for determination, and acting as the legal guardian for children admitted to State care.

Numbers of Children on Care and Protection Orders

Court ordered transfers of parental responsibility and transfer of guardianship to the State are the most serious form of intervention the State can take, and this is increasingly a measure of 'last resort'. Only a small proportion of children who are the subject of a substantiated allegation of child abuse or neglect are found to be 'in need of care and protection', necessitating a court order, and even fewer are removed from their homes or have guardianship transferred from their parents (Australian Institute of Health and Welfare, 2008).

While there is information about the numbers of children who enter care on orders, each year it is unclear how many orders are made for supervision, for the provision of services and what is included in care plans.

The trend in the numbers of children on care and protection orders and the proportion of children on guardianship or custody orders/arrangements are shown in Tables 2 and 3 (reproduced from the AIHW report on Child Protection for 2006–07). As the 2008 AIHW report points out, "There are large variations across states and territories in the types of care and protection orders that can be issued" (p. 38) so comparisons across states and over time is difficult. Nevertheless, it is clear that the number of children on care and protection orders in NSW has almost doubled (1.8 times) from 5,764 to 10,639 in the period from 1997 to 2007. The rate of children per 1,000 increased from 3.7 in 1997 to 6.6 in 2007 compared with the overall national rate for Australia from 3.3 to 6.0 per 1,000. It is also clear that most of these orders were for guardianship or custody orders/arrangements, with only Victoria having any substantial numbers of children on supervisory orders (1627, 26.7% of children); there were no figures available for NSW.

Table 2: Trends in the number of children on care and protection orders at 30 June 1997–2007 (AIHW, 2001 and 2008)

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1997	5,764	3,865	3,249	785	1,172	508	264	111	15,718
1998	5,987 ^(a)	4,215	3,433	799	1,102	520	255	138	16,449
1999	6,948	4,358	3,609	1,019 ^(b)	1,024	440	236	177	17,811
2000	7,661	4,752	3,612	1,105	1,210	470	232	220	19,262
2001	8,105	4,782	3,573	1,320	1,260	453	219	205	19,917
2002	8,229	4,975	3,765	1,384	1,286	463	261	194	20,557
2003	8,975	5,038	4,107	1,470	1,378	600	288	274	22,130
2004	n.a. ^(c)	5,251	4,950	1,639 ^(d)	1,455	634	353	345	n.a.
2005	8,620	5,658	5,857	1,783	1,553	716	464	414	25,065
2006	9,213	5,984	6,446	2,046 ^(e)	1,671	833	558	437	27,188
2007	10,639	6,179 ^(f)	6,156 ^(g)	2,629 ^(h)	1,881	897	574	451	29,406

^(a) New South Wales data from 1996 onwards do not include children on supervisory orders.

Table 3: Number of children on care and protection orders, by type of order, states and territories, at 30 June 2007 (AIHW, 2008)

Type of order	NSW	Vic ^(a)	Qld ^{(b)(c)}	WA ^(d)	SA	Tas	ACT	NT
Number								
Guardianship or custody order/arrangements	9,119	4,341	n.a.	2,024	1,795	754	435	408
Supervisory orders	n.a.	1,627	n.a.	65	–	32	59	–
Interim and temporary orders	1,520	211	n.a.	540	86	111	80	43
Total	10,639	6179	6156	2629	1881	897	574	451
Per cent								
Guardianship or custody order/arrangements	85.7	70.3	n.a.	77.0	95.4	84.1	75.8	90.5
Supervisory orders	n.a.	26.3	n.a.	2.5	–	3.6	10.3	–
Interim and temporary orders	14.3	3.4	n.a.	20.5	4.6	12.4	13.9	9.5
Total	100.0	100.0	n.a.	100.0	100.0	100.0	100.0	100.0

NSW has not provided data regarding supervisory orders. There are legislative provisions in NSW for supervisory orders to be issued. It is not clear whether these orders are not being used or whether NSW DoCS is not providing this data.

Numbers of Children in Out-of-home Care

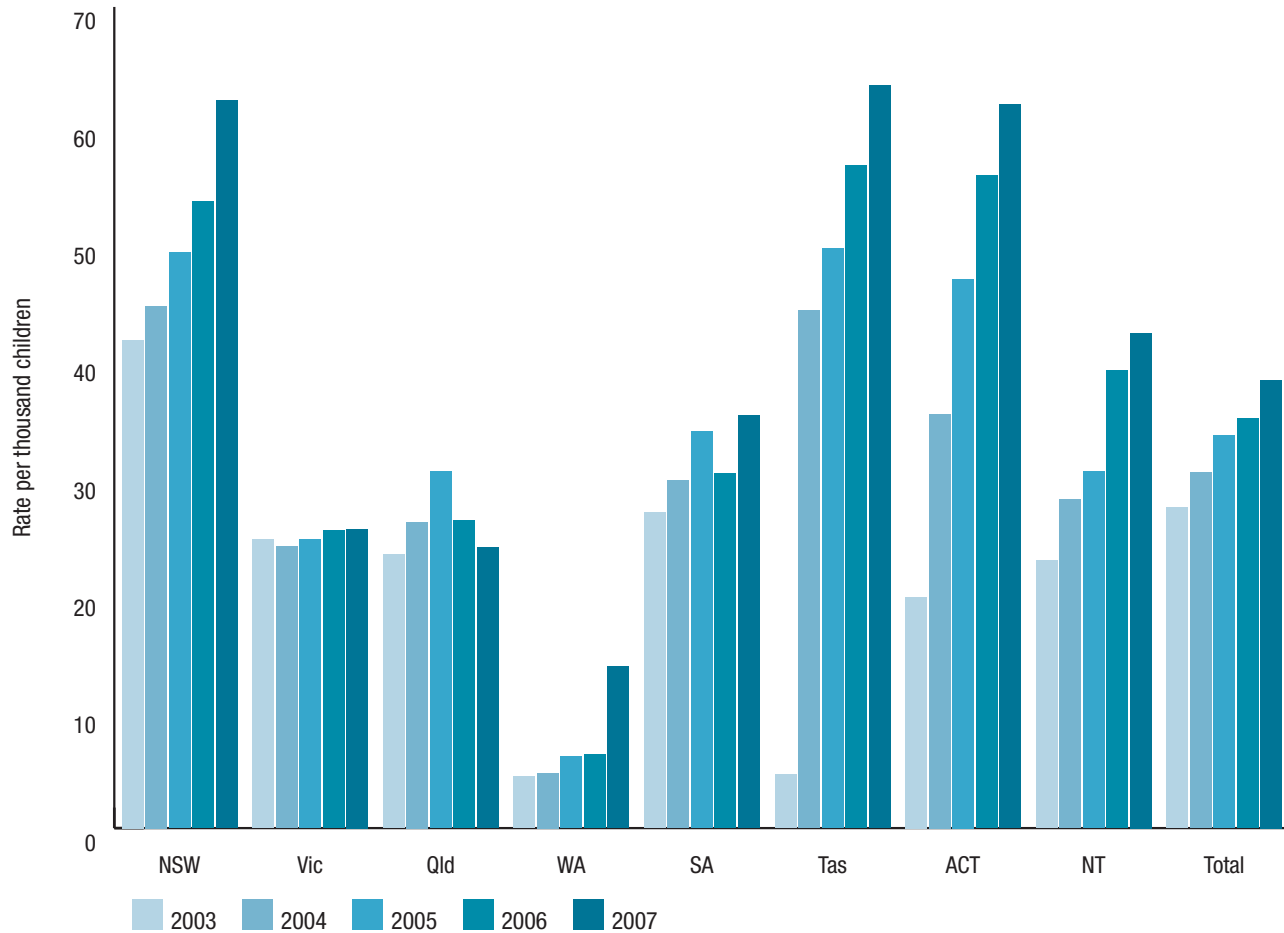
On 30 June 2007, there were 28,441 children in out-of-home care across Australia, double the number (14,078) in 1997. The increase in absolute numbers for NSW was of the same order of increase: 5,486 in 1997 and 11,843 in 2007. The increase in the rate of children per 1000 in out-of-home care for each state over the past five years is shown Figure 3, indicating that NSW has the highest proportion of children in State care. Making intra-jurisdictional comparisons over time on the basis of this data set is less problematic than that relating to notifications as all are based on an audit of the number of child in out-of-home care on June 30 each year. However, demographic differences between jurisdictions in relation to factors such as the proportion of Indigenous children or the proportion of children living below the poverty line make inter-jurisdictional comparisons difficult in terms of what the “right” level of children in out-of-home care should be.

It is possible, however, to compare jurisdictions in terms of the relative pressure they are under in caring for children in out-of-home care. It should be noted that what would appear to be small differences in the number of children per 1000 in out-of-home care represent a very significant number of children, especially in populous states such as NSW. Thus a difference between NSW and Victoria of 7.3 and 4.3 children per 1000 respectively means that NSW has almost 50% more children in care than Victoria relative to its population, which is a large difference.¹² On the other hand, it has nearly five times the number of Aboriginal children, and overall about one in four children in out-of-home care are Aboriginal.

¹² In absolute numbers, NSW has double the number of children in out-of-home care than Victoria: 11,843 compared with 5,052. It has 1.36 times the number of children aged 0-17 years in the population but nearly five times the number of Indigenous children.

Figure 3: Rates of children in out-of-home care by State and year**Rates of children in out of home care June 2003–June 2007 (AIHW, 2008)**

(age 0-17 years)

**Policy Analysis**

The interpretation of these various sets of figures, and particularly of the recent escalation in the number of reports and the number of substantiated reports, is subject to considerable debate and speculation. Like most complex issues, there is no simple answer and it is not clear to what extent the very high level of pressure on DoCS reflects a real increase in the prevalence of child abuse and neglect, increased awareness of the harm to children from abusive and neglectful parenting, or changes in the way we define and respond to suspected child abuse and neglect. It is likely that all play their part.

Increasing incidence of abuse and neglect of children

There is some evidence of an increasing incidence of parental substance abuse, domestic violence, and parental mental illness or disability. And all of these factors are significantly associated with child abuse and neglect.¹³ The combination of family violence, parental substance abuse and mental health is a particularly potent mix that is increasingly identified in notifications and reports to statutory authorities.

¹³ See A. Tomison, 'Child Maltreatment and Substance Abuse: National Child Protection Clearing House Discussion Paper No.2', Australian Institute of Family Studies, Melbourne, 1996a; A. Tomison, 'Child Maltreatment and Mental Disorder: National Child Protection Clearing House Discussion Paper No.3', Australian Institute of Family Studies, Melbourne, 1996b; A. Tomison, 'Exploring family violence: Links between child maltreatment and domestic violence', *Issues in Child Abuse Prevention*, no.13, Australian Institute of Family Studies, Melbourne, 2000. NSW Child Death Review Team, *Second Annual Report 1996–1997*, Sydney, 1998.

Table 4: Number and percentage of reports recording domestic violence, drug and alcohol issues as the primary, secondary or third reported issue for 2005-06 (DoCS, 2007)

Specific reported issue	No of reports	% of reports
Domestic violence	77,222	32.0
Neglect	50,700	21.0
Drug and alcohol	49,257	20.4
Drug issues only	29,974	11.6
Alcohol issues only	24,926	10.3

Note: The number of reports involving domestic violence, drug and alcohol are likely to be under-recorded because only three issues can be recorded as part of the initial assessment and there may be more than three issues present. Counts of drug issues and counts of alcohol issues cannot be added because some reports have both drug and alcohol issues reported.

A recent review of drug use in the family, for example, noted the findings from international and local studies that “at least half of the families identified by child and protective services have a profile that includes parental substance misuse”, often in combination with family violence, psychiatric disability, intellectual disability, physical disability, and financial stress.

These factors are evident in the 2005–6 DoCS figures on the main reported issues (see Table 4 above).

Significantly, there is evidence too that statutory departments and other departments and agencies are not intervening with these families in ways that protect children and prevent further reports. A study by the Victorian Department of Human Services (VDHS), for example, found that the child protection system is not able to provide the sustained help that is needed for families with chronic and complex problems, such as substance abuse, mental health issues, low income, and the burdens of sole parenting (AIHW, 2008, p. 5; VDHS, 2002). As a result, children in these families are subject to further notifications and re-substantiations. Anecdotal evidence suggests that the same issues are inherent in the NSW child protection system, although figures on the rate of, and reasons for, re-notifications in NSW are not available.

Young people

Data collected by DoCS in 2005-06 show that 30% of the 241,003 reports concerned children over 12 years of age. This trend is reflected in reports referred to Joint Investigation Response Teams or Community Services Centres for further assessment, with one in three of the reports referred for further assessment concerning children aged 11 years or over.

The age distribution of reports has changed considerably for females with the peak in female reporting across the age span being females aged 14-15 years. Further, this peak has intensified. In 1999-2000, 22% of reports for females involved females aged 13-17 years compared with 29% in 2004-05. This increase is reflected in an increase in the numbers of reports concerning young people 12 -17 years referred to Joint Investigation Response Teams or Community Services Centres for further assessment (DoCS, 2007 p. 29).

At 30 June 2006 there were 10,623 children and young people in out-of-home care; 40% were aged 10 years or over and 13.2 % were between 15 and 17 years. While young children should remain the priority for responding to neglect and abuse issues, we need to make sure that we do not ignore the vulnerabilities of young people. The numbers are smaller, but young people too require targeted interventions to protect and promote their interests, needs that will differ particularly from those who have grown up in out-of-home care.

Adolescence is a time of normal “uneven” development and for some young people it is a time of increased vulnerability – particularly when combined with social and economic disadvantage and inadequate parenting or support. Family conflict, including domestic violence, poor parental coping and conflict between children and parents, if unaddressed, may result in a young person being unable to live at home.

Where it does provide a response to young people, currently the child protection system provides mostly for short term safety, such as short term accommodation for young people at risk of homelessness. The current service system falls short in long-term planning both for vulnerable children and for young people. Responses have not gone far enough to address ongoing issues for young people and their families such as improving mental and physical health, facilitating ongoing connection to peers and communities, and keeping them engaged with education.

The solution is unlikely to be the introduction of a separate child protection ‘system’ for young people. The challenge is to develop the flexibility of existing systems and services to promote the wellbeing of all children and young people, so that such systems are not limited to responding to vulnerability.

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are heavily overrepresented in substantiated reports/ notifications, among children in out-of-home care and in child mortality figures. Depending on the State or Territory, Aboriginal children were from five to ten times more likely than other children to be the subject of a substantiated notification, particularly for neglect. Across Australia, they are 8.3 times more likely to be in out-of-home care than non-Indigenous children; in NSW, 57.0 Indigenous children per 1000 are in care compared with 5.3 per 1000 for non-Indigenous children, making Indigenous children nearly 11 times more likely to be in care than non-Indigenous children. This is despite the claims that Indigenous children are less likely to be reported and to have reports about them substantiated than their non-Indigenous counterparts (Pocock, 2003; Stanley, Tomison & Pocock, 2003). Given the higher prevalence in Indigenous communities of a number of the factors associated with child abuse and neglect (poverty, poor housing, family violence, early parenthood and single parenthood, parental substance dependence and a low ratio of adult caregivers to children) this over-representation is not surprising.

Table 5: Number of notifications, substantiations and children in out-of-home care in NSW and Victoria (AIHW, 2008)

	NSW			Victoria		
	Notifications	Substantiations	Children in OHC	Notifications	Substantiations	Children in OHC
1999–00	30,398	6,477	7,041	36,805	7,359	3,867
2000–01	40,937	7,501	7,786	36,966	7,608	3,882
2001–02	55,208	8,606	8,084	37,976	7,687	3,912
2002–03	109,498	16,765	8,636	37,635	7,287	4,046
2003–04	115,541	n.a.	9,145	37,956	7,412	4,309
2004–05	133,636	15,493	9,230	37,523	7,398	4,408
2005–06	152,806	29,809	9,896	37,987	7,563	4,794
2006–07	189,928	37,094	11,843	38,675	6,828	5,052

Policy and practice differences in Australia

The increase in the number of substantiated notifications, the number of care and protection orders, and the number of children in out-of-home care in NSW and across Australia suggests that there may have been an increase in both the awareness of, and the prevalence of, child abuse and neglect and children ‘in need’. However, the very dramatic nature of the increase in notifications following new policies such as the introduction of mandatory reporting or centralised intake services and the size of the differences between states and territories suggests that the increases may be more a function of system factors and broadening definitions of child maltreatment. The magnitude of the differences between NSW and Victoria, for example, is unlikely to reflect major differences in the prevalence of child abuse and neglect and children in need in these two states.

There are several clear differences between Victoria and the rest of Australia, and in particular, NSW.

- In Victoria, 1741 children started using intensive family support services in 2006–07 compared with only 265 in NSW (see Appendix A, AIHW, 2008 Table 5.1).

- The use of supervisory orders is more common in Victoria than elsewhere in Australia: 1627 children were on supervisory orders in Victoria in 2006-07 compared with only 165 in the rest of Australia, and none reported for NSW. These orders make the department responsible for supervising the level of care provided to the child, generally by parents and are less interventionist than guardianship or custody orders (AIHW, 2008, p. 37).
- Victoria also has pre-court mediation processes for contested cases, and in some regions uses family group conferencing extensively to achieve a mediated outcome.

Of particular interest is the impact of the new Victorian legislation which allows for multiple points of entry into the child welfare system and to early intervention services. Victoria has an alternative to statutory notification referred to as “community intake”. Under this approach, selected NGOs are funded to play a central role in responding to children who might otherwise be notified but who would be unlikely to receive an investigation because they are seen as being of lower risk than other cases. This approach was successfully trialled for several years under the “Innovation Projects” before being enshrined in legislation.

In contrast, in NSW, few children are in intensive family support services, supervisory orders are uncommon, alternative dispute resolution processes such as family group conferences are undeveloped, and referrals to the early intervention services are managed through the child protection gateway.

Victoria also has an extensive network of non-government child welfare services, and a traditionally high level of use of child and maternal health services, and “diversionary” policies and legislation (*The Children, Youth and Families Act 2005*; *The Child Wellbeing and Safety Act 2005*; and *The Children, Youth and Families Regulations 2007*) that are likely to have contributed to this outcome. Such approaches are traditional, strong preventive approaches.

Implications of these findings

While there may be a number of reasons for the increased number of reports, and the increased number of children in out-of-home care, it is clear that the NSW trajectory is unsustainable. It demands urgent change both to reduce the number of cases requiring child protective intervention and to manage the current demand more effectively.

No statutory child protection services can cope with the level of demand which DoCS reported in late 2007. The ‘solution’ of boosting the number of child protection workers has reached its limit. Despite a massive increase in the number of child protection positions in DoCS over the past two decades, the challenge of recruiting and retaining staff in the face of a global shortage of child protection workers and the very stressful circumstances in which they are expected to work, means there is little prospect of filling current vacancies, let alone filling additional positions.

What we can learn from overseas jurisdictions

There has been increasing concern over the last decade or so about the capacity of the system to respond to and provide appropriate services for the ever-increasing numbers of child protection reports that concern children in need rather than reports of children being harmed. Concerns about the focus and efficacy of the statutory investigative response were clearly articulated in the 1990s in both the UK and the US, and increasingly in Australia, New Zealand, and Canada.

These Anglo-American systems have become increasingly absorbed by receiving, recording and ‘investigating’ reports, more reliant on risk assessment methodologies to triage the flow of reports, and consequently have insufficient resources to help or support children and families that come to their attention. Indeed, the Dartington research in the UK (Dartington, 1995) indicated that families were often less receptive and less likely to receive services after being reported to the child protection authority than before being reported. As some (Melton, 2003; Scott, 2006) have argued, in these systems, the focus is on “What happened?” not “How is the child?” and “What can we do to help?”

While all western countries are facing the challenges of increased referrals of suspected child abuse and neglect cases, a very different policy context exists in some places. In most of Western Europe, for example, the assessment of, and response to, children at risk is largely done by non-statutory services. In the Netherlands, a government-funded but independent service called the Confidential Doctor Program, consisting of a paediatrician-led team of social workers, responds to referrals from organisations such as schools and from parents themselves, on a range of child-related concerns. The Confidential Doctor Program refers to statutory child protection services or the police only those cases where statutory intervention is needed.

In England, while child protection assessment is done by statutory child protection workers, other services, including all child health and education

services, now use a “common assessment framework” to identify and respond to a child and family’s needs, and only refer those cases requiring a more specialised statutory child protection assessment to social services. The absence of mandatory reporting in the UK, the strong local inter-agency collaboration processes, and the introduction of a common risk assessment framework allow potential referrers to make more balanced judgements so that the cases reported are those more likely to reach a threshold for statutory investigation and intervention. Such a system is likely to prevent the waste of the scarce resource of child protection workers and to provide earlier assistance to families.

While comparative data from European countries is not available, the differences between English speaking countries, all of which share fundamentally similar legal systems in relation to child welfare, are presented in Appendix B. Significantly, the proportion of children in out-of-home care is quite similar in Australia and England (5.3 per and 5.0 per 1000 children respectively), but there is an enormous difference in the notification rates in Australia and England (55.5 notifications per 1000 children and 6.5 notifications per 1000 children respectively).

Those nations where mandatory reporting is a central feature of the child protection system (Australia, United States and Canada) all have dramatically higher notification rates than other English speaking jurisdictions. The only exception to this is New Zealand where mandatory reporting has been rejected by successive New Zealand Governments (because of the effect this has had in those countries where it has been introduced). In New Zealand the very rapid increase in the notification rate followed extensive publicity about child abuse deaths, and the introduction of a central intake system and a policy requiring police to notify the statutory child protection service of all cases of family violence where there are children.

In summary, all English speaking countries have child protection systems which are less preventive and more bureaucratic and legalistic than western

European countries. Within English speaking countries there is a spectrum from the UK approach which does not have mandatory reporting and which has strong inter-agency shared responsibility, to the Australian systems which have mandatory reporting to different degrees, and finally to the extreme end of the reactive approach which operates in the US. While comparisons in terms of outcomes are very hard to make because of the complexity of factors involved, including the background levels of child poverty and different recording systems, the following statement made in the mid 1990s comparing the UK and US systems in the 1990s is instructive.

“...the USA has more cases reported (three times that for the UK) and more child abuse deaths (four times that for the UK). It also has twice as many children in state care, all of whom have been separated by court order.”

(UK Department of Health, 1995).

A Public Health Model of Child Protection

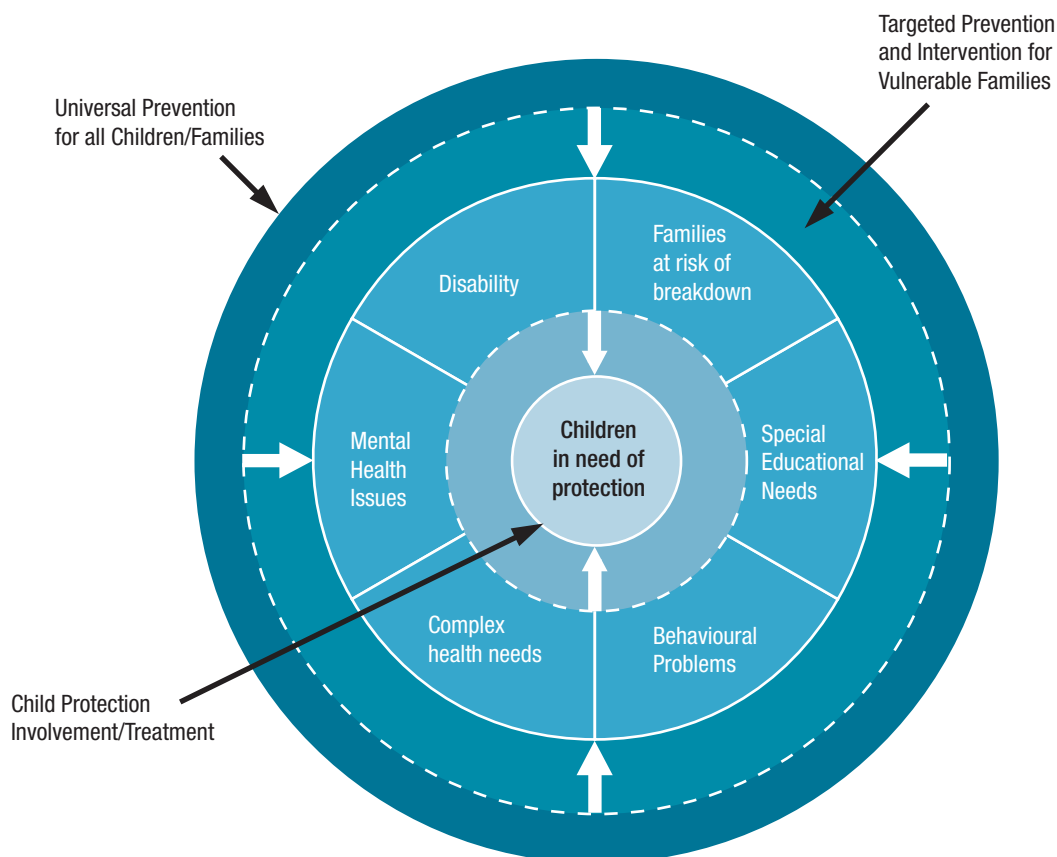
In the face of the growing crisis in Australian child protection systems there are now increasing calls for a public health approach to child protection. (O’Donnell, Scott & Stanley, 2008). A public health approach is similar to the traditional approach adopted in western European countries, but with the added dimension that it is underpinned by recent advances in knowledge about early childhood development, epidemiology and what is called “prevention science”. Based on whole populations or sub-groups within a population, and on intervening early in the “causal pathways” of a condition, public health strategies are commonly described in terms of primary, secondary and tertiary prevention.

For example, diabetes is tackled at a primary prevention level by a range of whole-of-community strategies aimed at reducing major risk factors such as childhood obesity, poor nutrition, lack of fitness, and at extending routine screening by GPs across the whole population to improve early identification. At a secondary prevention level those sub-groups at greater risk of developing diabetes due to heredity, age or lifestyle, are identified by health professionals for more targeted monitoring and education, and those with early symptoms of the disease are offered evidence-based case management. Tertiary prevention involves treating those who have developed diabetes to avoid a worsening of the condition which could otherwise lead to blindness,

renal failure, amputations and death. A major impetus for population-based prevention is that the resources that would be required for remediation are beyond the capacity of any society, not just economically but in terms of the health workforce. The same is true for child protection.

Applying a public health approach to child abuse and neglect needs to be based on known risk factors and “causal pathways”, as well as population-based measures of child maltreatment. Figure 4 below applies the notions of primary, secondary and tertiary prevention, commonly used for many public health problems such as obesity and heart disease, to child abuse and neglect.

Figure 4: Universal, Secondary and Tertiary Prevention and Intervention (adapted from Tony Morrison, 2006)



From O'Donnell, M., Scott, D. and Stanley, F., *Child Abuse and Neglect – Is it Time for a Public Health Approach?*

Factors associated with child abuse and neglect

There is an increasing body of knowledge on the risk factors associated with child abuse and neglect. The factors include:

- poor parent-child attachment in infancy
- a low ratio of adult caregivers to children
- early parenthood and single parenthood
- poverty
- social isolation
- family violence
- parental mental illness
- parental substance dependence.

Child abuse and neglect is strongly associated with other psycho-social problems such as low birth weight, school failure, behavioural problems, juvenile crime and juvenile substance misuse. Successful prevention can be very cost-effective given the long-term economic burden of all these problems on the community.

Implementing a public health approach

One of the challenges in implementing a public health approach to child abuse and neglect is that there are very few population-based measures of child abuse and neglect. That used in the NSW State Plan – the number of children reported to DoCS and referred for further investigation – is, on its own, an inadequate measure. It reflects reporting behaviour and resource-driven thresholds for investigation more than the actual prevalence of child abuse and neglect in the community. And it does not differentiate those investigated cases that are “substantiated” from those that are not. That is, it is akin to measuring the number of patients who have a medical examination rather than the number diagnosed with a specific condition. Similarly, the number of child deaths related to non-accidental injury is an inadequate measure as it underestimates fatalities related to neglect (for example,

failure to thrive in infants and subsequent death from pneumonia). The small numbers involved also make it difficult to interpret fluctuations from year to year.

The development of a comprehensive and reliable set of population-based indicators for child abuse and neglect and child-wellbeing is vital. Such indicators would allow us to determine the extent of the problem and to track its prevalence. They would also provide measures for assessing interventions in specific geographical areas. Some proxy measures such as the number of children admitted to hospital for non-accidental injuries, the prevalence of non-organic failure to thrive in infants, the prevalence of Sexually Transmitted Diseases (STDs) in pre-pubertal children and the level of school absenteeism in primary schools are also useful measures but are dependent on the reliability and universality of data sets.

There are significant gaps in the research concerning evidence which would support primary, secondary and tertiary prevention strategies. Thus a major research and development program is needed to support new initiatives to assess their effectiveness and possible unintended consequences. There are serious risks in prematurely “scaling up” new interventions without sound evaluation as they may have the capacity to do further harm and waste scarce resources. Nor is it a simple case of “replication” of successful interventions as in this field what works is very dependent upon context and personnel, not technique. Therefore a rigorous strategy of ‘innovation-evaluation-dissemination and transplantation’ is needed. This would require a five to ten year timeframe.

Primary, secondary and tertiary prevention strategies can be broken down into a range of interventions. A few promising examples are outlined below but they are not exhaustive and not all have a strong evidentiary base in the Australian context.

Primary Prevention Strategies

Primary prevention strategies are those aimed at the whole community to prevent problems from developing in the first place. In relation to child abuse and neglect, there are a range of approaches including health promotion and social marketing, community development, reduction in the availability and use of substances, and improving the reach and effectiveness of universal services.

Whole of Society Interventions

a. Reducing parental alcohol and drug misuse

Parental alcohol and drug abuse is a major challenge in the prevention of child abuse and neglect. This is especially so in some Aboriginal communities but is also a significant problem in the wider community. It is estimated that 10% of children live in households in which there is parental alcohol abuse and/or substance dependence, and that at least half of all child protection cases in Australia have a profile that involves parental alcohol and/or drug misuse (Dawe et al, 2007).

Alcohol abuse is “the elephant in the room” in child protection with more attention having been paid to abuse of illicit drugs. With an estimated 13.2% of Australian children at risk of exposure to binge drinking from at least one adult in the household (Dawe et al, 2007), alcohol abuse is far more prevalent than other forms of substance misuse. It is associated with every type of child abuse and neglect – from physical assault and irreversible brain damage to foetal alcohol spectrum disorder, emotional abuse, sexual abuse and neglect.

Effective population level measures to curb alcohol abuse include restrictions on advertising, reduced availability and increased costs. Unfortunately there are vested interests which make these measures difficult to introduce. But given the prevalence of parental alcohol misuse in Australian society, and the damage it causes to families and children, it is most unlikely that the level of child abuse and neglect in the community can be reduced unless the overall level of parental alcohol intake drops. Specific health promotion campaigns targeting parents (e.g. “children and alcohol don’t mix” campaigns) may also be of value, but have not yet been rigorously evaluated.

b. Social marketing and health promotion

There is insufficient evidence to date that mass media campaigns can modify parental behaviours directly associated with child abuse and neglect. Raising community awareness of children’s needs and bringing about attitudinal changes toward children through health promotion style interventions may be a more realistic goal than behaviour change. In the long term this may help shift community norms – for example, reducing the tolerance of family violence by depicting the impact on children exposed to this form of emotional abuse. Whether some of the health promotion approaches used in the field of childhood accident prevention (for example safety in cars and near water), or in areas such as skin cancer prevention, can be applied to the prevention of child abuse and neglect, is worthy of research.

Using mass media as a means of parent education (for example embedding effective models of dealing with challenging behaviour in popular TV programs) is a relatively new area and there is some encouraging evidence from the Positive Parenting Program developed by Professor Matt Sanders, University of Queensland, that this works (Sanders et al, 2000). Given that child behaviour problems can be a significant trigger for physical and emotional abuse, such use of television may be worth pursuing.

There are risks however associated with emotionally charged, confronting child abuse prevention programs. These may distress

children and even adults who were abused as children. Such programs could possibly be counterproductive by modelling aggressive behaviour (e.g. if they actually illustrate abusive behaviour such as shaking a baby). Once again research and evaluation is essential to make sure the interventions are used to maximum effect and without causing further harm.

This area of social marketing is one in which the Australian Government might be expected to perform a major role, as it has in relation to family violence strategies. It is something which the NSW Government, in partnership with other states and territories, should explore with the Commonwealth.

“Remember, no matter how upset you feel...shaking your baby is just not the deal”:

A general parenting program using an engaging animated DVD was developed and trialled in the Sydney West Area Health Service to give parents the skills to parent crying babies in safe ways and inform them of the dangers of shaking their infants. Parents recalled the key information and their attitudes changed significantly from seeing a crying baby as ‘spoilt’ or ‘naughty’ to regarding crying as normal infant behaviour. This is a very important change because a parent or carer with negative attributions towards a crying child is more likely to adopt a punitive attitude; if they think the baby is crying intentionally, they are more likely to ‘reprimand’ the child physically. This trial has demonstrated a clear link between supportive parenting education and safe and nurturing care, hinted at in previous research but not extensively researched.

Research outcomes of the Shaken Baby Prevention Project (Western Sydney), presented at the Shaken Baby Symposium, Children’s Hospital Westmead, September 2007.

Whole of Community Strategies

c. Cross-sectoral childhood initiatives in disadvantaged communities

One of the most promising recent examples of 'prevention science' in action is the Childhood Development Initiative in Ireland. The Office of the Minister of Children, an international philanthropic foundation (Atlantic Philanthropies) and a number of economically disadvantaged communities ('community engagement sites' with child populations of 3,000–7,000 with high level of anti-social behaviour and poor outcomes for children) are part of the ten year program. Appendix C provides an overview of the Child Development Initiative in Tallaght, West Ireland, one of the community engagement sites (Little, 2007).

The Initiative is based on two primary principles: "(1) the principle of freedom – action is geared towards releasing the capabilities of children and promoting children's own agency so that the child participates in valued outcomes; and (2) the principle of prevention – action is geared towards preventing needs emerging that block development, and towards intervening early so that needs are met to enable well-being at each stage."

Urban planning, community development, the introduction of model services, improved integration and accessibility of existing services, *and a very high level of participation* by children and parents in determining the local activities, are some of the key elements of the strategy. Performance measures are reductions in a range of anti-social behaviours and improved health and educational outcomes for children. While local in its implementation rather than bureaucratically-driven from above, the strategy is in line with national policy objectives and underpinned by a sophisticated evaluation.

There have been promising child-focused community development initiatives in Australia, but they have been handicapped by being short term, less well resourced, and lacking the vital support of both strong State or Commonwealth policy objectives. One is the Shared Action community development initiative by the non-governmental organisation (NGO) St Luke's Child and Family Care in the public housing community of Long Gully near Bendigo in regional Victoria (Beilharz, 2002). Another is the Pathways to Prevention initiative of Mission Australia in Queensland (Homel, 2004).

The previous Australian Government's Stronger Families and Communities Program supported a number of community development initiatives including the "Communities for Children" fund. However, short-term funding given only to NGOs, thinly spread resourcing, the lack of a sustainability and 'scale up' blueprint, and poor consultation and collaboration with State and Territory Governments, greatly diminished its chances of success.

It should be noted that NSW pioneered the first Australian cross-sectoral approach to strengthening and integrating early childhood services in disadvantaged areas through the Families First initiative. There are widely-held concerns, however, that the ethos of collective ownership and collaboration weakened after it shifted from central agency leadership to line agency responsibility.

Recent policy shifts in the UK are a good model of integrated, whole of government approaches. "Sure Start" has strengthened universal services for poor families, and this has been part of a major initiative to reduce child poverty. Under "Every Child Matters" the emphasis is on multi-agency services, joint strategic planning, joint funding agreements through 'Children's Trusts' and on common assessment frameworks across children's services.

Playgroups build child, family and community well-being

Orana Supported Playgroups has six established groups within Dubbo, Narromine, Trangie and Warren. Parents and their pre-school children – particularly Aboriginal families – who would not otherwise access early childhood services participate in the playgroups which are tailored to suit individual and group needs.

The playgroups provide opportunities for the parents to participate in all activities with their children, form social networks of their own and learn new skills. The approach strengthens and builds family and community wellbeing.

Strengthening Universal Children's Services**d. Child and family health nursing services**

Universal child and family health, or maternal and child health services were developed in most Australian states following the First World War to combat the problems of infant mortality and morbidity. In the post-Second World War period, other functions such as immunisation and developmental assessment were added. In the past two decades there has been increased recognition of psycho-social problems such as maternal depression and child abuse, and a growing interest in how existing services might be expanded to deal with child and parental emotional and social well-being. Because these services have a health focus, are available to all families and have been used by generations of families, they are widely accepted and do not carry the stigma of the child protection services. They are also locally based and thus highly accessible. For all these reasons these services are invaluable in both primary *and* secondary prevention.

In NSW, not all infants are seen by a child and family health nurse which means that a number of children still slip through this most important social safety net. Given that the risk of serious child abuse and neglect is greatest in the first two years of a child's life, and that infancy is a vital period for healthy parent-child attachment

and cognitive development, such services must be universal in any attempt to have a population-level impact on child abuse and neglect, and on the long term health and well-being of children.

NSW is behind states such as Victoria and South Australia in relation to child and family health nursing services, although significant advances were made in some regions following the introduction of the Families First initiative. In Victoria, for example, 98% of infants are enrolled in the maternal and child health service which is delivered by local councils with State funding. This high level of utilisation has historically been facilitated by legislation (*Child Wellbeing and Safety Act 2005* Part 7) which is unique in Australia. Notification of a child's birth must be sent within 48 hours to the CEO of the municipality where the mother resides, and where this is not known, to the CEO of the municipality where the birth occurred or to the Secretary of the Department of Human Services. The CEO of the municipality is required to forward the notification to the local maternal and child health nurse who is required to visit or communicate with the family as soon as practicable. The nurse has no right of entry to the home but the wide acceptance of this service by the community means that refusal to enrol the child in the service is very rare.

Compared with other states, Victoria has a high level of utilisation of the service in the first year of a child's life, with approximately 80% of infants receiving all ten key consultations in the first two years of life. Nurses also perform a major community development role, offering first time parent groups to all new parents, with two thirds of all first time mothers joining these groups. A two year follow-up study in two municipalities found that over 75% of these groups continued to meet in one another's homes after the eight nurse-facilitated sessions at the centre ended, and that they evolved into self-sustaining social networks (Scott, Brady & Glynn, 2001).

Given the significance of parental social isolation as a risk factor in relation to child abuse and neglect, increasing the potential of baby health centres, early childhood education and care centres, primary schools and sporting clubs to nurture family to family connections and a sense of neighbourhood belonging is vital.

e. Education services

Socially disadvantaged children are among those with the least access to high quality early childhood education and care. For some children in at risk situations, high quality child care is one of the few services which can closely monitor their well-being, monitor and meet their health and nutritional needs and provide stimulating and consistent care. Immediate measures need to be taken to increase the access of vulnerable infants and pre-school aged children to child care and pre-schools in NSW. To achieve this they will need to be low cost. They will also need to develop a warm and welcoming atmosphere to encourage hard-to-engage parents.

For vulnerable school age children, school can be central to their security and well-being. It is a place where they can learn in a safe and caring environment and a place too where they can develop a web of supportive relationships. Schools can also be vehicles for parent

education and community building, and a source of referrals for a range of services which families may need. The roles of school counsellors, chaplains, nurses and social workers need to be broadened to enable them to respond to families who are struggling to care adequately for their children. The Schools as Community Centres initiative in NSW has been a pioneer of this approach. Understanding the locations and local conditions under which such initiatives have been successful is a pre-condition to replicating the successes elsewhere.

Secondary Prevention Strategies

Secondary prevention is based on identifying and responding to vulnerable sub-groups in the population. This can be done using universal children's services as a platform to engage higher risk families. It can also be done via specialist adult-focused services for parents who are victims of family violence, are homeless, or who have a substance dependence, a mental health problem, or an intellectual disability. Often these problems co-exist yet it is very difficult to get an integrated response to families with such complex needs because 'single input services based on categorical funding' reflect the silos of government portfolios. New funding models are necessary if services are to respond to the multiplicity of such parental needs and the needs of their children.

The fear of child protection involvement can also act as a major barrier to parents accessing the specialist services they need such as drug treatment and domestic violence services. Improving access to such services without involving DoCS is important. Service providers need to be able to respond to vulnerable families without jeopardising their relationship with them by being required to notify cases which do not meet the threshold for child protection investigation or statutory intervention. A way in which this could be achieved while fulfilling mandatory reporting obligations is outlined in more detail elsewhere in this submission.

Some examples of promising secondary prevention interventions are outlined here.

a. Ante-natal services and GPs

Ante-natal services in hospitals and GPs are well situated to routinely identify women during pregnancy who are likely to need additional support to nurture their baby adequately. A number of hospitals currently use screening tools to achieve this. Women who may have additional needs include those with a childhood history of abuse or neglect, those exposed to family violence, those who are homeless and those with mental health or substance dependence problems. However, it is not a simple matter of making referrals to specialist services. Engaging vulnerable pregnant women in the services they may need is very dependent upon earning their trust and offering continuity of relationships. Holistic models of one-to-one midwifery care which extend from pregnancy through to post-natal support are best suited to achieving this.

b. Sustained Nurse Home Visiting

One of the best known and researched secondary prevention services is 'sustained nurse home visiting' (Olds et al, 1998). Vulnerable families are identified during pregnancy or shortly after the birth of their child and offered additional support delivered through a trusting and continuous relationship with a child health nurse who is specially trained. There are a few programs based on this model in NSW but these still serve a small number of families. There are also several volunteer home visiting services.

South Australia is the only jurisdiction in Australia which has a population-based sustained nurse home visiting program. Introduced following the Layton Child Protection Review in 2004, over 95% of families with a new baby in South Australia now receive an initial home visit by a Child and Youth Health nurse who skilfully and sensitively undertakes a comprehensive assessment. All families are entitled to the routine clinic-based paediatric surveillance

service, but approximately 12% of families (including all mothers under 20 years of age and all Aboriginal families regardless of socio-economic status) are offered a sustained nurse home visiting service for the first two years of the child's life. Mothers who are socially isolated or who have a mental illness, a substance dependence or who have been involved with statutory child protection services with a previous child, are also eligible.

A structured program involving 34 planned home visits is delivered and families are linked to a broad range of other services ranging from playgroups to specialist services. There is an acceptance rate of over 70% by both Aboriginal and non-Aboriginal families and initial evaluations of this program are very encouraging in terms of parental acceptance and continuation. A major evaluation of the outcomes is underway.

Supporting children Supporting families

SDN provides support for vulnerable families in the inner city of Sydney through their Child and Family Learning Centres. The program works with young parents, Aboriginal families, drug or alcohol using parents, and fathers who may need more support to raise their children and who may avoid services as they fear judgment. The program allows for children to access subsidised child care places through a scholarship program and links their families to additional support services to build family strengths and enhance parenting skills. The staff work closely with other local services to ensure that all the needs of vulnerable families are met, and to build mutual social support through strengthening the bonds between families. An evaluation of the project in 2005 found improvements in confidence in parenting, child-parent relationships, and an increased capacity to cope with challenges for families enrolled in the program (Udy, 2005).

c. Family-centred early childhood education and care services

A few early childhood education and care services have trained their staff to work effectively with hard-to-engage parents.

It is very difficult for most early childhood education and child care services to perform this broader role under current funding models, and commercial centres may not be motivated or equipped to do so. In some states such as South Australia “Children’s Centres” for children from birth to five years are being established in primary schools in very disadvantaged areas. This is similar to what has happened in the UK under the Sure Start program. Children’s Centres can form hubs to which a wide range of other services can be linked.

d. Child-sensitive specialist adult services

Services whose primary focus is on adults have a responsibility to children when there are factors relating to the parent which make children more vulnerable. This duty of care includes a preventive role as well as reporting statutory child protection services of suspected child abuse and neglect. Legislation and inter-agency protocols should make it clear that the responsibility of organisations making notifications does not cease with the making of a report. Legislative barriers to exchanging information between agencies in relation to a child at risk should also be removed.

Given that children of parents with an alcohol or drug problem, a mental illness or an intellectual disability are at much greater risk than other children, especially in a single parent family or where both parents have such conditions, organisations serving these client populations need to build their capacity to respond to children’s needs. This also applies to GPs

A toolkit for drug and alcohol workers

In 2004 the Victorian Department of Human Services (DHS) funded Odyssey House Victoria and the Parenting Research Centre to develop a parenting toolkit for drug and alcohol workers across Victoria. The toolkit was designed to help these workers identify the needs of clients for support in parenting skills to ensure their children’s wellbeing.

The toolkit is designed to improve workers’ knowledge and confidence in addressing their clients’ parenting role. Workers do not need to have specific expertise in parenting or child health intervention to use the toolkit. It provides information and resources that assist workers to develop comprehensive treatment plans for clients that include the important role that parenting plays in their lives.

The project involved broad consultation with key agencies, workers and clients from across the state and its development involved the generation of new material and the collation of existing material.

The Parenting Support Toolkit was introduced to more than 100 AOD personnel from the eight DHS regions during nine half-day training sessions during March 2005. The training introduced workers to the content and structure of the toolkit. Outcomes from the training indicated that trainees were highly satisfied with the training and felt the toolkit was a relevant and needed resource.

From the Parenting Research Centre website www.parentingrc.org.au

and other private health service providers.

An intake or initial assessment process which identifies whether the adult client has parental responsibilities is essential but many services do not seek such information. There are some promising initiatives which could be extended. For example the federally funded COPMI initiative (Children of Parents with a Mental Illness) has worked to increase awareness among adult mental health workers of the needs of children.

Professor Sharon Dawe, from Griffith University, has developed a home-based drug treatment service called PUPS (Parenting Under Pressure) specifically for women with young children. An evaluation of this program using a randomised control trial produced very positive results. There is a great need for all drug treatment services to be resourced and their staff to receive appropriate training, to enable them to deliver a family-centred service which is responsive to children's needs.

For parents with an intellectual disability, the national Healthy Start initiative of the Parenting Research Centre in Melbourne and the Faculty of Health Science, University of Sydney has pioneered ways in which parents with learning disabilities can be supported to provide safe and stimulating care to their children.

Some family violence services have evolved to be responsive to the needs of children as well as the abused partner. There are also correctional services which have used the opportunity of parents being in custody to deliver parent education courses.

While there are innovative examples in many fields of child-sensitive adult services, they tend to be few and far between. They are often based on short term funding, are poorly evaluated and are lacking in strategies to 'scale up'.

A whole-of-government policy aimed at addressing the well-being of vulnerable children wherever their parents receive services is required. To achieve this there will need to be a culture change from 'shifting risk' to 'sharing risk'. Funding models must allow for family-centred services. And a major professional development strategy is required to build the capacity of traditionally adult-focused services which are ideally located to protect and improve the well-being of vulnerable children.

e. Alternative pathways for mandated reporters

Currently a large number of cases referred to DoCS do not result in investigation, substantiation or statutory intervention. Many of the children of these families are nevertheless vulnerable, and if they do not receive appropriate assistance they may well be harmed, or re-reported until they do reach the threshold. Above all, these children will continue to suffer.

Many mandated reporters are aware that the case they are reporting is unlikely to be investigated or substantiated but are nevertheless legally obliged to make a report. If these reporters had available a child protection specialist within their own organisation (or in the case of a school, within a school district) with whom they could consult about such cases and who was familiar with the local service network, it may be possible to develop a case plan which effectively addresses the concerns and reduces unnecessary reports to DoCS.

Tertiary Prevention Strategies

Tertiary prevention strategies are aimed at responding to children who have been abused or neglected in order to prevent a recurrence and reduce the harmful effects.

DoCS successfully attracting Aboriginal staff

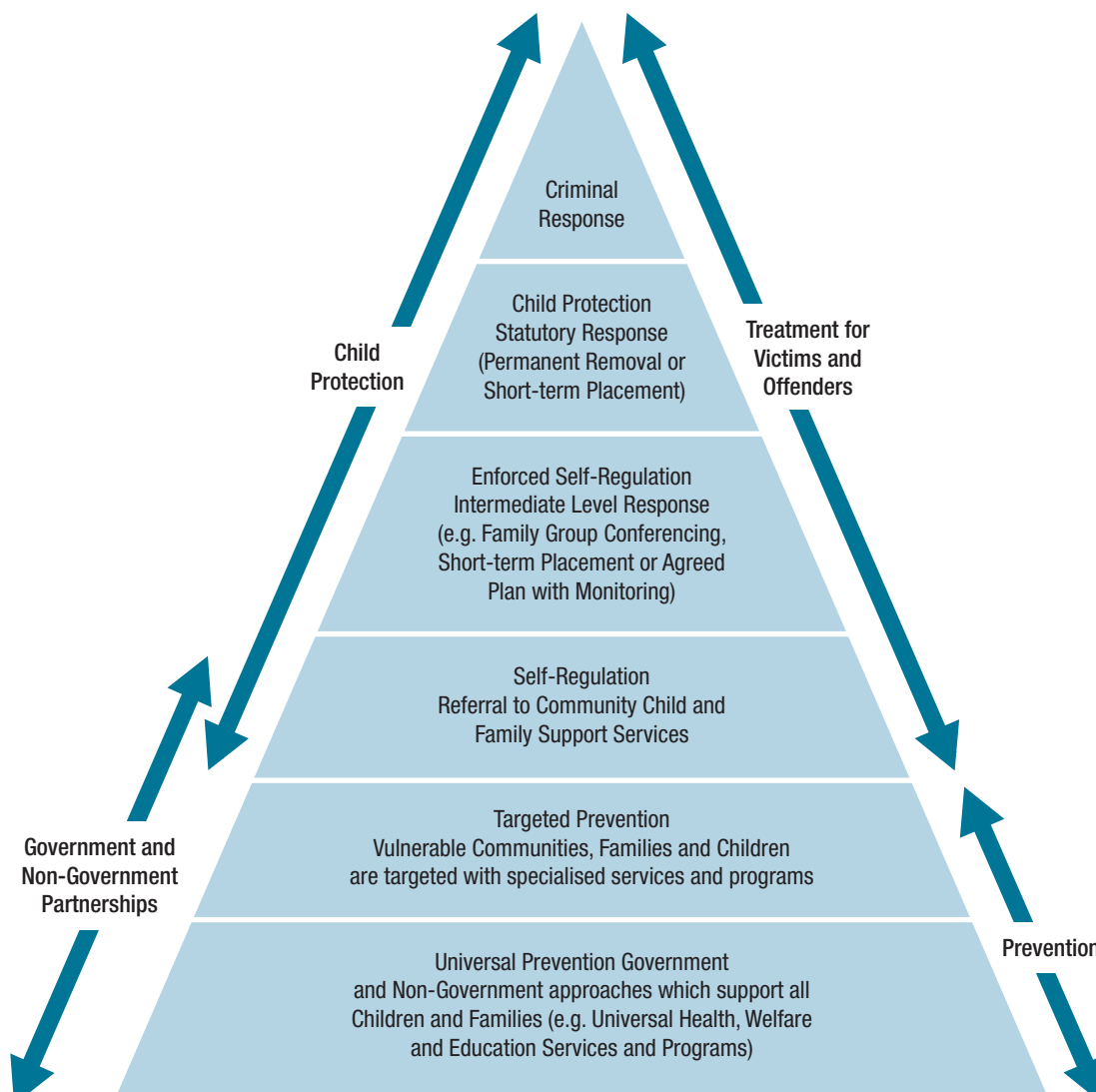
Seven per cent of DoCS' workforce self identify as Aboriginal. The NSW public service benchmark is a minimum of two per cent of staff in all public sector agencies should be Aboriginal.

Even with well funded primary and secondary prevention, there will still be a need for tertiary prevention (see inner circles of Figure 4 on page 30). Children need to be quickly assessed and provided with effective treatment for abuse and trauma, and appropriate and emotionally secure placements provided to avoid further damage where it is unsafe for children to remain at home (O'Donnell, Scott, Stanley, 2008).

Given that there are no reliable risk assessment instruments in the field of child protection and that the removal of children from their parents can both prevent significant harm and potentially cause harm,

it is imperative to reduce the number of families vulnerable to child abuse and neglect and the number of children who are abused. Statutory intervention and the removal of children will always be a requirement of the child protection system, but coercive and deterrent responses are not ideal for engaging families with support agencies. It is therefore vital to engage with parents and encourage regulation at low levels of risk with increasing levels of coercive and deterrent responses by the child protection system if cooperation and compliance is not achieved (see Figure 5 below).

Figure 5: Responsive Regulation Model of Prevention and Intervention in Child Abuse and Neglect
(Modified from the Allen Consulting Group, 2003 based on the model by Ayres and Braithwaite, 1992)



From Paper by O'Donnell, M., Scott, D. And Stanley, F., *Child Abuse and Neglect – Is it Time for a Public Health Approach?*

The case of PANOC

NSW Health PANOC (Physical Abuse and Neglect of Children) services should be effective in providing support to vulnerable families and children but at present there are some difficulties.

It seems the problem can best be cast as a misalignment between DoCS and Health at several levels that mean neither agency is getting the best out of the PANOC investment. Here is an example of one of the problems: DoCS often wants an immediate response to a referral because of the safety issues which PANOC can't meet, so the family is placed on a waiting list. Once Health accept the referral, DoCS then closes the case. This means Health can't 'borrow' DoCS authority to back up the intervention. Furthermore if Health reports to DoCS two weeks after the referral has been accepted, because of another safety concern, then it goes back into the general system of the Helpline and may well be allocated to a *new* DoCS caseworker.

Out-of-home care

Removing children from their family in a transfer of guardianship to the State is the most serious form of intervention the State can take. It is increasingly a measure of 'last resort' for several reasons: recognition of the importance of family connection, acknowledgment that being in care does not always result in positive outcomes for children, and a shortage of carers and placement options.

When the State determines that children are unable to remain safely in their parents' care, and parental responsibility is transferred in whole or part to the State, those children are owed a duty of care by the State. How can the State meet their duty of care to children in care? There are three primary aspects: making sound evidence-based decisions in bringing children into care and returning them home; providing quality care and a range of services for children and young people while they are in care; and providing follow-up services when children return home.

The Children's Guardian has now conducted a series of audits of children in care, based on different sampling frameworks, but the findings from these audits as reported in her Annual Reports are too broad-brush and limited for research purposes. These audits have the potential to be a valuable source of data and, based on reliable sampling, are indeed valuable research in themselves. Their findings, suitably de-identified, should be publicly reported and available for research and monitoring purposes, particularly collaborative research involving the Children's Guardian and universities.

Making decisions

One of the most contentious and difficult issues in child welfare policy and practice is how to achieve some certainty and permanence in the lives of children in out-of-home care. The problem of children 'drifting in care' without proper planning and with constant changes of placements, and the instability and insecurity this causes, has been recognised since the 1970s. While most jurisdictions have attempted to implement policies and practices, backed by changes in legislation, to promote timely, long-term decision-making for children in care, the reality is that permanence and security for children continue to be difficult to achieve. A significant number of children are 'oscillators', cycling in and out of care. While most children who enter care return home fairly quickly, it is also clear that a number of children entering care are doing so for a second or even third time (Delfabbro, Barber & Cooper, 2000). The consequence of children moving *in and out* of care or remaining at home in unsafe and inadequate care for too long means that when they do come into care they bring significant levels of disturbance and attachment difficulties (Delfabbro & Osborn, 2007). This increases the likelihood of further placement breakdowns and "corrodes the very core of the capacity of a child to develop trust" (Scott, 2006).

Out-of-home-care decisions are notoriously difficult to make. For example, specialist expertise is needed in an increasing number of cases to determine the

prospects of a parent being able to manage their substance dependence and provide appropriate parenting. This work also needs to be informed by an evidence-base, and good longitudinal research and monitoring of outcomes.

Another major issue is that children are often returned home with insufficient preparation and very little support. Marianne Berry's work in the US indicates that engagement with the family is crucial and that re-abuse and re-entry to care for children are less likely the more time and help families receive in their own homes (Berry, McCauley & Lansing, 2007). Families often need help with housing, managing debt and financial stress, overcoming substance abuse, addressing mental health issues and engaging with the community.

Quality of care and new models

The main problem facing the out-of-home care system is the shortage of carers: a problem that is likely to become more pressing as increasing numbers of children enter care and stay longer. Increasing numbers of children with more complex needs not well suited to foster and kinship care are also entering the system. The two main forms of out-of-home care in New South Wales and Australia are kinship or relative and foster care with non-related carers.

There are now more children in relative or kinship care in New South Wales than in foster care (57.2% compared with 40%: AIHW 2008), and a higher proportion than in any other state or territory. The reasons are both ideological and pragmatic. Relative care fits with notions of family preservation and the importance of children maintaining connections and feelings of belonging within their families. It is cost effective and practical because of the shortage of foster carers and the difficulty of finding suitable placements for children in need of care. And it has particular advantages for Indigenous children as it is consistent with traditional practices of caring for children within their kinship groups. While some research points to positive benefits for children in relative care, especially in terms of

stability and continuity of family contact, the findings in relation to outcomes are mixed and there are concerns about the lack of proper assessment and support for relative or kinship carers. Many relative carers, especially in Aboriginal communities, are grandmothers, who are older and single, with minimal economic resources. They are called on to care for young children with little financial and practical support.

Improving stability and emotional security of children in care

A critical issue for children in care is the need for stability and emotional security. Secure relationships and connectedness are the key to good outcomes and to good experiences for children in care (Cashmore & Paxman, 2006; Mason & Gibson, 2007; Schofield, 2005). Stability is therefore a means to this end – for children to stay in one place for long enough to develop networks and relationships, for carers to come to know and understand their emotional, health and educational needs, and to have some stability in school and neighbourhood. It does not mean, however, that the over-riding aim is to minimise placement changes per se if it means staying in an unsatisfactory or inappropriate placement.

There are a number of considerations and possible strategies to reduce instability and maximise a sense of security. First, permanency can be achieved in various ways – by returning children home where it is safe to do so, by placing children with someone already known to them, by using appropriate forms of therapeutic placements, and by adoption. Bouncing in and out of care, or delayed entry to care, is, however, associated with more disturbance and with more likelihood of placements breaking down (Cashmore & Paxman, 2006; Delfabbro & Osborn, 2007).

Matching children to appropriate placements is of course easier if the carers are committed to the child (family members and significant others), if the demands of the task do not exceed carers' capabilities, and if there are fewer children to place

relative to the supply of carers. One strategy may therefore be to provide for arrangements where their care is shared: for younger children with child care or family day carers during the day, and for older children with appropriate residential schools for weekday care. Adoption should also be considered more often than it is now – with only 21 children across Australia being adopted by their carers in the year 2005-2006. Practically, many carers cannot afford to lose the carer allowance for the children, and many workers do not have the time and the skills to process the adoption, especially if the parents are not contactable or not willing or able to give consent. In many cases, children are also in the care of relatives and adoption by a relative is neither necessary nor appropriate.

Second, research shows that children who are perceived to be very difficult to manage have more placements that break down, often on a repeated basis. Helping carers to understand and manage their behaviour and having on-call assistance when there are real difficulties should be available. As should professional care.

Third, placing children with siblings and allowing them to have some say in the decisions that are made about them are both likely to reduce children's anxiety and distress, and promote a sense of security.

Children and young people with complex needs

Fortunately, Australia (and New South Wales in particular) has a much lower proportion of children and young people in residential-style out-of-home care than in other countries such as the UK (15% in 1999) and the US (approx 20%). In 2006–7, only 2.2 per cent of children and young people in care in New South Wales were in residential care or group homes. However, there is a need for different placement options for older children and troubled adolescents for whom foster placements are not appropriate. These are the children whose level of disturbance and behaviour contribute disproportionately to placement breakdowns and to

the stress on foster carers (Delfabbro & Osborn, 2007). DoCS' funding models are attempting to encourage the development of new therapeutic models of care, but these need to be properly evaluated.

There is also a need for new models of shared care and extended respite care with professional 'foster carers' or 'boarding school' residential care arrangements which provide support to the whole family and care for the child on a shared basis. These could provide mid-way options and alternatives to leaving children at home or placing them in foster care. The Boys Town model of a residential boarding school arrangement during the week and return home for weekends provides one alternative model for secondary school-age children who are not coping with school. It also provides respite and support for parents or carers. Child care for vulnerable children and children in foster care can also provide useful respite and quality daytime care for vulnerable preschool children.

Comprehensive care and annual reviews

According to the legislation, the statutory responsibility for children in out-of-home care is held by the Minister and the Director-General of DoCS. None of these bodies has the capacity to meet the physical, emotional and mental health needs, as well as the educational and accommodation needs of these children and young people. There has to be a whole of government/whole of community response to the children's needs. They should have priority access to all Government health, education and housing services, including such specialist areas as child and adolescent mental health, remedial educational support and dental services.

Further, legislation, departmental policy, and the Children's Guardian all require children in out-of-home care to have an annual review. But this is not happening for all children in care. There needs to be an audit of this situation and remediation so that all children have reviews that include attention to their education, health, and stability issues as well as their contact with family members and other people who are significant in their lives.

Need for comprehensive assessments

It is not possible to know what children's needs are, on entering care, without a comprehensive assessment. Such assessment is also useful in establishing baselines to monitor whether children's physical and mental health and educational status is being nurtured, harmed, or is unaffected by, their time in care. While there are expectations that good quality care can overcome a child's disadvantage, it is also important to recognize that there are "limits to the degree of remediation possible in relation to both the social and educational development of young people admitted as older children and adolescents, following a childhood deprived of adequate education, affection, appropriate attention, and proper controls" (Minty, 2000, p. 997).

There is considerable evidence concerning the health and educational needs of children in care. Both local and overseas studies highlight significant health problems which include a range of chronic physical health conditions, lack of immunisation, poor dental health, behavioural and emotional health issues, and significant mental health issues

(Nathanson & Tzioumi, 2002). Very few children have a clean bill of health. Nathanson and Tzioumi have outlined the barriers to children in care receiving proper health treatment. These include problems in recording and transferring information about children's health where there is minimal medical history available (often no 'bluebooks' or Medicare cards) and a tendency to rely on carers who may be ill informed, especially if there have been frequent changes in placements and in case workers.

Three pilot clinics have been established in NSW to address this issue. Children are referred by DoCS for comprehensive assessments of health of children in care. One is at the Sydney Children's Hospital, one in the Hunter region, and the other, KARI, serves Aboriginal children (see p 8). But these clinics serve a very small proportion of children in out-of-home care in NSW.

Such comprehensive assessments of children entering care and follow-up monitoring of all their health and developmental status and needs are essential if we are to improve the lives of children in care.

Understanding the health care needs of children in care

In a local initiative between the Sydney Children's Hospital child protection service and the local office of DoCS, a clinic was established in February 2005 to assess the physical and mental health of children in out-of-home care on a trial basis.

The findings of the comprehensive assessments for 80 children aged 4 to 17 seen at the clinic indicate a significant number of health problems for children in care:

- *Immunisations – for 51% of children, these were not up to date*
- *Vision – 20% of children failed the screening test and were referred for optical services*
- *Dental – 30% of children had caries*
- *Hearing – 25% failed the hearing test*
- *Developmental assessment – 68% of under 5s failed the screening test*
- *Speech – 50% of under 5s had speech delay*
- *Growth problems included failure to thrive (1), small stature (7), and being overweight (2)*
- *Infections and other conditions – 12% had respiratory and ear infections and 21% had skin problems; the other conditions included orthopaedic problems, asthma, iron deficiency, recurrent urinary tract infections, etc*
- *Behavioural and emotional health problems were the most significant issue for 53% of children, and for seven children there were significant mental health issues including depression, suicidal thoughts, post traumatic stress disorder, and significant grief and loss issues requiring counselling.*

Nathanson, D. & Tzioumi, D. (2007) Health needs of Australian children living in out-of-home care. *Journal of Paediatrics and Child Health*, 43, 695-699.

Educational needs

Education is critical to children's progress and recovery, both academically and socio-emotionally. But the evidence both here and overseas consistently points to the poor educational achievement of children in care. Once again this is a result both of their pre-care history and experiences and of the failure to catch-up when they are in care. Clearly, schools and the public education system have a key role here. To give these children the attention they need, delivered with some sensitivity, a trial model and evaluation of designated teachers in state schools, who would have the responsibility for monitoring and supporting the progress of individual children in care, would be useful. The teaching load would need to be adjusted to take account of the extra responsibility.

There also needs to be some emphasis on minimising changes of school for children in care. When children change placements, efforts should be made to keep them in their current school as far as possible. This is particularly important because of the cumulative and long-term effect of instability. The more placements children are in, the more schools they attend, the less likely they are to complete Year 12.

Since foster carers can play an important role in supporting children's education, a training and information package should be developed to help them to understand the importance of education, to support children's educational progress, and to engage children in their education.

Younger children in out-of-home care should have priority access for at least two days a week in a quality childcare service to provide both early educational experiences and respite, and support for their carers. DoCS and the Commonwealth should cover the fees for the child to attend.

Data matching on education for children in out-of-home care

Currently the data collection schemes between DoCS and the Department of Education and Training (DET) are non-compatible and until the recently introduced collection of out-of-home care status on the enrolment forms, DET were not routinely informed which children and young people were in out-of-home care. Currently for data to be matched between the two departments, DoCS must provide the full name, date of birth, gender and Indigenous status of the children who are then manually matched with the DET data system. DET then provide unit level data back to DoCS. The first round of this data matching for the Basic Skills Tests

took approximately 6 months to match. DET is establishing individual identifier numbers which should help this process in the future. Currently the data available is restricted to Basic Skills Test results and School Certificate and HSC results. There is no data available on the following aspects since DET collects this data only at a regional or school level and in a non-identified way:

- Rate of enrolment
- Levels of attendance
- Levels of grade retention
- Age for year attending (older or younger or correct age)
- Suspension and expulsion rates, reasons etc
- Rates of exit at school leaving age
- Rates of retention for each year post compulsory school leaving age is not available at all.

Meeting the education needs of children in care

Australian research highlights a range of factors that support improved educational engagements and outcomes for children and young people in out-of-home care.

At a systemic level what appears to work is:

- *Statewide agreements between education and community service departments that are implemented at a regional and local level resulting in inter-disciplinary co-operation*
- *Individual education plans for all children and young people in out-of-home care (implemented in SA, VIC, ACT and QLD for all children and young people in care, and for children in long-term care in TAS) and a designated person responsible for overseeing that plan.*

For individual children and young people what works is:

- *Continuity in schooling particularly by funding travel to existing school and looking at the school community for placement opportunities where appropriate*
- *Support at home and school through mentors, tutors and support teacher time but the South Australian experience is that “short term mentoring for children and young people in care can cause considerable distress when it is removed, particularly if it occurs without negotiation or is not during a natural transition period.”*

(SA Children’s Guardian, 2007, p. 23)

In the absence of data matching between the two departments we have no way at a state-wide or even regional level of knowing how one of the most vulnerable groups in the education system are faring and where are the points for the required policy and practice changes to improve the educational outcomes and engagement of this group. DoCS is not always provided with data for individual children and young people in care. School reports and state-wide test results are provided to carers and DoCS and other agencies rely on carers to pass that information on, and this does not always occur. DoCS are now collecting some educational data through the out-of-home care Minimum Data Set, but the first round of data is not yet publicly available.

A number of jurisdictions have been tracking educational data at a state-wide level over a number of years, these include QLD, SA and Vic. ACT and Tas also recently undertook this exercise in the recent Australian Institute of Health and Welfare study on educational outcomes for children in care (AIHW, 2007). This tracking has led to a range of initiatives being implemented to improve the educational outcomes of children and young people in out-of-home care.

Leaving Care

The relative disadvantages of young people on leaving care compared with their age-mates who have never been in care are well documented: these include having low levels of educational attainment, and high rates of unemployment, mobility, homelessness, financial difficulty, loneliness and physical and mental health problems (Cashmore & Paxman, 1996, 2006). Although the state clearly has a duty to continue providing support, this responsibility has been recognised only recently with the establishment of aftercare services and some allowances for young people after leaving care. Indeed, NSW has led the way on this in Australia. But there has been no evaluation of the effectiveness and availability of these services for the young

people who need them and it appears that priority access to services for young people either in care or after leaving care is not well established in practice despite the principles of the Charter for Children in Care.

Participation of Children and Families

The current legislation provides for various avenues for the participation of children and families in decision-making processes that affect them in the child protection and out-of-home care systems. These include the participation principle (section 10) and the role of alternative dispute resolution (S.37 and S.114) and pre-hearing preliminary conferences (s. 65). There is mounting evidence that, as far as possible, working with families in a respectful way can minimise the anger and distress of families whose children have been reported to statutory departments and may lead to better and less harmful interventions for children (Dumbrill, 2006; Thorpe, 2007). Evaluations of family group conferences and the research concerning family inclusion have pointed to the benefits of participation (e.g. improved practice, better outcomes for children and their families, and greater commitment and compliance with decisions by families).

There has, however, been little implementation of alternative dispute resolutions processes or other inclusive ways of working with families. There are few Children's Court registrars to conduct pre-hearing conferences and minimize the issues in dispute at court. Indeed, it appears that there has been little use of alternative dispute resolution at all – although this was very much the intention of the review of the 1987 legislation, it is clearly provided for in the Act at various stages of the process, and considerable planning work was undertaken. There has been no evaluation of the implementation or outcomes of the participation principle and the extent to which children and young people are involved in the decisions that are made about them.

Children's Court

The Children's Court plays a critical role in hearing cases involving very significant decisions in children's lives. Yet we know little about the process in terms of the profile of cases that come before it and the orders that are made. There is no reliable information on a court data-base and no comprehensive record of judgments or appeals from the Court.

There is also cause for concern about the lack of a specialised magistracy for care and protection matters, and a specialist knowledge base in the appeal process. These are critical decisions in children's lives and those who are making them should have a real understanding of the legislation and of the issues concerning abuse and neglect, child development and the outcomes for children in such matters. They should not be heard and determined by magistrates in Local Courts who have no expertise in the area and whose days are filled with minor criminal and civil matters. There is a case for the Court to be headed by a Judge as it is in other states such as Victoria, Western Australia and South Australia. There is also a need for the Judicial Commission to run specialist training for Children's Court magistrates and District Court

judges selected to hear these cases and to include appeal judgments on the Judicial Information Research System (NSW Judicial Commission).

Advocacy, regulation and complaints handling

The agencies and the system for protecting children which we have considered above make life-altering decisions and have significant powers. They have power over the lives of the children who are the most vulnerable in our community. Advocacy, regulation and complaints handling are the important complement to these systems, promoting children's well-being and helping to build the system which will protect children from becoming vulnerable.

Currently advocacy, regulation and complaints handling are divided among three agencies which focus on:

- advocating for children's well-being and providing advice to Parliament, Executive Government and others
- improving service quality through complaints handling and review
- accrediting providers of out of home care.

Children's Court: what we don't know

The lack of reliable information from the Children's Court means that we don't know:

- *How children in care matters are dealt with via the court system?*
- *How long does it take to make a final decision? What factors have an impact?*
- *How often cases return to court e.g. after restoration? after supervision orders? after removal?*
- *Have the legislative and procedural changes produced the intended outcomes in relation to:*
 - *A less adversarial process?*
 - *A more expeditious process?*
 - *Increased use of ADR?*
 - *The effect of and use of pre-hearing conferences?*
 - *Increased range of orders being used? Are they effective?*
 - *Effect of and use of court reviews?*
 - *The value of assessments by Children's Court Clinic?*
 - *The impact of the participation principle (s. 10)?*
 - *On what grounds are appeals made? And are they successful?*

The three agencies, the NSW Commission for Children and Young People, the Ombudsman and the Children's Guardian, also have other functions and constituencies: none are solely focused on the child protection system.

The legislation sets out the role and functions of the three agencies.

The NSW Commission for Children and Young People is unique in its role and function. There is no other agency or authority in NSW that has a mandate exclusively to represent and advocate for the interests of all children and young people in the State. The Commission is concerned with the wellbeing and interests of all children and young people regardless of whether or not they are in the child protection system. As part of its advocacy (which includes policy, research and public awareness raising functions) for all children, the Commission influences the system for protecting children. It also influences through its work with the Child Death Review Team work and the Working With Children Program.

The Children's Guardian has a regulatory role in accrediting those agencies that provide out-of-home care. She also has a role in promoting the interests of a specific sub-population of children and young people, those in out-of-home care.

The Ombudsman's role is in complaints' handling and oversight of the public service. He also has the function of improving the quality of responses by designated agencies to allegations against staff.

The legislation provides some clarity between the Commission and Ombudsman. The *Commission for Children and Young People Act 1998* prohibits the Commission from dealing directly with the complaints or concerns of particular children (Section 16(1)). Individual matters are referred to the appropriate body such as the Ombudsman, Health Care Complaints Commission or Independent Commission Against Corruption.

The Act also provides for the Child Death Review Team to research all deaths of all children. The *Community Services (Complaints Monitoring) Act 1993* limits the Ombudsman's responsibilities to reviewable deaths. The Child Death Review Team is able to conduct research into all deaths, including reviewable deaths. To prevent unplanned duplication, the Minister is required to seek and consider the Ombudsman's views about proposed Child Death Review Team research, before approving any such research. The exception is the Team's Annual Report.

MOUs and exchange of letters provide clarity for Guardian and Ombudsman. Issues could arise where there is a potential lack of clarity about whether an activity is part of a standard-setting and monitoring role, or an investigation and complaints role, and therefore whether it is an activity of the Guardian or of the Ombudsman. In these cases, Memoranda of Understanding or an exchange of letters has been used effectively to clarify responsibility.

The need for a separation of powers

Advocacy, regulating and complaints handling are distinct functions which do not appropriately sit in the same agency.

Complaints handling should be undertaken by impartial arbiters so that people get a fair hearing and the outcome is seen to have integrity. In setting standards and monitoring regulations a balanced view of the system is realised which considers both the economic realities and the range of stakeholders within that system. The Commission, an advocate for children, is not impartial and gives primacy to children and young people's views and interests. Setting standards, monitoring regulations and handling complaints should be located separately to the advocacy role.

The Guardian's regulatory functions mean that she is part of the child protection service system. As such, her decisions need to be subject to oversight and there needs to be a separate impartial body that can deal with complaints about those decisions. The Ombudsman can appropriately undertake these functions only because the Guardian is a separate entity.

The legislation itself is clear about the distinct roles of the agencies. The agencies work in a complementary manner, and there is currently little or no duplication in their roles.

The need for an evidence-base

A research-led reform strategy is urgently required in the field of child protection in Australia. While international research can be a valuable resource, a strong research base which is relevant to this country's needs, legislation and service systems is essential. Two recent audits of Australian research completed over the past decade – one on out-of-home care and the other on child protection more broadly – have highlighted significant gaps in existing research. There is a number of important topics that have not been addressed – as well as an over-reliance on small-scale, qualitative studies and a very low level of funding for research. (Cashmore, Higgins, Bromfield, & Scott, 2006, p. 4)

While DoCS has developed a research agenda and funded PhD and post-doctoral research, there is still little Australian research relating to the outcomes for children, whether or not they enter care or receive services. The KIDS system is not designed to support research and apart from several relatively small sample studies, there is no tracking of children's pathways through the system and understanding of their outcomes over time.

DoCS has committed to a longitudinal study of children coming into the child protection and care system but the design, framework and funding has not yet been finalised. Knowing how, when, under what circumstances children enter the system and what services they receive and how children fare with different forms of services and care is essential. Are children better off entering care than not? Are children who are returned home, or who remain at home better off? Under what circumstances? Are the new services for children with high and complex needs achieving what they are intended to achieve? What changes can be made to promote children's stability in care, and how effective are these?

Implementation

The history of reforms to the child protection system in NSW reflects a tendency towards organisational restructuring as a response to problems. This highlights the reactive way that we respond to child protection and, as such, we should view with caution a focus on creating yet more new structures to 'fix' the issue.

Research from the United Kingdom into the impact of changes in structure on the delivery of services to children and families found only weak connections between management structure, output and outcome, concluding "there is a case for greater organisational stability" and suggesting that "it is more fruitful to concentrate on what professionals actually do and how they go about it" (Packman & Hall, 1998).

Rather than organisational change what is called for is a shift in the way in which children and young people's needs are understood and services for children and young people are delivered. We also need to shift the system towards reducing demand on DoCS by increasing other services' involvement and investment in children and young people.

Services and policies to support children and young people need to focus on overall well-being rather than on time-limited responses to crises or adverse incidents. One of the most effective ways of establishing what is needed and important to young people is to ask them. Children and young people have legitimate views on their own well-being that need to be taken into account when developing policy services and monitoring frameworks. The participation of children and young people in the development of approaches that are designed to protect and promote their well-being is essential for effective, appropriate services.

Implementing changes of policy or direction, in Government and other organisations, can sometimes be superficial: the law, language and practice guidelines may change, but the scope and parameters of the organisations and the behaviour of their staff does not change sufficiently. Consequently children and young people don't experience anything differently. "Implementation" can sometimes be rushed in an unrealistically short timeframe, or made the responsibility of a peripheral team so it does not integrate into the everyday business and governance of organisations and Government.

So implementing the recommendations in this submission is not, fundamentally, about changing laws or redesigning child protection services. It is a complex task which requires change across a number of domains, including:

- the way community members, service providers, businesses, Governments and the media think about families, children and their protection
- the relative emphases placed on efforts to:
 - support families to nurture their children
 - target support to those families and communities where children are vulnerable
 - respond appropriately when children are harmed
 - support children and families to recover if harm has occurred

- jointly and collaboratively planning and developing the service system and the services within that system
- embedding different roles for many organisations in each organisation's values, policy, practice and culture
- the leadership, resource allocation and accountabilities of Government, and in some cases other, organisations.

Implementing the recommendations of the Special Commission needs to be handled differently: acknowledged as a key Government priority, led at the highest levels, driven from the centre of Government and allowed sufficient time for change to be measurable.

In 2008, this means that implementation needs to become part of the NSW State Plan, overseen by the Premier's Delivery Unit and the Human Services and Justice Chief Executive Officers' Forum, with accountability to the State Plan Performance Committee of Cabinet and regular public performance reports against a detailed delivery plan.

The current State Plan target F7, *Reduce rates of child abuse and neglect* and its associated Priority Delivery Plan should be replaced with a five to ten year implementation plan for the Special Commission's recommendations. Given that implementing the recommendations will require active whole of government collaboration beyond the traditional child protection system, lead agency responsibility should lie with the Department of Premier and Cabinet rather than with a service delivery agency.

It is important that other State Plan priorities be reviewed and their delivery plans modified to incorporate the Special Commission's recommendations, particularly those priorities under the goals *Keeping people safe, Building Harmonious communities, Healthy communities, Students fulfil their potential, Strengthening Aboriginal communities, Opportunity and support for the most vulnerable and Early intervention to tackle disadvantage*.

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Appendix A

Table 5.1: Number of children aged 0-17 years commencing intensive family support services, by age at commencement of service, states and territories, 2006-07 (AHIW, 2008)

Age (years)	NSW	Vic	Qld	WA ^(a)	SA	Tas	ACT	NT
Number								
0-4	106	408	328	235	22	15	150	23
5-9	58	333	442	144	19	28	151	19
10-14	73	464	278	78	16	8	86	15
15-17	28	117	106	38	3	2	31	4
Unknown	–	419	86	3	–			
Total	265	1,741	1,240	498	60	53	418	51
Per cent								
0-4	40.0	30.9	28.4	47.5	36.7	28.3	35.9	37.7
5-9	21.9	25.2	38.3	47.5	36.7	52.8	36.1	31.1
10-14	27.5	35.1	24.1	15.8	26.7	15.1	20.6	24.6
15-17	10.6	8.9	9.2	7.7	5.0	3.8	7.4	6.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) In Western Australia, not all services are able to report on the age of the child when the child is over 12 years. These children are included in the 'unknown' category. Therefore the percentages should be interpreted carefully as it cannot be assumed that the 'unknowns' are evenly distributed among the age categories.

Notes

1. Percentages exclude children of unknown age.
2. Percentages in tables may not add to 100 due to rounding.

Appendix B

International Child Protection Statistics (Rate per thousand) age 0–17yrs						
Country	Notified/ Reported Cases ¹	Registered/ Substantiated cases	Subject to a court order	Admitted to care and protection order	In out of home care	Admitted to out of home care
	2006	2006	2006	2006	2006	2006
Australia	55.5 ⁴	7.2 ^{3a, 4, 4b}	5.7 ⁵	2.7 ^{4a,b,c}	5.3 ⁵	2.6 ^{4a,b}
New Zealand	65.0 ^{4, 5a}	n/a	3.4 ^{5a,b}		5.0 ^{5a}	n/a
England	6.5 ⁶	2.4 ²			5.0 ^{8a,b}	2.1 ⁸
Scotland	10.0 ⁶	2.2 ²			7.0 ^{8a,b}	n/a ^{8c}
Northern Ireland	6.5 ⁶	3.8 ²			4.5 ^{8a,b}	1.6 ⁸
Wales	n/a ⁶	3.4 ²			6.2 ^{8a,b}	n/a ^{8c}
	2005	2005			2005	2005
US ⁹	47.3 ¹⁴	12.0 ^{3b, 14}			6.61 ⁵	4.1 ¹⁴
	2003	2003			2001	2003
Canada ^{10,11,12}	45.7	21.7 ^{3b}			9.2 ¹³	2.8 ⁷

Notes

- Refers to numbers of notifications/reports, not children.
- Refers to numbers of children on registers as at 31 March 2006 (only those children who are considered to be at risk of harm are placed on registers).
- 3a. Refers as near as is possible to the number of children (although in some cases children may be the subject of more than one substantiation).
3b. Refers to numbers of substantiations (children may be counted more than once during the year).
- 4a. Refers to period 1 July 2005–30 June 2006.
4b. Refers to number of children.
4c. Data for children on juvenile justice orders not included.
- 5a. Children aged 0–16 yrs.
5b. Refers to numbers of children on 30 June 2006.
- Refers to period 1 April 2005–31 March 2006.
- Number of episodes rather than children.
- 8a. Children may be counted more than once. It is not possible to differentiate child protection statistics for children on court orders or in out of home care from other looked after children.
8b. Refers to number of children on 31 March 2006.
8c. Unable to differentiate children starting to be looked after out of home, from children starting to be looked after.
- Statistics for US based on case level data from 45 states and aggregate data from remaining states.
- Statistics for Canada, based on weighted national annual estimates derived from 14,200 child maltreatment investigations conducted in 2003.
- Figures do not include Quebec as had only recently introduced a system of reporting similar to the rest of Canada.
- Age 0–15years.
- Age groups vary across provinces and territories from 0–15 yrs to 0–16 yrs. Placement details were not available for all provinces and territories thus figures for children living away from home may be overstated in some provinces and territories and understated in others.
- Refers to period 1 October 2004–September 2005.
- Refers to number of children in care on 30 September 2005.

References

Australia

Period: 1 July 2005–30 June 2006

Source: *Australian Institute for Health and Welfare 2007: Child protection Australia 2005–2006*

Rates per thousand: Calculations based on population statistics used in *Australian Institute for Health and Welfare 2007: Child protection Australia 2005–2006*

Population: 4,802,641 as at December 2005

Age: 0–17 years

New Zealand

Period: 1 July 2005–30 June 2006

Source: (1) Child, Youth and Family Services Annual Report for the year ended 30 June 2006.
(2) Personal correspondence with James Mansell, (CYF 2006)

Rates per thousand: based on estimated resident population of New Zealand at June 2006, aged 0–16 years. www.stats.govt.nz

Population: 1,018,530 at 30 June 2006

Age: 0–16 years

Scotland

Period: 1 April 2005–31 March 2006

Source: (1) Scottish Executive, *Child Protection Statistics 2005–2006. A Scottish Executive National Statistics Publication Notice (29 September 2006)*, (2) *Looked After Children 2005–2006. A Scottish Executive National Statistics Publication Notice (16 November 2006)*

Rates per thousand: based on General Register Office Scotland, mid-year population estimates. Population: 1,050,190 at 30 June 2006

Age: 0–17 years

England

Period: 1 April 2005–31 March 2006

Source: (1) Department for Education and Skills. *National Statistics, First release: Referrals, Assessments and Children and Young People on Child Protection Registers: Year Ending 31 March 2006 (Final)*, (2) Department for Education and Skills. *National Statistics, First release, Children Looked After in England (Including Adoptions and Care Leavers), 2005–2006*.

Rates per thousand: based on mid-2006 Population Estimates. England. www.statistics.gov.uk

Population: 10,996,700

Age: 0–17 years

Wales

Period: 1 April 2004–31 March 2005

Source: *Local Government Data Unit – Wales, November 2006*. Local authority child protection registers: Wales 2006; Social services Statistics Wales 2005–2006.

Rates per thousand: Based on mid-2006 Population Estimates. Wales. www.statistics.gov.uk
Population: 640,900

Age: 0–17 years

Northern Ireland

Period: 1 April 2005–31 March 2006.

Source: *Health, Social Services and Public Safety: Children Order Statistical Tables 1 April 2005–31 March 2006*

Rates per thousand: Based on mid-2006 Population Estimates. Northern Ireland. www.statistics.gov.uk
Population: 432,100

Age 0–17 years

US

Period: 2005

Source: (1) US Department of Health & Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2005*. (2) *National Data Analysis System (<http://ndas.cwla.org>)*.

Rate per thousand: Based on figure supplied by the *National Data Analysis System*.

Population: 73,469,984

Age: 0–17 years

Canada

Period: 2003

Source: (1) Public Health Agency of Canada: *Canadian Incidence Study of Reported Child Abuse and Neglect – 2003*. (2) Federal-Provincial Working group on *Child and family Services Information Child and Family Services Statistical report 1998–1999 to 2000–2001*

Rates per thousand statistics supplied in: *Canadian Incidence Study of Reported Child Abuse and Neglect – 2003*

Population: 4,757,795 (excluding Quebec)

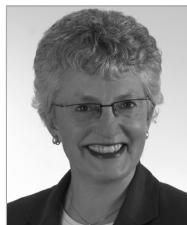
Age: 0–15 years

Appendix C

Child Development Initiative in Tallaght, West Ireland, one of the community engagement sites (Little, 2007).

Interview with Katherine Zappone: Freedom and prevention: developing effective children's services in Tallaght, Ireland

¹ Dartington Social Research Unit, UK, and Chapin Hall Center for Children, University of Chicago, US



Katherine Zappone, Chair, Childhood Development Initiative, Tallaght West, Ireland, was interviewed on 1 May 2007 by **Michael Little**¹

This is the third in a series of articles based on interviews with policy-makers, philanthropists and community activists about the reforms to children's services in Ireland. Subsequent series will examine reform efforts in other countries.

Preamble

Ireland has suddenly become a hub of activity around children's services – at central and local government levels, involving the primary statutory and voluntary agencies, and engaging some of the more disadvantaged communities. In the first article in the series, Sylva Langford (2007) described the origins and work of the Office of the Minister for Children (OMC), of which she is Director General. In the second article, Michael Little and Ali Abunimah (2007) considered the role of \$200 million philanthropic investment in the reforms, specifically a 10-year programme of work funded by Atlantic Philanthropies to encourage strategy development and service design to improve outcomes for children on the island of Ireland. Part of that investment is being made in what are called 'community engagement sites' – economically disadvantaged communities with a child population of between 3,000 and 7,000. In this article, Katherine Zappone examines the reform process at local level as the leader in one of the community engagement sites. She describes the approach they took and products of the work so far and discusses problems and opportunities that have been encountered along the way. The next (and last) article in the series (by a leading figure in the voluntary sector) will put the reforms into the context of the evolution of children's services in Ireland over the last 20 years.

The first section of this article draws on the Tallaght Strategy document, written by Katherine in dialogue with a research team, followed by an edited transcript of Katherine's interview.

Introduction

Promoting the well-being of children – particularly those whose freedom to develop is inhibited by under-resourced social and economic circumstances – requires theory and practice that brings about substantive, lasting change at a number of levels. In Tallaght, we knew that we needed to be attentive to change happening at the levels of the individual child, the relations between children and their families, the community within which the child grows

and develops and the social and economic conditions that the child is born into.

If positive change happens only at one or two of these levels, the individual child will be less likely to have their needs met or to be free to develop their unique capabilities and powers into adulthood. Methods for securing lasting change for the largest percentage of children from disadvantaged backgrounds are, we believe, guided by two primary principles: (1) The principle of freedom – action is geared towards releasing the capabilities of children

and promoting children's own agency so that the child participates in achieving valued outcomes; and (2) The principle of prevention – action is geared towards preventing needs emerging that block development, and towards intervening early so that needs are met to enable well-being at each stage. These principles became embedded in our overall approach and day-to-day activity of planning for services that would bring about genuine change in the lives of our children.

The place and the people

Tallaght is an extensive and diverse area at the foot of the Wicklow Mountains, 13km southwest of Dublin City. It has the largest population of any urban area in the Republic of Ireland, after Dublin City and Cork City. The four communities of Tallaght West (Brookfield, Fettercairn, Killinarden and Jobstown), which are the focus of our strategy, have a combined population of 21,026 (Census, 2002). It is a fast-growing area; the population in Tallaght West increased by 18% in the period 1996–2002, more than twice the national rate. A distinctive feature of this area is the large number of children living in it; one-third of the local population is under the age of 15, compared to a national average of just over one-fifth.

While the local region has a rich community life with many strong and deeply rooted voluntary organisations, it has lagged far behind the socio-economic progress experienced nationally. The children of Tallaght West continue to live in one of the most marginalised and disadvantaged areas in Ireland. Unemployment, measured at over 10% in the 2002 Census, was more than twice the national average. Fifty-seven per cent of all households lived in rented local authority accommodation – five times the national rate. And one-third of all households were headed by a lone parent – three times the national rate. Most strikingly, local research estimates that one in three of Tallaght West's children live in poverty, compared to a national rate of one in five.

A long-term children's strategy

In the light of the context described above, the Childhood Development Initiative (CDI) has created a 10-year strategy to improve the health, safety and learning of the children of Tallaght West, and to strengthen their sense of belonging in their own communities (CDI, 2005a). The strategy has been developed by a consortium of people living and working in Tallaght West who came together in 2003 determined to find a better way to use their collective resources to improve the health and well-being of

their children. CDI places children at the centre of its vision for the community; its strategy embraces the broadest community participation, builds on the strong history of partnership among statutory, local development and voluntary agencies, and is underpinned by a clear logic model¹ informed by rigorous prevention science methods of needs analysis, service design and innovation.

Outcomes

In the long-term, the strategy sets out to make a significant impact on four child outcomes: (1) Health, including physical and psychological; (2) Safety, by reducing the harm children experience as a result of risks in the home, school and community; (3) Learning and achieving, by improving children's readiness for transition to school, strengthening their participation in school and empowering them to become more reflective and creative in all aspects of learning; and (4) A sense of belonging, including giving to and receiving from family, friends and the community. The strategy also includes family outcomes, with the specific targets of improving parent–child relationships and the skills and enjoyment of parenting.

Achieving this ambition requires a focus on the following three intermediate outcomes: (1) building delivery capacity through the governance structure, dedicated staff and a community engagement plan; (2) creating and sustaining integrated county systems that meet the needs of children and families in a holistic way; and (3) providing evidence and experience to support and influence national policies for prevention and early intervention, including disseminating proven components of exemplar services.

In the first five years, the medium-term outcomes expected are that more children in Tallaght West will be ready for the transition to school and those in school will attend more regularly and learn better; they will suffer from fewer health problems early in life and as they grow up they will feel safe in and happy to belong to the community of Tallaght West. All children will enjoy improved community facilities in a context where the whole community is engaged in the production and maintenance of a nurturing and supportive environment.

Activities

The strategy has three distinct elements. The first is creating new exemplar services targeted at individual children and families. These are: an early childhood care and education service; two after-school services to promote literacy and pro-social behaviour respectively; and a 'healthy school'. The latter is inspired by 'community schools' in the US and designed to heed

‘Methods for securing lasting change for the largest percentage of children from disadvantaged backgrounds are, we believe, guided by the two primary principles of freedom and prevention...’

‘The children of Tallaght West continue to live in one of the most marginalised and disadvantaged areas in Ireland.’

‘CDI's strategy embraces the broadest community participation... and is underpinned by a clear logic model informed by rigorous prevention science methods...’

Interview with Katherine Zappone

Interview with Katherine Zappone

‘The strategy has three distinct elements: (1) creating new exemplar services targeted at individual children and families; (2) enhancing the quality and integration of existing services; and (3) creating and sustaining an improved neighbourhood environment in which all children and families can thrive.’

‘All of these activities will be rigorously evaluated to capture lessons and solutions for use in other communities locally, nationally and internationally.’

Health Service Executive (HSE)² policy recommendations to ensure ‘best health for children’. Two primary schools will implement a health promotion and early intervention programme through an HSE ‘health worker’ working with principals, teachers and families to improve children’s physical health and increase their access to primary care services. This will be done by regular health screening of all children (approximately 400 children per school), children being referred to other appropriate health services and followed up to ensure positive take-up of services, and the integration of a health promotion approach within schools. The Early Years and after-school services are tightly specified in manuals setting out desired outcomes, target group, logic model, service components and inputs (staff, money, premises etc).

The second element comprises activities to enhance the quality and improve the integration of existing services. An Integrated Services Forum (ISF), comprised of regional health, education and family support officials, will focus on improving the integration of health, education and family support services in the Tallaght West area. It will have a particular focus on services operating under the aegis of the HSE and the Department of Education and Science (DES). Expected outcomes include the development of flexibility between services, improved communication and dialogue among services, more co-ordinated planning to identify and address gaps in service delivery, and information gathered and documented on local, national and international models of best practice in relation to positive integration.

The third element entails activities aimed at creating and sustaining an improved neighbourhood environment in which all children and families can thrive. One part of this, the Tallaght West Community Safety Initiative, will display a new approach to building community safety through residents, community gardaí (police) and the local authority developing and implementing a community safety contract and activities that identify and address the factors that negatively impact on the community’s experience of safety. Through this co-operative initiative, it is expected that strong community engagement will help to reduce the high levels of anti-social behaviour and crime that currently exist in the neighbourhoods. A related initiative, A Safe and Healthy Place for Children and Families, has been designed in conjunction with South Dublin County Council. Activities include regenerating a child-centred family friendly environment through a novel approach to urban planning, and re-focusing current Council resources and community facilities to support the implementation of the CDI strategy.

All of these activities will be rigorously evaluated to capture lessons and solutions for use in other communities locally, nationally and internationally. These complementary strands will maximise the impact on outcomes for children and families and help to establish a joined-up system to support the well-being of everyone in the community, as articulated in Ireland’s new social partnership agreement Towards 2016 (Department of the Taoiseach, 2006). **Table 1** shows the logical links between these outcomes and activities.

How we developed the strategy

The CDI strategy is based on extensive and in-depth use of epidemiological and other research evidence, consultation with children, parents and other local stakeholders, reference to national policy, and international literature and expertise regarding what works in prevention and early intervention.

(1) The needs of children and families in Tallaght West

In order to better understand the needs and risk and protective factors for children and families in Tallaght West, CDI conducted a detailed epidemiological study of 81 randomly selected and representative households with 187 children living in the area in Spring 2004 (CDI, 2004a). In addition to analysis by researchers, the data were discussed and interpreted in a series of participatory sessions involving CDI consortium members, parents and children. The survey was supplemented by other sources.

The study revealed significant levels of need across all dimensions of children’s lives. Half of all children lived in families that have been personally affected by crime, including burglary, mugging, drugs and car theft. Children and parents view some public play spaces as unsafe and unhygienic. Nearly half of all children lived with parents who feel overburdened, and in eight per cent of cases parents felt they could not cope with their child all or most of the time. Thirteen per cent of children live with parents who experience persistent parenting difficulties. Indeed, a high percentage of adults in the sample have poor physical or psychological health, and in one quarter of households the parent had a long-term illness or disability. While children’s health was generally good, 15% of children had a long-term illness or disability that limited their daily activities.

For too many children, school is sometimes experienced as a difficult environment. Two-fifths of school-age children had recently been bullied at school, and one in ten were bullied several times per

Interview with Katherine Zappone

Table 1 Links between activities and outcomes in Tallaght West

Focus	Outcomes 5 years	Outcomes 3 Years	Activities
Child development Birth–under 5	Ready for transition to school	Year on year improvements in:	(1) Two-year Early Childhood Care and Education Service
	Reduce health problems early on Improved skills & enjoyment of parenting	Children’s social, emotional & cognitive skills Children’s physical & psycho-logical health Parent-child relationships & family support for children	
5–under 13	Strengthen participation in school	Year on year improvements in:	(2) After-school service to improve children’s literacy
	Reduce health problems early on	Children’s literacy skills and school attendance	(3) After-school service to improve children’s pro-social behaviour
	Improved skills & enjoyment of parenting	Children’s relationships with peers and pro-social behaviour	
	Improved access to early intervention for children’s health	Children’s physical & psychological health Parent’s support of child’s learning and health Integration of health promotion in schools	(4) ‘Healthy School’ model
Neighbourhood For Children Physical Fabric Social Fabric	Feeling safe in and happy to belong to the community of Tallaght West	More safe play areas & public spaces;	Regenerating a child and family friendly environment
	Improved community facilities, accommodation & public spaces for children & families	Less litter & traffic pollution & improved public accommodation	
	Wide community engagement in maintaining safe and healthy environment	Contract for community safety agreed and implemented by stakeholders	Developing and implementing a community safety initiative
		Local capacity developed to implement community safety actions Improved safety and pro-social behaviour across the four communities	

‘Half of all children lived in families that have been personally affected by crime, including burglary, mugging, drugs and car theft.’

week. Across the age range, children are also experiencing difficulties with literacy, as demonstrated by comparing literacy scores of pupils in the first, third and sixth classes with national norm data (CDI, 2005b). Low achievement scores in the first year indicate that 33% of younger children are not ready for the transition to school, while 27% of 5–13-year-olds have been absent from school for more than 20 days (CDI, 2004b).

Although children in Tallaght West clearly face many risks, there are great strengths on which to build. Eighty-seven per cent of children have regular contact with one or both parents, and two-thirds of households have lived in the area for over ten years, indicating stability in the neighbourhood and in many children’s lives.

(2) Evidence about existing provision

Before proposing new service responses to identified needs, it is essential to understand the existing supply. CDI conducted an audit of 214 services that cater for children, young people and families from Tallaght West, including Early Years, in-school support, out-of-school and family support services (CDI, 2005d). This audit demonstrates the deep commitment of service providers from voluntary, community and statutory sectors to meeting the needs of families from the area. Yet it also identifies significant gaps and challenges that are real obstacles for individual children and families.

There are, for example, insufficient quality Early Years services. Three-quarters of under-fives never

‘Three-quarters of under-fives never attend a playgroup or pre-school’

‘When we asked children in Tallaght West about what they wanted to see in their neighbourhoods, key themes included the need for more playgrounds and sports-grounds, more things to do, support for the adults who care for them, fixing up houses, and a fair and happy school life.’

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attend a playgroup or pre-school, and fewer than half of 5–13-year-olds benefit from after-school or out-of-school provision during the school year. There are long waiting lists for essential developmental supports such as speech and language assessment and therapy. There is only one GP for every 4,000 Tallaght West residents, compared to one GP for every 1,555 nationally. There is a severe dearth of services that provide activities for children and adults together, and few play spaces for older children.

(3) A strategy shaped by dialogue with children, parents and key stakeholders

At every stage, CDI has reached beyond its own membership to ensure that the perspectives of community members, children, parents and other stakeholders fundamentally shape its strategy. This proposal has evolved through their engagement within every possible forum – staff, the local consortium, working groups and formal consultations. This proposal has been overseen and approved by the CDI Ad Hoc Steering Committee, whose membership includes the county manager, county statutory and local development officials, and co-ordinators of the CDI consortium.

When we asked children in Tallaght West about what they wanted to see in their neighbourhoods, the key themes that emerged were the need for more playgrounds and sports grounds and more things to do. They wanted everyone to be safer, and to live in a clean and tidy Tallaght West that stays well looked-after. Children thought that the adults who care for them needed more support, and that houses should be fixed up, especially those of people who are short of money. They wanted a fair and happy school life. These are only the ‘headlines’ of the views that emerged from an extensive consultation with 140 girls and boys aged 10–11 in seven Tallaght West schools (CDI, 2005c). The rich views and ideas that emerged are one important element of the broad and deep community engagement that has fundamentally shaped CDI’s strategy.

Alongside the consultation with children, CDI undertook extensive consultation with parents and other key stakeholders. In total, 44 consultative sessions were held in Spring 2005, including 13 group meetings with parents and 29 meetings with teachers, health service providers, local councillors, estate management committees and other community and statutory groups. Two meetings were held with 13 county agencies and departments (CDI, 2005e). The key themes that emerged from the process were: the need to improve the availability and integration of statutory services for families and children; the need to support community and voluntary providers of children’s

services; the need to improve parental involvement in children’s services and parental support services; and the need to address the development needs of traveller and international children living in Tallaght West.

Two public meetings were held to provide an open forum to debate the baseline research findings from the community survey and to sign off on the outcomes and activities of the 10-year strategy. The published strategy was launched with over 1,000 adults and children from the local community present. All representative sectors will maintain involvement with implementation through CDI governance structures and the community engagement plan.

(4) A local strategy in harmony with national policy objectives

Ireland’s National Children’s Strategy (2000) acknowledges the need to reorient supports and services so that ‘they provide a strong community-based response’, ‘there is a renewed emphasis on prevention and early intervention’ and ‘the supports and services are fully integrated and more easily accessed’.

The centrepiece of CDI’s strategy is to help pioneer the shift from services focused on protecting children once they are already facing difficulties to prevention and early intervention using integrated, needs-led services of high and consistent quality. From the outset CDI has consciously planned its approach to complement, support and benefit from articulated and emerging national policy objectives. CDI undertook a detailed mapping and analysis of national child- and family-focused policies as a first step to ensure eventual alignment not only with the National Children’s Strategy, but also across all the domains that directly impact on the lives of children and families, including (CDI, 2005f):

- reducing and moving towards eliminating poverty and child poverty and building a socially inclusive society in Ireland in line with the National Anti-Poverty Strategy (2002)
- ensuring educational inclusion and preventing educational disadvantage, in line with Delivering Equality of Opportunity in Schools (DEIS, 2005)
- ensuring quality and fairness in health and delivering the best health for children in partnership with families (Department of Health and Children, Health Service Executive)
- ensuring that social policy places the citizen/child at the centre of supports and services (Towards 2016).

The outcomes and activities embodied in the CDI strategy may also be seen as supporting the goal set

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out in DEIS to combat emerging problems with cognition, language skills and other aspects of development with high-quality early childhood services, extra support for children's literacy and support for parents' involvement in their children's education. They will also put in place a framework and practice to improve quality in provision of care and education as articulated in *Síolta* (2006)³.

(5) A strategy shaped by evidence of what works

The strategy is informed to the greatest extent possible by scientific evidence about what works. Throughout the development of its strategy, CDI has consulted with Irish and international experts in children's services and carefully surveyed the state-of-the-art research literature about local and national models.

The following key messages emerging from the scientific research base are relevant to achieving the health, safety, learning and belonging outcomes identified by the stakeholders in Tallaght West:

- children's readiness for transition to school is affected by physical and psychological health, family factors, the quality of early childhood care and education and community and neighbourhood effects
- high quality, intensive Early Years programmes can have long-term social and economic benefits for children and parents
- children's attitudes and proficiency in literacy are strongly related to parental attitudes, practices and the home environment, and problems arise where the training of teachers is inadequate
- several factors shape pro-social behaviour, including the influence of parents and children's peers, environmental resources and safe neighbourhoods, a healthy diet, and positive role models
- improved access to primary care and specialist health services can reduce health problems early on
- there is a strong link between quality standards and improved outcomes for children
- a community approach emphasising positive social norms and pro-social behaviour can support enduring change to reduce the prevalence of anti-social behaviour.

Evaluating the strategy and services

Finding out whether the strategy and component interventions achieve the improvements in outcomes

sought by the Tallaght community is fundamental to the CDI approach. Not only does CDI want demonstrably to improve the lives of children in Tallaght West, we also want to discover whether the innovations developed locally will be useful to other communities experiencing disadvantage in Ireland.

The evaluation strategy will have four strands. First, building on good baseline data on the well-being of Tallaght West children collected in the planning stage, an annual survey of need will be undertaken using methods consistent with similar efforts at the national level. These data will be used to indicate the broad trend of children's well-being in Tallaght West.

Second, CDI will rigorously evaluate the effectiveness of the three new services using experimental methods to give the best indication of impact on child outcomes. For a fourth new service (the 'healthy school'), where the experimental approach would be impractical, quasi-experimental methods will be used.

Third, CDI will monitor the community's engagement with the initiative through two surveys held at the beginning and end of the first five years of implementation, complemented by qualitative methods to evaluate the community safety initiative.

Fourth, CDI will monitor the impact of the strategy on the ethos and work of children's services by commissioning a study using ethnographic methods to chart the development of the project during the first five years of implementation, and through an action research project to estimate strategy impact on integration of services.

All four approaches to evaluation will include attention to implementation of the strategy, particularly with regard to questions of fidelity⁴. In addition, CDI will continue to submit itself to external independent scrutiny of its work, particularly with respect to: expenditure; quality of innovation sponsored by CDI; fidelity of implementation of activities in the strategy; and quality of evaluation. CDI will expect the organisations it commissions to be similarly open to external independent advice.

Governance and structure

A new independent charitable legal entity was established in 2006 to govern strategy implementation. It reports to the Office of the Minister for Children on CDI work, links directly with South Dublin County Development Board through the establishment of a 'Children's Services Committee', and is informed by the local community (providers, parents and children) on the experience of strategy delivery through the CDI Forum (a sub-committee of the Board). Board members

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‘...the generous philanthropic support for long-term planning was a key motivating factor for getting people around the table...’

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include those with an expertise relevant to CDI work (eg. early childhood development, public policy, family support) and representatives from the CDI Forum and community councils.

The CDI Board is responsible for the leadership of the strategy implementation, governance and accountability. The ‘Children’s Services Committee’ will support the CDI in the implementation of its strategy, in particular by ensuring that statutory bodies operate in line with its provisions and that it fits with existing and future initiatives in the area. CDI staff will manage strategy implementation through: (1) contracting of service providers and evaluation team; (2) supporting community engagement and quality enhancement of existing provision; and (3) developing policy implications of the work. In addition, a scientific committee will be established to support staff oversight of quality delivery of exemplar services and evaluation.

Distinctive features of the approach

The process of service development we have gone through differs from other approaches I am familiar with in at least three respects. The first was bringing together all of the key actors around a table to collaborate. That helped us to move beyond the competitiveness over territory that had marked so much previous work with children in Tallaght West. We formed a consortium, and people committed to being there for the good of the whole and to changing their behaviour so that they would think about the whole rather than just their own organisation.

Second, the generous philanthropic support for long-term planning was a key motivating factor. Getting people around the table was a problem initially because many had done a lot of that kind of planning in the past and then when it got to the point of delivery found they were dependent on resources from government, which then didn’t come (or came two or three years later). Philanthropy’s presence in this early phase was extremely positive; it presented a significant opportunity, which we seized. Service providers and planners now know each other better, understand the different organisations better and have established informal as well as formal ways of communicating what is going on within the separate organisations. People began to act and behave differently because of their new knowledge and relationships.

I wanted strong representation from the schools, without overwhelming people, so we got a principal from a school in each of the four communities. We asked some of the strongest and largest voluntary and community organisations, especially An Cosán and

Barnardos, and some of the smaller players. The HSE was there from the beginning and the local authority joined later. So there were key education, health and local authority agencies sitting alongside voluntary and community groups. We also wanted to involve local people and to support their participation in the process. In fact, a third of the people sitting around the table were actually living in the community as well as working locally in children’s services. Having sat around a lot of the public policy and social partnership tables, I was anxious to avoid filling the group with people who were so organisationally-driven that they could not be free to be creative and entrepreneurial. Of course, full representation is impossible. But as momentum built and the work sounded more exciting, more people wanted to be there and we drew in more and more people by setting up themed working groups, each of which involved members of the consortium and other people representing different agencies in the community.

A third feature was the direct involvement of an external research organisation, again with a commitment to providing long-term support. For a long period prior to that we (the community and voluntary sector) had been starved of the resources to do things differently. Now we had a partner that would bring some expertise and learning to the table.

Reflections on problems and opportunities

Engaging the community

From my perspective some of the community consultation events were extraordinary. For example, when we launched our 10-year strategy it was a huge event, with over 1,000 people from within and beyond the community filling a big tent (literally), and people in the outside world driving up and down the M81 wondering what was going on. But it’s not so much the numbers. One of the Secretary Generals⁵ who attended still often says to me that what impressed him was that anyone he talked to, children or adults, knew what the event was about, had been consulted in one way or another, and understood the significance of it. That said, we are conscious, a couple of years on, that people in the community may have become disenchanted and think that the initiative is like others and has fallen by the wayside. My reading is that they do still feel it is different and that because of that they are gracious enough to give us the time to get things up and running. It helps that it was a deeper, more respectful form of community engagement than anything people had experienced before, and I have worked in the community for 20 years.

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Balancing planning and action

Of course, we all wish the process had not taken as long. Part of this is that we were learning many new things as we were going, especially about philanthropy in its approach to children's services. It did sometimes feel like things were shifting in terms of what needed to be done in order to satisfy all of the interests, particularly the main ones of philanthropy, government and the community. These three big interests had to learn how to work together in very different ways, each trying to respect the other, and each committed to negotiating in a way that would best support the interests of the children and their families.

On reflection, Atlantic might be clearer about their vision in relation to children, even if it was evolving (which of course is entirely appropriate). The same could be said for Government, although at least they have strategies that are written down, including the National Development Plan, Towards 2016, the action plan for social inclusion, and the national children's strategies. A document that described Atlantic's strategy accurately would have made a difference to how we went about the work in the planning phase, because we could say 'Yes, this is how we can fit in' or 'No to that part' and 'Why don't you think about this?'. We would have known what was required now and what could wait. I can understand that they were reluctant to be overly directive, telling us what to do, but if there is a clear strategy then I think it is more fruitful if it is communicated, especially with key stakeholders and would-be grantees. There could have been some discussion about it and a greater sense of ownership at an overview perspective, because we would have participated in critiquing or affirming that particular strategy. There is an irony to all this in that there was a requirement on us by philanthropy to be clear about our outcomes, to use a common language, to embrace very rigorous evaluation, community ownership, and so on.

When we began, Government was not on board, although it was fertile ground insofar as in public policy circles they had made every commitment possible in terms of the kinds of things that we were starting to try to practice with philanthropy's support. Even so, requirements still changed when they came on board formally (see Langford, 2007), and there was lots of work behind the scenes. With Atlantic we were engaged in passing on the learning to the high-level civil servants and politicians, telling them what was different about the process, specifically the outcomes focus and the requirement for a strong evidence base and logical approach. I personally visited the Ministers for Education, Social Welfare, Community Affairs, and Children, telling them what we were doing. Significantly, they were interested in hearing it.

This was very different. I have done a lot of lobbying where you effectively say 'Here's our shopping list', whereas this was more 'Let me tell you how we're approaching this, and how it's different, and how it fits in with your approach to policy making'.

Then there is what I call the 'perfection syndrome'. This means that you have to plan forever until you actually start delivering, and there is a danger of being accused of being 'all talk, no action'. It is not easy in this phase continuing to negotiate and manage the interests in a way that people feel equally respected. In a five-year cycle we have to balance the importance of thinking carefully about what we are going to do and how we are going to evaluate it – the focus of philanthropy and research – with the urgency of actually starting to do something – the concern of the community. Ultimately, leaders need to maintain the motivation and the spirit.

Managing stakeholders

It is evident from the preceding discussion that there are various potentially competing stakeholders in the work, including philanthropy, government, the community and scientists. Ownership of the project is shared, and that means, ultimately, that there is a sharing of power. At the moment, philanthropy has a bigger share, but as their share wanes our share increases; indeed, if philanthropy is moving on in 10 years it is arguably more about government and the community. It is appropriate that Government has ownership in it – not just because they have the money but because they want to deliver high-quality services and a nation of well-developed children. Obviously the community does not have the money, but it has the capacity to learn and to deliver and to bring about the change in a brand new way – specifically one that is beyond the people who run and plan services, notably government and philanthropy. The people with the money have to maintain a respect for that, and I think often that they do, but this is a big challenge for those who embrace a business model of change. Unless they let go of a piece of that they will not get the change, because the most sustainable way that health and learning are activated is by children themselves and their families.

Engaging with research

Then of course a lot of scientists feel that they own the programme. One of the reasons that so many external people are interested is the emphasis on experimental evaluation. At the beginning there was resistance to this in the community. We know it is not the only way to evaluate services, and some would still question whether it is the only or best way to demonstrate with

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‘Unless the people with the money let go they will not get the change, because the most sustainable way that health and learning are activated is by children themselves and their families.’

‘Do we need a CDI in every county? Personally I do not believe that a group of people representing statutory systems, without some external support or force, are going to recreate and reinvent themselves; it is not part of organisational life...’

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validity that outcomes have been achieved. But it is not necessary to completely agree with that view in order to adopt that form of evaluation, so that is what we are doing. Time will tell if it gives us that kind of certainty in the context we operate in, in the same way it gives the certainty in those larger scale studies that are undertaken in the US. We do not feel that we absolutely have to do it, but we recognise that there is some value in it and so we will do it for some of the services, and in the most ethical manner. Our issue is that demand is going exceed supply, so it makes some of those issues (eg. random allocation) a little bit easier.

The involvement of a research organisation has also provided the opportunity to learn, and I can still remember our excitement about having the time to learn some new concepts, to learn a new way of speaking to one another. If you are going to get people to work with you, to embrace new ways of thinking, you need to give them something too. Practitioners had not experienced this learning form of engagement before.

Integrating services

A critical part of our strategy is not just designing new services but also integrating other services. We are trying to do this not just in the strategy planning but also in the actual service or activity planning and delivery. Numerous different agencies have roles to play and they need to change their behaviour in order for the service or activity to be implemented in the way that it is collectively designed. This has to happen from early on; integration is not something that happens later in order for the service to be delivered.

For example, as part of our Early Years service the children need to have quick access to particular health services, alongside their learning through the curriculum. The analysis of need suggested that speech and language was the most needed service, so we have agreed that the HSE would work with us to provide that by securing an additional post within their agency. This process has required the HSE to change its behaviour. There was an alternative approach available. If children aged under five who needed occupational therapy or speech and language therapy did not receive it within a period of three months, we could have said that they could get it through a scheme called the National Treatment Purchased Fund. This is a government means of removing people from hospital lists by paying private providers (whether they are here [in Ireland] or in the UK or US) to treat them. But this does not change the system.

Maintaining a creative edge

There are many ways that we could have set up the CDI. We took the approach we did to maintain its

entrepreneurial nature and the culture of creativity as distinct from conforming to the system. It originated in the community but it is still clearly linked into policy-making at the county and national levels; in the planning phase these groups had to be communicated with, brought on board and their learning received in order to create something that excited people, and in my view the same has to continue in the implementation phase. Some of the other sites have taken a different approach and formed a consortium within the context of an established state-funded local partnership company. In order for us to achieve something unique and driven from the ground with its own flexibility, however, we created something new as distinct from a subset of an old.

Of course, a question is whether all agencies and partnerships have this edge in the beginning but that it dies with age – that bureaucracy eventually crushes the innovation. Or, in five years time, will we have learned so much, and will everybody be behaving so differently, that we can all just pack up and go home, and let the schools and the HSE look after all of us? It is hard to know. But it raises an additional question, which is whether we need a CDI in every county, or if the children’s committee will be sufficient. Personally I do not believe that a group of people representing statutory systems, without some external support or force, are going to recreate and reinvent themselves; it is not part of organisational life, especially for something that is so part of the mainstream.

Sharing the learning

We were working through this process at the same time as several other sites were doing similar work. This was very positive, as we felt part of a broader community, but it was also a challenge. This was partly because there was no time to consistently tap into the richness of what was there but also because we did not have the over-arching strategy that I mentioned earlier. There could have been more learning then, a lot more connection between the sites, as everybody had something to teach everybody else. We are starting to do that more now, which is good, and I think it will continue.

There is an opportunity to integrate the learning that comes from the demonstration we are doing into the systems at the local (county) level, and the statutory people are on board with this. This is at the micro level but at a macro level there is also an opportunity to use the learning to support change in terms of the way Ireland develops, both socially and economically. This could be viewed as a new way to re-distribute resources, not just by income supports, which Ireland is strong on, but also through investment in the highest

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quality services for children and families, especially in disadvantaged areas. This is potentially a much more sustainable form of redistribution. So the outcomes also have to be about what happens in terms of the way the country does its business. If we see something like this evolve, more children will experience the freedom to choose the life they want to lead.

Conclusions

We are trying to support a community (which includes practitioners of children's services as well as

residents) by implementing services for children that make them healthier and better learners and enable them to feel a pride and sense of belonging in their communities in a better way than what is currently happening. Scientific intelligence, policy analysis and community creativity have combined over and over again in the planning of CDI activities. This is a brand new approach in Ireland, not yet demonstrated on a local basis in any other part of the country.

So much learning has already happened, and now is the time for implementation of that learning so that our children benefit – soon.

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Endnotes

- ¹ A logic model articulates the linkages between programme goals, activities and expected outcomes.
- ² The Health Service Executive (HSE) provides health services and social services for people living in the Republic of Ireland.
- ³ Síolta is the National Quality Framework for Early Childhood Education in Ireland. www.siolta.ie.
- ⁴ In the context of children's services 'fidelity' refers to the extent to which an intervention is implemented as intended by the designers of the intervention.
- ⁵ In Ireland the Secretary General is the lead civil servant in a Government department.

Brief biographical details

Dr Katherine Zappone is an educator, independent researcher and human rights advocate. More recently she has worked with Atlantic Philanthropies and others to develop a long-term strategy and new services to improve the well-being of Irish children in a local region of social and economic disadvantage. She has worked at national and international levels on public policy issues, authored numerous research reports on children, equality and education, and taught for a decade in Trinity College Dublin. She is co-founder of An Cosán, one of the largest community-based non-profit organisations in Ireland, committed to eradicating poverty through adult and child education. She is in her second term as a Commissioner for the Irish Human Rights Commission.

‘...there is also an opportunity to use the learning [from this programme] to support change in Ireland’s social and economic development. This could be viewed as a new way to re-distribute resources, not just by income supports, which Ireland is strong on, but also through investment in the highest quality services for children and families, especially in disadvantaged areas.’

Appendix D

Developmental Pathways in WA Children Project

The Developmental Pathways in WA Children Project (DPP) is a landmark project taking a multidisciplinary and holistic approach to investigate the pathways to health and wellbeing, education and juvenile delinquency outcomes among Western Australian children and youth. To achieve this, researchers from the Telethon Institute for Child Health Research are collaborating with colleagues at the Crime Research Centre at the University of Western Australia and a number of state government departments, including the WA Department of Health, Department of Education and Training, Department for Child Protection, Department of Corrective Services, Department of the Attorney General, Disability Services Commission, and the Office of Youth. The project is pioneering the process of linking the longitudinal, population-based data collected and stored by the Telethon Institute for Child Health Research and each of the WA government departments.

Vision

The vision of the Developmental Pathways in WA Children Project is to establish linkages, not only of data, but between people, organisations, and disciplines. To use these linkages and partnerships to:

- identify multi-level and early determinants of developmental outcomes and the complex interrelationships among them;
- enable early, cost-effective and holistic interventions;
- enable improved policy development and planning that emphasises prevention, protective factors and initiatives that are culturally appropriate and cost efficient; and
- enhance inter-agency and inter-sectoral collaboration and coordination

... that all lead to improved health, well-being and development for children and youth, families and the community.

Project Aims

The Developmental Pathways in WA Children Project has numerous aims:

1. Adopt a multidisciplinary approach to research into the health, development and wellbeing of children and youth.
2. Establish population level data linkage across organisations and government departments.
3. Use the unique longitudinal and linked population level data to provide an overview of temporal, regional, socioeconomic and racial differences in developmental outcomes, and to describe key risk and protective factors.
4. Identify pathways to health and wellbeing, education and juvenile delinquency outcomes among WA children and youth, including those who have had contact with the child protection system.
5. Identify risk and protective factors for persistent juvenile offending.
6. Explore and define risk and resilience factors for Aboriginal juvenile delinquency.
7. Identify risk and protective factors for those who enter the child protection system and determinants of adverse outcomes after leaving the system, with a separate component for Aboriginal children and youth.

Funding

The Developmental Pathways in WA Children Project was made possible by the generous cash and in-kind contributions made by all of the collaborating organisations and government departments, which was matched by the Australian Research Council (ARC) through an ARC Linkage Project Grant.

History

In June 2004 the Minister for Education, Science and Training recommended that the Developmental Pathways in WA Children Project (formally known as 'Developmental pathways to health, education and delinquency outcomes in Western Australia children: a holistic approach to inform early intervention strategies') be funded under an Australian Research Council (ARC) Linkage Project grant.

The project commenced on the 24 of March 2005, when a research and intellectual property agreement was made between the University of Western Australia and the State of Western Australia (represented by the various state government departments).

Initially the grant contained funding for four Australian Postgraduate Award Industry (APAI) scholarships and an Australian Postdoctoral Fellowship Industry (APDI). However, with additional funds being made available by the Department of Corrective Services; the success of a researcher receiving a scholarship through the Australian Rotary Health Research Fund; and another self funded doctorate candidate, there are currently eight postgraduates completing research projects under the umbrella of the project. The number of research projects is expected to grow, as even more researchers and students become aware of the value and efficiency of using this unique research resource.

Governance Structure

The Developmental Pathways in WA Children Project is governed by:

- a Research Management Group, which meets bimonthly to ensure team members are kept informed of all scientific, research and managements issues, and to develop and monitor the strategic direction of the project
- a Project Coordination group, which meets bimonthly and as required to manage the outputs of the work program
- a Postgraduate group, which meets on an ad-hoc basis to facilitate and encourage communication and teamwork between the postgraduate students on the project.

There is also:

- a Research Submissions Review Group, which meets as required to review applications of new research projects which may fall under the umbrella of the project
- a Communications and Consumer Representation group, which meets on an ad-hoc basis and as required to facilitate and implement the project's communication strategy and engage with consumer and community representatives.

- an Advisory Panel group, which meets biannually to provide high level advice and expertise

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