Families, policy and the law

Selected essays on contemporary issues for Australia

Edited by
Alan Hayes and Daryl Higgins

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Contemporary issues in child protection intake, referral and family support

Leah Bromfield, Fiona Arney and Daryl Higgins

> If we … were assigned the task to deliberately design systems that would frustrate the professionals/para-professionals who staff it, anger the public who finance it, alienate those who require or need its services and programs, that would invest in reactive responses … and bear the brunt of public criticisms should a child be harmed in any way, we could not do a better job than our present children's protection systems (Barter, 2005, p. 317).

Numerous inquiries into child protection services in Australia and internationally have concluded that failures in child protection service responses are in large part attributable to: rising demand on child protection services; a workforce suffering low morale who are ill-equipped for the role; families receiving too little too late in the form of intervention; and a rising population of children in care paired with a lack of suitable placements (Ford, 2007; Layton, 2003; Munro, 2011; Board of Inquiry Into the Child Protection System in the Northern Territory, 2010; Wood, 2008).

Data on children coming to the attention of state/territory child protection authorities show that, since collation of the data commenced, the workload of these departments has escalated in terms of the number of concerns raised about child welfare. Looking at patterns of notifications (reports of concerns relating to the abuse/neglect of children) over the past two decades, the scale of the increase can be readily observed in Table 1 (on page 122), whether considering the absolute number of notifications (which reflects the initial workload, as departmental staff need to screen and potentially respond to these), or the rate of notifications per thousand children in the population (Higgins, 2011).

A fairly consistent trend across Australia over the past decades is that around one in every five or six of the concerns notified to statutory child protection departments are substantiated (i.e., meet the threshold for a department to intervene due to the child/young person having been harmed, or being at risk of harm from abuse/neglect).

This leaves around four in every five cases where there is no legislative grounds for intervention, and yet some level of vulnerability, need or risk has been notified.

The growth has not just been at the referral of safety concerns; the number of children taken into out-of-home care has also seen similar levels of growth. For example, the numbers of children residing in non-parental care due to the intervention of the statutory authority on the night of 30 June in each year, have risen sharply over the past two decades (see Table 2).

Table 1:	Child protection notifications in Australia, children aged 0–17 years, 1989–90 to 2009–10		
Year	Notifications	Total population of children	Rate per 1,000
1989–90	42,695	4,188,795	10.4
1999–2000	107,134	4,766,920	22.5
2009–10	286,437	5,092,806	56.2

Sources: Australian Bureau of Statistics (2010); Australian Institute of Health and Welfare (AIHW; 2001, 2011); WELSTAT (1991)

Table 2:	Number of children on care and protection orders living in out-of-home care in Australia on 30 June 1990, 2000 and 2010		
Year	Children in out-of-home care	Total population of children	Rate per 1,000
1990	12,406	4,188,795	3.0
2000	16,923	4,766,920	3.6
2010	35,895	5,092,806	7.0

Note: While the number of children and young people *entering* care in the last five years has remained relatively stable (at just over 12,000 per year), the total number of children *residing* in out-of-home care at any one time has grown significantly due to the increased number of children entering the care system early in their lives and staying in it for longer.

Sources: AIHW (2001, 2011); WELSTAT (1992)

In this chapter, we briefly consider the historical origins that underpin the current approach to child protection in Australia, discuss the theory and intent underpinning current reforms, and discuss the promise of a public health approach and why it appears not to be delivering the desired outcomes.

Child protection services were originally established in the 1960s as a residual response to the problem of child abuse and neglect. In their seminal paper, Wilensky and Lebeaux (1958, as cited in Ife & Fiske, 2003) conceptualised the typology of "residual" compared to "institutional" approaches to social welfare. Under a residual approach to social welfare, people are expected to meet their own needs through the primary institutions of the market and the family. Welfare is a secondary institution, which only comes into effect where the primary institutions have failed. In comparison, an institutional approach sees welfare applied to all as a dominant institution with a preventative focus, under which the state is responsible for providing comprehensive and universal programs of health, education, housing, social security, personal services, and so on. Theoretically, under a residual approach, costs are kept to a minimum, as

selective services are provided only to those most in need; whereas the provision of universal services dictated by an institutional approach are seen to be very costly. The two philosophies are fundamentally opposed, and represent alternative views of the place of welfare (in the form of the welfare state) in modern society (Ife & Fiske, 2003). Child protection services are a clear example of a residual approach, whereby a welfare response is triggered when an individual suspects that a child has experienced, or is at imminent risk of, abuse or neglect. At that time they are required (often by law; see the Mathews & Walsh chapter in this book) to report their suspicions to child protection services, which then assess the allegation and investigate and intervene only when necessary.

When contemporary child protection services were established in the 1960s—catalysed by Kempe and colleagues' (1962) discovery of the "battered child syndrome"—child abuse was thought to be severe (i.e., multiple fractures), to affect a small number of children, and to be perpetrated by parents with some form of psychopathology. A forensic-legal response predicated on a residual approach to social welfare was a reasonable response to a problem of this nature.

Over time, the growing evidence base regarding the effects of violence and adversity on children's outcomes saw both an expansion in the types of maltreatment acknowledged and a decrease in the threshold at which undesirable parenting behaviours were considered abusive or neglectful. Child protection services incorporated this evidence base through a corresponding expansion of scope.

More than 40 years on, child protection services have a mandate to respond to physical abuse, sexual abuse, emotional abuse, neglect and witnessing family violence; and the threshold for intervention now includes outcomes such as bruising, developmental delay and psychological harm, as well as "cumulative harm"—the cumulative effects of multiple events that might not individually reach the threshold for intervention (Bromfield & Holzer, 2008; Wood, 2008). The gradual evolution of this shift saw child protection services increase their scope of responsibility without conducting a critical appraisal of whether a residual response system continued to be the best fit to address the size and nature of the problem.

This is by no means the first time this expansion in scope has been documented, nor should senior executives in child protection services be characterised as being unwitting or passive victims of issues relating to demand. Many strategies and initiatives have been implemented to better respond to families known to child protection services. One of the major strategies implemented from the mid-1990s was the "differential" response (also referred to as a dual track, multiple track or alternative response; Merkel-Holguin, 2005; Schene, 2005). The differential response system directly relates to the broadened scope of child protection services as it pertains to children who are "perceived by members of the community as experiencing or being at risk of abuse and neglect and needing protection" (Schene, 2005, p. 4).

The rationale underpinning differential response is twofold: (a) responses to concerns about a child should be commensurate with the level of risk; and (b) non-accusatory assessments and responses to families are typically more effective than adversarial approaches (Merkel-Holguin, 2005). Differential response provides a process for less severe allegations to avoid being investigated and instead be referred to voluntary family support services. Connolly (2005) explained that while the language and systems vary between countries, differential response essentially comprises the following process: reports received by child protection services are assessed to determine whether a child

protection investigation or referral to voluntary family support services is warranted. This is presented pictorially in Figure 1. Connolly noted that though a team within the statutory child protection service may provide family support services, more typically these services are provided by non-government agencies.

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│          │    Assessment of      │─────▶│ No further action │       │
│          │    service need       │      └──────────────────┘       │
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│ │ Child protection      │──▶│ Family support service │             │
│ │ response              │◀──│ response and follow-up │             │
│ │ and follow-up         │   └──────────────────────┘              │
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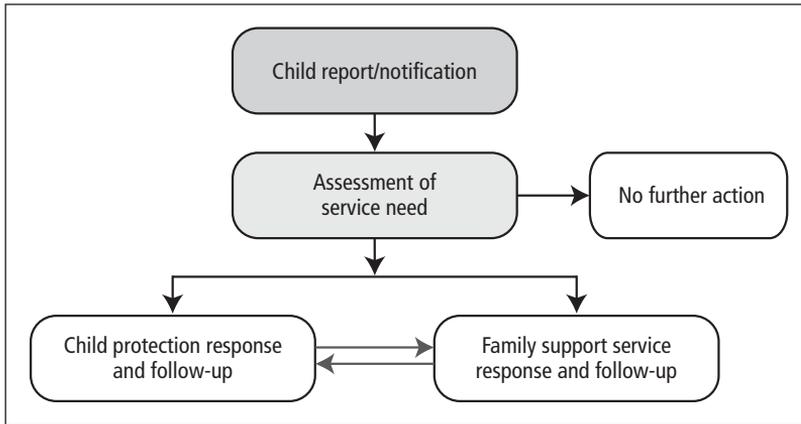
Source: Connolly (2005), p. 15

Figure 1:   Pathways of a differential response system

By itself, differential response is an "add-on" to existing child protection services, and does not fundamentally alter child protection as a residual response. Reports of concerns about a child are still referred to child protection services for an intake assessment, and where concerns meet the statutory threshold they are referred for an investigative response. For the majority of families, reports are either not investigated or no harm or risk of harm is substantiated, and these families are referred to alternate services and supports. The unintended consequence is that child protection services become the most visible entry point for mandated professionals and others concerned about a child and their family. For example, Justice Wood (2008) in his Inquiry into Child Protection Services in NSW found that the large volume of reports to its Helpline requiring a child protection intake and investigation response had become a bottleneck into the child welfare service system.

Differential response is a pragmatic and sensible addition to child protection services, but it does not resolve the problem of a traditional residual response system that is unable to appropriately respond to the vast population of vulnerable children whose families require support rather than coercive court-ordered interventions to meet their children's needs. Indeed it cannot; a reality recognised in the mid-1990s when differential responses first emerged. Academics at the time envisaged differential response within a broader context of welfare reform, such as the seminal work by Jane Waldfogel (1998a, 1998b). Essentially Waldfogel proposed a differentiated level of response that extended across the service system (Maluccio, 1999; Waldfogel, 1998b). Specifically, she argued that child protection investigations should be applied to serious maltreatment allegations, that families be offered a customised response based on their individual needs and, critically, that child protection services should collaborate with community partners (professional and non-professional) to provide more supportive services to all families (Waldfogel, 1998b). In essence, she proposed a systemic reform to the residual response model of child protection services.

A public health approach also offers a conceptual framework for a systemic alternative that is more in keeping with the institutional approach put forward by Wilensky and Lebeaux (1958, as cited in Ife & Fiske, 2003) than with residual child protection response systems. It retains the forensic-legal role of statutory child protection services for the most serious of cases, but situates this response within a broader system of services and supports that provides differentiated pathways *into* the service system as opposed to merely a differential response by child protection services (i.e., "screen-in" vs "screen-out and refer").

Adapted from work with preventable illnesses, a public health approach is used for severe and prevalent problems that are associated with significant detrimental effects on individuals and populations. Such an approach requires an understanding of the prevalence, causes and consequences of the problem, knowledge of interventions to effectively prevent and respond to the issue, and a detailed understanding of how these interventions can be implemented at scale for a population (Garrison, 2005). A public health approach strongly emphasises health promotion and disease prevention and incorporates a population focus, with increasingly targeted interventions based on recognised risk and protective factors (Baum, 1998; Garrison, 2005). Although typically characterised as having three levels of intervention (primary, secondary and tertiary), public health approaches incorporate a range of strategies based on the target of intervention efforts (see Box 1 on page 126).

A public health approach to child protection has garnered extensive support within Australia, culminating in the adoption of such an approach to underpin the National Framework for Protecting Australia's Children, endorsed by the Council of Australian Governments (COAG; 2009). In Australia, public health is synonymous with prevention and has primarily been conceptualised as a system of primary, secondary and tertiary services. The major preventative strategy has been to increase investment in family support services. In some jurisdictions, new systems of intake and referral have been designed to divert families from child protection intake services. Implied in these strategies is that if we reduce the demand on child protection services, this would mitigate the practice problems within these services. In initial evaluative findings and service data trends, these initiatives appeared to be promising (Holzer & Bromfield, 2008; Thomas & Naughton, 2005); however, the rising number of children in care has proven intractable. Although there were signs—at least in some jurisdictions—of the increase in notifications plateauing, recent child protection activity data show a return to an upward trajectory of reports and investigations. At this juncture, some have queried whether a public health approach is indeed the right approach to child protection.

Central to a public health approach is a focus on prevention through addressing the underlying determinants of social problems (Baum, 1998; Garrison, 2005). A primary assumption underpinning contemporary child protection reform agendas has been that this can be achieved through improving the mechanisms for families to access "the right services at the right time" (Adamson et al., 2010). In Australia, over the last decade, this objective has primarily been enacted through two inter-related reforms: (a) improved intake and referral pathways (primarily into family support services) for highly vulnerable and at-risk families (e.g., Family Referral Services in NSW); and (b) increased investment in targeted family support services for highly vulnerable families (e.g., Child FIRST and Integrated Family Services in Victoria).

Family support services are designed to (a) prevent problems in highly vulnerable and at-risk families from escalating into child abuse and neglect; and (b) support

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Box 1: Levels of intervention in a public health approach

Child wellbeing promotion interventions are usually targeted to the general public or a whole population, and aim to enhance children's abilities to meet developmental targets and enhance wellbeing.

Universal preventive interventions (primary prevention) are targeted to the general public or a whole population that has not been identified on the basis of individual risk and is desirable for everyone in that group. Universal interventions have advantages when their cost per individual is low, the intervention is effective and acceptable to the population and there is a low risk from the intervention.

Selective prevention interventions (secondary prevention) are targeted to individuals or a population subgroup whose risk of experiencing parenting difficulties is significantly higher than average. The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological or social risk factors that are known to be associated with child abuse and neglect. Selective interventions are most appropriate if their cost is moderate and if the risk of negative events is minimal or non-existent.

Indicated preventive interventions (early intervention/tertiary prevention) are targeted to high-risk individuals who are identified as having parenting needs or concerns, but whose child is not at risk of significant harm. Indicated interventions might be reasonable even if intervention costs are high and even if the intervention entails some risk.

Treatment and maintenance are for high-risk individuals where child abuse and neglect has occurred and the child is or has been at significant risk of harm.

(Adapted from Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions, 2009, p. 66)

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families in which children have experienced abuse and neglect, to prevent re-abuse. The prevention rationale is therefore that family support services will prevent abuse and neglect, and in turn prevent reports to, and the need for a response from, statutory child protection services. In comparison, alternate highly visible pathways into services are primarily designed to divert families away from child protection into other services. A direct prevention strategy for reducing child protection notifications may additionally serve to prevent abuse and neglect by facilitating families accessing services earlier. Like differential response, these are sensible reforms for the detection of, and response to, highly vulnerable and at-risk families. However, we identify three issues that influence the potential effectiveness of these reforms in reducing the demand on child protection services.

First, the assumption is that the establishment of new intake and referral pathways will be accompanied by a change in reporter behaviour. However, the majority of reports are received from mandated reporters (e.g., police, teachers, health professionals) whose reporting requirements are prescribed by legislation (see the Mathews & Walsh chapter in this book). Child protection services, in turn, are required to assess these allegations in light of the legislative definition for what constitutes a child in need of protection

(Bromfield & Holzer, 2008). Existing regulatory frameworks may prevent reporters from effectively using new intake and referral pathways. Two notable examples of legislative change enacted in Australian jurisdictions aim to address this problem. Provisions made in Tasmania's *Children, Young Persons and Their Families Act 1997* (enacted in August 2009) provide that mandated reporters report their concerns about the care of a child to the non-government Gateways services (a community-based intake service), and that such a report fulfils their mandatory reporting obligations. From January 2012, amendments to the NSW *Children and Young Persons Care and Protection Act 1998* were enacted, which changed the threshold for reporting upward from "risk of harm" to "risk of significant harm". Both of these reforms aim to effect a reduction in reports to child protection services by re-establishing the remit of the agency to respond only to severe allegations of child maltreatment, where a forensic-legal response is more likely to be required.

Second, there is a limited number of family support service models and programs that have been found to be effective in addressing risk of abuse and neglect in highly vulnerable families (MacMillan et al., 2009). In Australia, there is a significant gap between "what we know and what we do", with many family support services being funded without a clear practice or program model and without being underpinned by an evidence base. These services run the risk of being ineffective and thus failing to aid in the prevention of child abuse and neglect. At worse, they may do further harm to highly vulnerable children and families. Paradoxically, it is in this area that we have some of our most promising evidence for intervention emerging. Parents Under Pressure is an evidence-supported, non-manualised program, which has been developed and trialled in Australia and shown to be effective for parents with complex problems, including substance misuse (Dawe & Harnett, 2003, 2007). Project SafeCare is an evidence-based program for child maltreatment developed in the US that is notable for its effectiveness in addressing neglect (Edwards & Lutzker, 2008), particularly since there are few evidence-based interventions available for neglect even though it is one of the most common forms of maltreatment.

Finally, there has been a tendency for a public health approach to child protection to be viewed as being synonymous with reforms to statutory intake and referral pathways and increased investment in secondary services focused on the provision of family supports to vulnerable families (COAG, 2009; Wood, 2008). These reforms have the potential to be key platforms within a public health approach, but by themselves fail to address core aspects of the public health model. Critically, neither of these reforms address the urgent need for preventative strategies to address the leading underlying social determinants of child abuse and neglect: domestic violence, mental illness, and substance misuse. Further, Australia continues to lack national data on the incidence or prevalence of child abuse and neglect in the community—a core component of a public health approach required to determine whether reforms are creating meaningful population change.

Fixsen and colleagues (2005), in their landmark synthesis of implementation literature, concluded that poor implementation can result in even the most promising systems reform being ineffective, and that failure to attend to implementation issues within evaluations of the effectiveness of programs or reforms may "lead to an incorrect conclusion that an intervention is ineffective" (p. 5). There is a risk of "throwing the baby out with the bathwater" if the public health approach were to be rejected due to its failure to deliver the substantial reduction in demand on child protection services that

might have been hoped for, as the failure to deliver could be attributable to a failure of implementation rather than a failure of the approach. The degree to which the rhetoric of Australia's public health approach to child protection actually equates with a public health model is debatable. Its apparent failure is a function of the limited forms in which a public health approach has been applied to child protection rather than the public health approach per se. The key elements of a public health approach need to be re-examined as it pertains to child welfare reform in Australia, and missing elements need to be systematically implemented to complement existing reforms if we are to continue to move closer to our goal of "a substantial and sustained reduction in the incidence of child abuse and neglect" (COAG, 2009, p. 11).

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