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developing practice

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INSIDE THIS EDITION:

Opinion:

- > Belief and ability: Essential qualities of an effective child protection workforce

Articles:

- > Using early childhood development research in child protection: Benefits, boundaries and blind spots
- > Parent Responsibility Contracts: The evidence
- > Getting more bang for your buck: What works best in professional development in the child, youth and family workforce
- > Evidence to inform out-of-home care policy and practice in NSW: An overview of the Pathways of Care Longitudinal Study

Plus:

- > Practitioner's Response
- > Practitioner's Perspective
- > Book Review
- > Sector Resource

developing practice is a refereed journal published by the Association of Children's Welfare Agencies and NSW Family Services Inc. (FamS) for the child, youth and family services sector.

The journal is aimed at practitioners and managers who provide programs and services for vulnerable children, young people and families. It is designed to provide an opportunity to present and discuss practices, programs, ideas and practical initiatives aimed at assisting children, young people and families.

Key content areas include:

- Family work
- Out-of-home care
- Child protection
- Young people at risk
- Early intervention
- Group work and community development programs for children and families

Contributions relating to direct service delivery or research and policy with a direct application to practice are invited and encouraged. Submissions are subject to a blind peer review process to ensure objectivity in the selection of articles for publication. Articles may be either brief reports (1000 – 1500 words) or longer articles (2000 – 3500 words). Resources to support good practice and books may also be submitted for review.

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Number 39 July 2014

CONTENTS

FROM THE GUEST EDITOR.....2

Maree Walk

OPINION

Belief and ability: Essential qualities of an effective child protection workforce 4

Kate Alexander

ARTICLES

Using early childhood development research in child protection: Benefits, boundaries and blind spots 16

Sarah Wise and Marie Connolly

Practitioner's Response 29

Sandra Heriot

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Parent Responsibility Contracts: The evidence 32

Natalie Parmenter

Getting more bang for your buck: What works best in professional development in the child, youth and family workforce 42

Morag McArthur and Bronwyn Thomson

Evidence to inform out-of-home care policy and practice in NSW: An overview of the Pathways of Care Longitudinal Study 56

Marina Paxman, Lucy Tully, Johanna Watson and Sharon Burke

PRACTITIONER'S PERSPECTIVE

Principles in practice 73

Kerry Lane and Elaine Thomson

A review of pre-birth child protection planning in a tertiary maternity hospital: Engaging vulnerable pregnant women 80

Celine Harrison and Jenny O'Callaghan

BOOK REVIEW

'Violence against Women: Current Theory and Practice in Domestic Abuse, Sexual Violence and Exploitation' 88

Reviewed by Liane Flynn

SECTOR RESOURCE

Working with families where an adult is violent 92

Victorian Government Department of Human Services

FROM THE GUEST EDITOR

MAREE WALK

Deputy Secretary, Programs and Service Design
Families and Community Services, NSW

Not Exhibit A

It is with great pleasure that I welcome you to the 39th edition of *developing practice*. It is timely that the theme of this issue is contemporary child protection practice.

For the last two years Australia has had a Royal Commission into Institutional Responses to Child Sexual Abuse. Sitting in the court listening to survivors is a sobering experience for any of us involved in child protection. I have left the court wondering what the mistakes of today are that we will be held accountable for in 30 years time. What will our child welfare professionals of the future be apologising for, possibly shaking their heads in sadness that we let happen to children? I have also wondered what are we doing well that we should do more of, and what will be held up to the light and found at worst, destructive, and at best, benign to children's lives, in 30 years time.

Whilst we have not sought to make this edition of *developing practice* an 'Exhibit A' in a future enquiry of our current practice, let us hope that it goes some way in showing that the professionals of the day are courageously and humbly seeking to learn from their clients, to change and adapt their work, and to critique their own practice, the systems they work within and the laws, processes and methods we use.

Inside you will find a rich and diverse range of opinions, research and practice examples of the challenges and complexities involved in keeping Australian children safe and well. Rightly, the issue shows that child protection practice is not the province of statutory child protection work, but indeed highlights the shifting focus of statutory child protection away from investigation, assessment and risk management towards relationship-based practice with our families and child and family workers in health and community organisations - government and non-government alike.

'Science does not usually speak for itself'

Three articles in this edition discuss the growing demand for child protection policy and practice to be informed and validated by research. The lead article by Sarah Wise and Marie Connolly looks at research findings in the fields of attachment and developmental neuroscience and their application to child protection decision making. The authors caution against the misapplication of knowledge generated from other disciplines to decision making within the child protection system. They call for careful evaluation of scientific knowledge that is communicated to practitioners in an engaging manner, quoting researchers who counsel us against the 'allure of infant determinism' or 'magical thinking'.

Their piece proves both helpful and provocative in analysing what is 'evidence'.

Marina Paxman, Lucy Tully, Joanna Watson and Sharon Burke describe the aims and methodology of the prospective longitudinal study that follows the pathways and outcomes of children and young people in their first five years in out of home care in NSW.

Prompted by changes to legislation in NSW, Natalie Parmenter's article presents evidence on the use and impacts of parent responsibility contracts, highlighting the need for such contracts to be developed in partnership with parents, with parents being able to take the time to develop close relationships with service providers.

A service system is only as strong as the quality and morale of the professionals working within it. Kate Alexander, the Senior Practitioner from Family and Community Services, NSW reminds us that the most important resource the system has to offer a vulnerable child is the practitioner who knocks on their door. Morag McArthur and Bronwyn Thomson's paper furthers this discussion by providing an overview of the most effective professional development models and pathways.

The Practitioner Perspectives include a reflection by Celine Harrison and Jenny O'Callaghan on interagency case management to engage vulnerable pregnant women in a tertiary hospital in Western Australia. The development of a pre-birth framework is showing promise in reducing the number of newborns being taken in statutory care and, importantly, breaking down the barriers to vulnerable women seeking support.

Kerry Lane and Elaine Thomson describe the new service delivery model, Practice First, currently being implemented in NSW. The new model aims to develop a child protection culture founded on principle based practice. The article describes how relationship-based practice, the use of respectful language, and respect for families and context helped the team in their service outlet to make small but significant shifts in practice and culture.

I thank the clients whose life stories have given rise to this body of work. I also thank the authors whose commitment and reflective practice will help us avoid mistakes now and in the future so we all truly make a difference for vulnerable children and their families. Please read and reflect on 'Not Exhibit A'.

BELIEF AND ABILITY: ESSENTIAL QUALITIES OF AN EFFECTIVE CHILD PROTECTION WORKFORCE

BY KATE ALEXANDER

Executive Director

Office of the Senior Practitioner

NSW Department of Family and Community Services

The most important resource a child protection system has to offer a vulnerable child is the practitioner who knocks on their door. While this may seem obvious, investment in the relationship between practitioners and families often takes second place to other system priorities. Procedures, policies, laws, rules and tools, in and of themselves, do not keep children safe; people do. Accepting this simple truth means statutory systems need to shoulder responsibility for sustained focus on the development of effective relationships between the frontline workforce and vulnerable families and communities. This article is based on the premise that children and families benefit when the child protection workforce has professional confidence (defined as “*having the belief and ability to do one’s job effectively¹”*) and relies on that confidence as a foundation for building relationships that help families keep children safe.

The Office of the Senior Practitioner in the New South Wales (NSW) statutory child protection agency² has identified and actively promoted five essential qualities that build and strengthen practitioner belief and ability. These

qualities - clarity of role, hopefulness, empathy, good written skills and connection to theory - are fundamental to good practice, are mutually reinforcing and sit at a higher level than core knowledge and skill. They are described with the backing of research findings from Australia and overseas. They are demonstrated by practice evidence taken from direct work with families and frontline practitioners in NSW; stories which are told with great respect.

It is difficult to think of many vocations that are more important than the protection of children. It is hard work, requiring exceptional skills, knowledge and perseverance. It is work that exposes practitioners to the bleakest and most confronting of human experiences, against an almost constant backdrop of impoverishment and disadvantage. And it is work that can be immensely rewarding because its impact can extend into generations of relationships. As the most vulnerable members of our society, children are frequently without a voice and many live in fear and with shame. Those who have the ability and passion to understand children, advocate for them and help others to see, love and cherish them are the backbone of an effective child protection system.

1 Australian Council of Professionals

2 The NSW Department of Family and Community Services

Vulnerable families must be able to rely on workers who believe in themselves and have the trust and respect of others. Yet there are sobering indications that the confidence of the child protection workforce may not always be as strong as it could be - both in how practitioners regard their own role and abilities and in how others perceive them. Take the example of how files are kept for children who have been reported to the child protection system or brought into care. Rather than detailing the practitioner's analysis or why they decided to take a certain course of action, often files contain long verbatim accounts of what people said and did, or even what they wore. Or take the disquieting fact that many practitioners rely solely on safety and risk assessment tools rather than also using their own judgement which is based on knowledge, experience and expertise (practitioners should be guided by tools, but not solely dependent upon them). Lastly, consider that the Children's Court may place more value on the evidence of other professionals, than that of the practitioner who has been inside the family's home and holds the history.

There is much that can be done to build up child protection practitioners' perceptions of their own role, and in turn how others perceive it. There are many ways to improve their capacity to make a meaningful difference in the lives of others. The following five qualities lay the foundations for relationship based practice to flourish.

1. Clarity of role: What the job is and what it is not

A recent Australian study (Lewig, 2013) identified role clarity as one of three key factors associated with a resilient child protection workforce, along with being older and having hope. Practitioners

who were very clear about their role were found to be more resilient to work stress, worked with more autonomy and were more positive about their work. While this study reflects practitioners' self-perception, their clarity of role is obviously influenced by the messages from their agency and from the broader welfare system.

If the whole system (government, non-government and community) does not have a shared view about the primary role of the statutory agency, and if that role has not been well communicated to those on the frontline, it is likely that the role of the statutory agency will be blurred by other agencies that are unequivocal about the parameters of their own roles. For example, does the statutory agency solely investigate, assess and refer on, or is it accepted that it can also act as an '*agent of change*' and work in partnership with families and the sector to bring about change in order to reduce risk?

In addition, the risk of practitioners developing into '*jacks of all trades, masters of none*' is high when extra responsibilities are loaded (for example, onerous requirements for data entry, form filling and recording) on statutory agencies that divert their workforce from their primary role (building relationships to keep children safe) and, in doing so, give mixed messages about what work is most valued.

Most would agree that the best use of a teacher's time is in front of a class, and most would agree that midwives come to work to deliver babies. Their definitive roles and the tricks of their trade - teaching and birthing - are clear, measurable and quantifiable and the importance of their skill set is universally accepted. It would be unacceptable to

have midwives spend significantly more of their time with computers than with mothers and babies, in the same way it would be inappropriate for teachers to spend more time writing reports about their students than teaching them. Clearly, a practitioner's role would be defined in terms of spending time with families, using skills of relationship building to support parental change and keeping children safe. However, the majority of time on the frontline in contemporary child protection systems is spent on written records, detailed case plans, data entry and compliance with procedures for assessments.

Frameworks that clearly state the authority and principles of the agency serve to define and clarify roles. In NSW, the recent introduction of the 'Care and Protection Practice Framework' and Practice Standards has meant a clear mandate for the workforce about their role and gives explicit permission for relationship building. NSW has also recently published its first report about good practice³ - a collection of stories from the frontline - and has introduced the annual presentation of awards for practice excellence. Both the report and the awards promote, recognise and reward relationship building in practice and, in doing so, help strengthen a vision of what good practice looks like as well as building positive perceptions of and respect for the role.

The work of child protection is more than assessment, and this is known by the confident practitioner. It includes encouraging change. Consider the case of four young children who came into care because of their mother's chronic addiction. The mother was explicit in

saying that, at its worst, her heroin habit was all consuming and, however skilled, her caseworker could do little at that time to help her prioritise her children. She reached a point where she accepted that she needed help and presented at the office of her caseworker, without an appointment. The caseworker was in a case meeting but saw an opportunity. She asked the mother to wait, telling her she would be with her shortly, gave her a magazine and said words to the effect of: "*While you are waiting have a look through here and see if you can find any picture or story that represents what you want for your children*". When the caseworker returned the woman had cut out a picture of an eight-seater vehicle and said: "*This is what I want - a car with my kids in it and me driving them to sport on Saturdays*". Her children were later returned to her once she had become drug free.

The importance of the above example is the ability of the practitioner to capitalise on an opportunity, right from the beginning. Tapping into the mother's motivation and allowing her to share her hopes was obviously only the first step for the long hard road ahead, but it speaks volumes about the potential of the role to motivate and help bring about change if the practitioner has the confidence, belief in her role and a mandate to build and work with relationships to leverage change.

One practitioner in a specialist role in a very busy NSW office described a challenge she had experienced that further emphasises the point about role clarity and its importance for relationship building. A mother had rung the centralised intake line to make a report about her own 12-year-old son. She was distressed and said that she wasn't

³ Shining a Light on Good Practice in NSW – stories from child protection and out of home care

copied with his behaviour. She admitted she had forced him to sleep in the garage under the house and was making him eat down there away from the rest of the family. The case was allocated to a new practitioner and the specialist was asked to provide support. As a first response, the practitioner wanted to start by interviewing the boy at school. She said she wanted to give him a chance to disclose any additional information and she wanted to “*get to him*” before his mother might “*stop him talking*”. The specialist suggested an alternate first step - starting with the mother, acknowledging her courage in making the report, building trust with her from the outset and allowing her some control of the process. The specialist was able to divert the approach from a more forensic one (where the prime focus was investigation) to a more helping one, focused on the best way to illicit information as well as to motivate change. Her influence led to the development of a positive relationship where the mother was very open, agreed for her son to talk, and together they (mother, son and practitioner) came up with clear bottom lines about safety and a plan for support.

2. Hope for families, belief in the role

In the words of Turnell (1999), “*we must organise around our best hopes, not our worst fears*” and guard against work practices that are overtly preoccupied with risk management. Constant worry about something awful happening to children in vulnerable families (those on open caseloads and equally those that cannot be allocated due to conflicting priorities) can manifest itself in defensive practice that keeps practitioners at their desks recording every move they have made, and managers in their offices monitoring compliance and documenting the reasons cases cannot be allocated.

This leads, however unintentionally, to a disconnect between the frontline and families where more time is spent writing about them (usually their problems) or recording reasons why they are unable to be seen, than the time actually spent talking with them, understanding their struggles and investing in their potential for change.

The case study above, where the four children were eventually restored home safely to their mother, emphasises the importance of the role of child protection, but is also a nice illustration of the power of hope and the practitioner who tapped into it. The second of three key elements identified in Lewig’s study (2013) on the resilience of the workforce is hope and belief of practitioners in the potential of their role to make a difference. However, it is not just the level of the practitioner’s hope that is important but, equally, the hope that families hold for a different future and how this can be used as a motivator for change. In a large scale study of family support interventions, McKeown (2000) outlined the factors most likely to contribute to successful outcomes for families. Relationship based practice was strongly linked with successful outcomes, as was the family’s sense of hopefulness. This research emphasises the value of practitioners working with the hope of the family as a very important motivator for leveraging change. At an organisational level it is equally important that hope is encouraged and reinforced - practitioners need to feel supported by people in higher positions who hold hope and belief in the power of practice and relationships to bring about change.

A commonly expressed concern is that investing in the hopes of a family can lead to over identifying with parents at

the expense of children - because the risks become obscured. Reder, Duncan and Gray's (1993) work on disguised compliance illustrates powerfully the dangers of over identification. Yet concentrating only on concerns can lead practitioners to become deficit focused. It is as dangerous to fail to see strengths as it is to over invest in hope, because of the missed opportunities to motivate change. The key to 'success' lies in the ability of practitioners to be optimistic and realistic (Parton & O'Byrne, 2001), to keep the focus squarely on the child, to have very clearly communicated limits regarding safety and to be confident enough to trust that seeing strengths and investing in hope about the future does not equate to being blinded to the risks.

A practitioner in a rural office spoke about her experience of "*being burnt before*", and how she now protects herself from feeling hope. She described that she had been "*naïve*" in believing in the parents' capacity to change and also how her hope for their children having a different life had blinded her to the fact that there had not eventually been meaningful change. She had felt herself "*tricked by false promises*". Her defense mechanism, to not let herself feel hope again, was working to protect her from disappointment. She was looking after herself but, worryingly, not the children on her caseload. While one can sympathise with the plight of this worker, the more important issue is the harm she can do if not supported, or indeed challenged, to think more openly about families. Group supervision, if well facilitated, can provide a powerful forum for practitioners to share risk and talk about their hopes and worries.

It is also useful for practitioners to remember that the first time they meet a

family is very often one of the lowest points in that family's life. An important step in the process of assessing risk and building respectful relationships is to ask parents to describe their hopes in the language of what a better life would be like for their children and asking children to describe their hopes of a safe and happy home. This can be illuminating and lay the foundation for ongoing work. It also allows families the dignity to describe themselves in a different place and time.

A woman, whose child had been removed from her care and was later successfully restored, spoke courageously at a child protection conference⁴. She described hitting "*rock bottom*" with a substance addiction and the grief of having her son taken. In the following weeks, she told her caseworker that she had decided to enter drug rehabilitation. Her caseworker said: "*I think you have what it takes to succeed*". More than five years later this mother recalled the significance of this simple sentence, the genuine feeling behind it and how it surprised and motivated her to remain drug free. This example illustrates that the importance of hope goes beyond just keeping a practitioner strong in their role - it is a prerequisite for effective relationship based practice and a strong catalyst for change.

3. Appropriate record keeping: Writing about what matters

Child protection workers need to be supported at an organisational level to spend more time with families, although workers who lack professional confidence may not make the best use of their time, regardless of the systems put in place. Computers can act as a

⁴ Rising to the Practice Challenge. University of Adelaide 2012.

safety net or crutch for workers who are fearful about what they might have to deal with when visiting a particular family, or for those who lack confidence about their ability to bring about change when working with entrenched problems.

Practitioners may need guidance as to what to record, as they frequently tend to over report some information so as to “cover all the bases” (because they are so worried that something will go wrong) and at the same times under report other information like critical decisions (because they may not have the confidence to articulate their rationale). When encouraged to write with more analysis and less verbatim recording, one practitioner responded: “*But I don’t know what not to write*”. This practitioner did not know what information she might need in the future (a reference to a possible tragic outcome or that the case may end up in Children’s Court). She thought that everything she had ever done with the case, or everything the mother had ever said, might be needed as evidence. At its worst, this style of case recording highlights a significant lack of confidence. Rather than presenting an analysis of the information, it merely lays out the material for someone else to draw conclusions from or to interpret. In doing so, it relegates the practitioner’s role to one of mere observer and recorder - which in turn likely impacts negatively on the relationship they are building, because they are more focused on recording than interacting and supporting the families to overcome entrenched problems.

At the same time there is a danger in formulaic style, computer driven recording, because the “deconstruction of circumstance” via tools, written jargon

and labelling can mean that the child’s experience is not well portrayed, clustered in generic groupings and is then at risk of being minimised. Statements like: “*the child is at risk because of her parent’s problems with alcohol*” does not describe the individual circumstance and how the parent’s drinking places that child at risk. Another example is the common recording of a sentence like: “*the child was witness to a domestic incident between his parents*”. Consider the concern that sentence may evoke compared with: “*Peter saw his father hit and push his mother and he heard her cry out for help*”. Recording what has happened and who did what to whom can be confronting, but this information is critical to any analysis of risk. Where such information is available it needs to be recorded. There are ethical as well as safety imperatives for correctly assigning responsibility to those who perpetrate harm, and in being clear in case plans about what and whose behaviour needs to change.

Supporting a young adult as they read their child protection file can be a powerful learning experience where one is reminded of the enormous responsibility involved in documenting a childhood. The bits of a family history that are often so sought after are frequently lacking or are written in a way that may be unnecessarily bureaucratic or judgemental. Practitioners can be supported to record differently by considering what is relevant (having the confidence to sift information for meaning), by being accurate (being ethical about recording in context), by being balanced (reinforcing the fact that writing about strengths does not detract from the identification of risk) and by being transparent (clearly articulating decisions and being confident to

describe the weighting of options). Writing in this way is a developed skill, but has added benefits when well practised - many practitioners describe the importance of writing to help them analyse and clarify their thoughts and observations.

At a recent group supervision session in a *Practice First*⁵ office in a rural area of NSW, the child protection team shared their thoughts about the progress of six young Aboriginal children who had been brought into care the previous week. It was obvious that this had been a distressing experience for all involved. Practitioners spoke about their sadness that the children's mother had not been able to sustain change, despite her best efforts and their best work, that her children had suffered from her neglect of them and that her chronic problems of addiction had got in the way of her parenting. Skilled casework had resulted in the mother agreeing that the children were not safe in her care. She was invited to guide the planning about the best way for the children to be taken from her and she was asked for advice about the best places for them to go.

Sadly, six young children in the bush do not go neatly into one placement - three different homes, a mix of family and foster care, were located and the mother was supported throughout several hours one Friday afternoon to say goodbye to her children in three lots of pairs. She did so bravely and gave them clear messages that she needed time to get some help so she could be a better mother for them. She told them that they were going to be cared for by good people and that she wanted them to be

happy. She gave them permission to be receptive to the care of others by giving them her blessing. Her efforts to pack for each child and reassure them were touching and sensitive. Yet the skillful casework was not just reflected in these interactions, it was also in the written record. The decision about why the children were removed was described clearly and honestly, but laying no unnecessary blame, at the same time as recording all of the mother's kindness and courage in helping them leave. If any of these children should enquire about what happened to their family in the future, they will know that their mother was respected, they will understand why decisions were made and they will read examples of her love and care for them. The experience for these six children can be contrasted with other situations where children have been forcibly removed from their parents' care without an opportunity to say goodbye, left carrying forever a sense of abandonment and rejection.

4. Empathy: Walking a mile in someone else's shoes

The link between the practitioner's ability to be empathic and their professional confidence may not be obvious, but there is plenty of evidence about the importance of empathy in child protection practice. In order to fully understand what has been happening for the family, practitioners need to appreciate the context of their life - including, for example, the debilitating impact of poverty, the impact of third generation unemployment, or the traumatic effects of family violence.

Forrester et al. (2007) found that a practitioner's use of empathy was associated with significantly more client disclosure and less resistance. Conversely, where the worker showed

5 Practice First is a new model of child protection and out-of-home care service delivery in NSW. It is based on a set of foundation principles and is structured around group supervision and team work with different emphasis on the role of management, specialist and administrative staff.

less empathy, the client became more resistant and less likely to disclose. Similarly, Gambrill (2006) found that “helpers who are cold, closed down and judgmental are not as likely to involve clients as collaborators as are those who are warm, supportive, and empathic”. Ferguson (2011) also found that empathic social workers created less resistance and increased the amount of information disclosed by clients. Importantly, both the Ferguson and Gambrill studies found that empathy did not detract from the practitioner’s clarity about child protection concerns and was not associated with failure to identify and discuss risk.

McArthur et al. (2011) surveyed 859 Australian statutory practitioners on the role of values in child protection practice. One area the study focused on was worker values and beliefs about inclusion and empowerment of the family. The findings were reassuring as they showed strong consensus at a philosophical level about involving parents. For example, 94 per cent of respondents agreed that parents should be involved in making decisions about their children and 96 per cent believed parents should be given a chance to make changes that show they are good parents. Yet there was less consensus on how to be inclusive (the skills that operationalise empathy), with only 77 per cent agreeing that negotiation and compromise are needed when working with families. Worryingly, a mere 54 per cent of respondents believed that “*only by understanding a parent’s perspective can workers be effective*”. This finding suggests that many workers do not see that understanding a parent’s perspective is of absolute importance if one is to work meaningfully with them to increase the safety of their children. It may also be a by-product of an overly

forensic approach - reflecting a fear, similar to the one highlighted in the section on hope, that being empathic means losing investigatory objectivity. Either way, it is concerning.

This point is highlighted powerfully by the story of a practitioner in one of NSW’s country offices in the early months of working at a *Practice First* site. She said that by embracing relationship building with families as the most effective way to affect change she had to consciously step away from her traditional approach, which she described as forensic. In doing so, she relied on tangible aids to signify a difference and went out and bought herself gardening gloves, washing up gloves and boots. She said this was because her work was now “*alongside families in their kitchens, laundries and gardens*”. She gave a case example to demonstrate the change in her practice that was about two small children at risk with a young mother in a very squalid home. The worry was that the children were suffering from chronic neglect. She said that by working from a stance of curiosity she learnt that this mum had never herself slept in a bed with two sheets on it and, not surprisingly, did not know how to make a bed. The mum could not cook, had barely been cooked for and had no knowledge about nutrition. She found her children all hard work and no joy because they had no routine. She and they were tired and without much hope. The first meetings involved the practitioner taking the mother out to buy new sheets, showing her how to make the beds, buying groceries, helping her clean up, plan meals and create a routine. By rolling her sleeves up and, in her words, “by being real”, the practitioner described a turning point in her work with this family and in her practice broadly. She reported

proudly that the mum said: “*So you people actually do care*” and noted, with irony, that by being less “forensic” she had gained far more meaningful information (because the mother had felt safe to talk and drop her guard). The practitioner reflected on her previous work and said that she would once have been quick to judge the state of the home with little understanding and, in turn, would likely have formed an adversarial relationship with the mum. The bottom lines about the children’s safety were never compromised, but the outcome for the family was excellent because the mother started to feel hope about a better life, to see that it was possible, and that her children were responding positively and to build on the changes she had made.

Although this example shows how an empathic response assisted the practitioner to work as an agent of change, it also ties in with the earlier point about role clarity and the value of clear mandates. In the roll out of the *Practice First* model in NSW, a common comment from staff was: “*finally we have been given permission to work the way we wanted to when we joined this Agency*”. This comment surprised Executive staff who, quite rightly, responded by saying that permission had never been taken from the frontline for relationship based work. Obviously though, an unintended message had been communicated and it had been to the detriment of families. Leadership is critical in modelling empathy and supporting role clarity.

A powerful way to encourage empathy in practitioners is through modelling and reflective practice, for example: “*I am curious as to how the mother copes*”, “*I feel very sad when I think about what it must be like to be so young and to*

watch your mother be hurt like that”. Group supervision can also be very helpful. In NSW we have found strategies such as allocating one team member the job of being the “*eyes and ears of the child*” throughout the discussion, or playing the devil’s advocate (to guard against the danger of the group reaching consensus too quickly), or to take the perspective of the mother, can help centre conversations and decisions around a genuine regard for the experience of others.

The language used to talk with and about children, young people and parents also helps create empathy among workers⁶. Lohrbach and Sawyer (2003) describe how they banned the words “uncooperative” and “resistant” when staff talked about parents. They asked that these words be replaced with “fearful” and “reluctant” and gave powerful examples as to how this simple change in language opened doors in the hearts and minds of workers - it led to curiosity and empathy. Sawyer and Lohrbach maintain this change in dialogue was at the centre of improved relationships and better outcomes for children in Minnesota.

5. Being professionally engaged enough to want to keep learning

While the following study is an oldie it is also a good one because the results are still considered significant today. Fryer et al. (1989) profiled the needs and attitudes of over 300 child protection practitioners. The study found that the group had “*virtually no familiarity with the current most salient research on child abuse*” and made a distinction between workers who claimed to have read research and those who had not.

⁶ Language is one of the Principles of Practice in the Practice First model in NSW.

Respondents who had read at least one of some commonly cited and well known articles were much more convinced of their capacity to help clients and did not agree with the indicator: *“I sometimes feel there is nothing I can do to help these people”*.

Connecting practitioners with theory and research should be encouraged as an important “on work time” activity, while selecting relevant and accessible articles and distributing them with opportunities for follow up conversations can be helpful. In the *Practice First* sites in NSW, all decisions about children are made in group supervision. It is also the place where research is discussed, theory is explained (psychologists and casework specialists are allocated to each group) and skill development is encouraged. Equal importance is placed on knowledge derived from theory and skills gained through practice. This recognises the fact that the system had been heavily focused on what needs to be known (the risks, the indicators, the laws) and what needs to be done (the assessment, the enquiries and referrals), rather than on how to do it (how to decide what to say, how to ask, how to listen and how to motivate). In the child protection context, using domestic violence as an example, knowledge is the practitioner’s awareness that exposure to violence harms children, and skill is the practitioner’s ability to talk openly about it with a traumatised mother or an angry father. Good practice relies on both ‘knowing that’ and ‘knowing how’.

Good practitioners tap into skills and knowledge but do not get there by themselves. The importance of continuous skill development can be sold to practitioners (who may not like the idea of putting their skills on the line

in front of their peers) under the banner of respect. If practitioners are feeling unsure about asking the hard questions of families, they must show respect to those families by practising before they knock on the door. It is not okay in any profession, to practise interventions for the first time on real people outside of learning environments. Practitioners could consider whether they would feel comfortable with a nurse taking their blood without having had any previous practise in doing so. When practitioners are leading conversations that may have impacts for future generations, they owe it to families to be at their best.

Conclusion

Sadly, far too many children in Australia live in fear, with neglect or with violence. Too many live with chronic disadvantage. The problems of their parents impact on them heavily. The future wellbeing of our society depends on the quality of the child protection workforce to make a difference for these children - to keep them safe and promote their development. At the heart of all good models, tools and successful interventions, is a practitioner who builds an effective relationship with a family, who believes in their role and has the ability to make a difference. This article has demonstrated importance of role clarity, hopefulness, written skills, empathy and continuous learning for building and sustaining the professional confidence and effectiveness of the child protection workforce. In doing so, it is written with a genuine and abiding respect for the profession of child protection and strong hope about its potential.

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Biography

Kate Alexander currently works in the position of Executive Director, Office of the Senior Practitioner for Community Services, NSW Department of Family and Community Services.

Kate has a Masters of Social Work (Family Therapy) and has worked in the child protection field for more than 20 years in a variety of roles including therapeutic, casework and management.

In 2010 Kate was awarded a Churchill Fellowship and travelled to the UK, Norway and America researching child protection systems with a focus on the skill set of the frontline workforce. The Practice First model was designed by Kate and based on this research.

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USING EARLY CHILDHOOD DEVELOPMENT RESEARCH IN CHILD PROTECTION: BENEFITS, BOUNDARIES AND BLIND SPOTS

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Introduction

The child protection process has several key decision making points. A vital question at intake is whether a report should be investigated and how quickly. The task of investigation is to determine whether a child is suffering or is likely to suffer significant harm and, if so, what initial response will manage children's circumstances and prevent recurrence. After significant harm or its likelihood has been identified, more planned decisions need to be made about the interventions, care and contact arrangements that will safeguard and support children's future development. These questions all need to be considered with a mind to a child's age, developmental stage and culture.

In Australia today, infants and very young children are more likely than children at any other age to be assessed as having experienced significant harm, or its likelihood, and of needing alternative care to prevent the recurrence of maltreatment. In 2012-13, 14.4 per 1000 children less than one year of age were the subject of substantiations of child protection notifications (AIHW, 2014). Of those children admitted to out-of-home care (OOHC) in the same period, 44.5 per

cent were aged less than five years (AIHW, 2014).

Messages from attachment research and new discoveries in neuroscience (the study of the brain and biological pathways) are increasingly used to inform child protection decision making. While a comprehensive review of the evidence base and detailed analysis of its policy implications are beyond the scope of this paper, an overview is provided of the key evidence from these two lines of empirical inquiry. The paper goes on to explore the ways in which neuroscientific and attachment research has been applied in child protection. This is to emphasise both the value of this research as well as its limitations, including the ways in which research findings can be overstated, misinterpreted and misapplied. The paper concludes by offering an approach to knowledge utilisation in child protection that involves an evaluation of research evidence and thoughtful application of knowledge.

Defining properties of attachment theory and developmental neuroscience

Bowlby's attachment theory and

advances in neuroscience are prominent in the fields of social and emotional development.

Attachment theory

The British psychiatrist John Bowlby pioneered the concept of attachment in the 1940s and defined it as an enduring affective bond between a child and a specific adult caregiver who serves as a source of safety in times of stress (Bowlby, 1969). This classic work has continued to be influential in areas of child welfare practice as attachment ideas have developed over time.

Attachment theory assumes that through repeated interaction during times of stress and discomfort, an infant develops specific expectations concerning the responsiveness of an attachment figure. If the attachment figure has acknowledged the infant's need for comfort and protection, and respected his or her need for independent exploration, the child is likely to develop a model of the self as competent and deserving of love and of the attachment figure as emotionally available. Conversely, if the caregiver has rejected or ignored attachment behaviour and/or discouraged exploration and autonomy, the child is likely to construct a working model of the self as incompetent and unworthy and of the caregiver as emotionally unavailable (Stams, Juffer & van IJzendoorn, 2002).

Patterns of attachment behaviour and attachment representation

Individual differences in infant patterns of attachment behaviour have been identified through research and classified as 'secure', 'insecure-avoidant', 'insecure-resistant/ambivalent' and 'disorganised/disoriented'. Bowlby imagined that

patterns of attachment translate into complementary mental models of attachment figures and of the self that develop early in the preschool years. It is suggested that a child's 'internal working models' influence how a child thinks and acts in relationships with other caring adults and peers, as well as with future mates and offspring in adulthood (Bowlby, 1988).

Attachment, parenting and human development

Mary Ainsworth advanced the argument that maternal sensitivity is the key influence on the child's pattern of attachment (Ainsworth, Blehar & Waters, 1978). Each style of attachment reflects the child's response or adaptation to the type of caregiving he/she has received.

Secure attachments develop when caregivers are emotionally available and responsive to their children's communications. Early secure attachments contribute to the growth of a broad range of competencies, which can include motivation for learning, self-esteem, social skills, emotional intelligence and other positive aspects of human relationships (National Scientific Council on the Developing Child, 2004).

The emotional needs of children in insecure relationships are not met as warmly or as consistently as in secure relationships. Insecure relationships, however, are still thought to involve attachment behaviour or strategies that enable the child to regulate his or her emotional arousal and find comfort and safety, such as by exaggerating their attachment behaviour or over-regulating their emotions. Associations between insecure-avoidant attachment and externalising problems and ambivalent-

insecure attachment have been confirmed in several samples (Weinfield, Sroufe & Egeland, 2000).

Children with a disorganised attachment are left emotionally overwhelmed and distressed for long periods of time and they do not possess a clear strategy for dealing with their distress. A high proportion of infants and young children who have experienced severe abuse and/or neglect from their caregivers show a disorganised/disoriented pattern of attachment (Carlson, Cicchetti, Barnett & Braunwald, 1989; Lyons-Ruth & Jacobvitz, 1999). Disorganised/disoriented attachment is strongly associated with later psychopathy (Green & Goldwyn, 2002).

Disruptions in attachment relationships
Disruptions in attachment relationships, or the absence of maternal care at a developmental point when maintaining proximity to caregivers as a key biologically based task, has powerful predictable effects on later behaviour and functioning. Stovall-McClough and Dozier (2004) remarked that experiencing separation from a primary caregiver through placement in care is a clear threat to the availability of an attachment figure.

Developmental neuroscience

Developmental neuroscience is an exploding field and important advances in the understanding of the developing brain have been made in a relatively short space of time. The idea that the brain grows most rapidly during the first year of life, that babies' brains develop and grow in interaction with the environment (particularly the environment of relationships), and that positive stimulation and nurturance aids healthy brain development while extreme deprivation and stress can

disrupt brain architecture, is noncontroversial.

Rapid synaptic development during the first years of life

Recent developments in neuroscience have highlighted the substantial changes that the human brain undergoes in the early years of life. Research has shown that the first three years of life is a period of rapid synaptic development. Just before puberty the brain experiences a further growth spurt which continues through adolescence. The brain continues to grow and develop into young adulthood (see Giedd et al.).

Brains grow in interaction with the environment

The sequence of brain development is genetically determined and follows a logical pattern. Regions involved with regulating emotions, the development of language and higher cognitive function develop after birth (associated with 'higher' limbic and cortex regions of the brain) (Glaser, 2000).

Brain development occurs through the interaction between a child's genes and their environment. During postnatal brain development, the brain requires input from the environment to allow each individual to adapt to their specific circumstances, especially in the area of stress, regulation of emotions, learning and memory. While the study of parenting and brain development is in its infancy, a child's experiences in close relationships is thought to play a critical role in shaping the structural maturation of brain circuitry. The child's brain will adapt just as readily to a negative environment as a positive one (Brown & Ward, 2013).

Stress, neglect and brain architecture

Some stress is a normal part of life. Brief or temporary stress in the presence of supportive relationships leads to the development of healthy stress response systems and can even help children learn to cope with adversity. Research suggests however that prolonged exposure to extremely stressful conditions in the absence of supportive relationships can have negative effects on the brain, leading to system deregulation and greater risk for anxiety, depression, cardiovascular problems and other chronic health impairments later in life.

Prolonged activation of the stress response system through extreme and long-lasting stressful conditions results in the brain being flooded by cortisol (stress hormone) for an extended period, which has a toxic effect on the brain. Recurrent abuse, severe neglect, caregiver mental illness or substance abuse, and/or violence or repeated conflict are major risk factors for 'toxic stress' (Shonkoff, 2010).

Applications of attachment theory and developmental neuroscience in child protection

Evidence from attachment and neuroscience emphasise the importance of parent-child interactions in healthy development and highlight infancy as a particularly important period where the foundations for future development - strong or weak - are established. The value and limits of this knowledge in child protection as well the potential for misinterpretation/misapplication of research findings need to be understood and considered when responding to child protection concerns.

Benefits

The association between children's

attachment styles and their developing emotionality and functioning in close relationships has long focused attention in child protection on the importance of ensuring children form a close, enduring bond with an attachment figure. This includes professional efforts to assist birth parents to increase their sensitivity and attunement to their baby's communications.

Research evidence concerning the role caregiver ties, disorganised/disoriented attachment and parental separation play in future maltreatment and child psychopathy is also applied to decisions about risk of significant harm, or when and under what circumstances to intervene in children's lives. For example, lack of a strong 'caregiving bond' and disorganised/disoriented attachment is a recognised risk factor for future maltreatment (Hindley, Ramchandani & Jones, 2006). Studies examining the consequences of prolonged separations to attachment figures warn of the emotional upheaval that can be caused by removing a child from a parent (even a maltreating one). Reactions including rage, grief, sadness and despair (Bryce & Ehler, 1971; Shealy, 1995), depressive withdrawal, resistance to care, an inability to be soothed or excessive clinging behaviour (Stovall & Dozier, 2000) have all been documented in research involving children placed in OOHC.

Attachment theory has also been used to justify the closure of large care institutions and the use of kinship care and foster care placements as the preferred alternative to residential care for children entering OOHC. Also based on this theory, permanency planning and long-term care decisions aim to reduce reliance on temporary arrangements to enable children to form

or maintain enduring relationships with one or more primary attachment figures.

The far-reaching influences of early developmental processes highlighted through new findings from neuroscience have intensified attention to the way child protection systems respond to infants and young children growing up in threatening home environments. Responses have included a greater emphasis on prevention and early intervention in the early years, in particular how universal/primary or targeted/secondary services provided by a range of government and community sector agencies can work with statutory tertiary child protection systems to promote the safety and wellbeing of vulnerable children within a 'public health approach' (Wood, 2008; ARACY, 2008).

New neuroscience has also shifted the way child protection systems think about and respond to young children in the care of parents experiencing persistent poverty complicated by mental ill health, substance abuse and interpersonal violence. Advances in neuroscience point to the potential risks of experiencing multiple caregivers and the importance of making timely decisions on whether to permanently separate young children from their birth parents (Brown & Ward, 2013, p.16). The United Kingdom (UK), for example, has recently responded to a wide body of research evidence concerning the impact of maltreatment on child development in the early years by introducing a 26-week timeframe for adoption proceedings (Department for Education, 2014). Child protection systems in Australia such as New South Wales and Victoria have also introduced definitive timeframes for reunification to occur.

While many treatments remain scientifically undetermined, attachment theory and recent neuroscientific discoveries have also spawned a range of noncontroversial therapeutic techniques and treatments to assist children who have experienced maltreatment (Dozier, Dozier & Manni, 2002; Fisher, Gunnar, Dozier, Bruce & Pears, 2006; Marvin, Cooper, Hoffman & Powell, 2004; Schofield & Beek, 2005). Such therapies aim to improve the positive quality of carer-child relationships, provide a stable environment and take a calm, sensitive, non-intrusive, non-threatening, patient, predictable and nurturing approach towards children (Chaffin, Hanson, Saunders, Barnett, Egeland, Wolfe et al., 2006; Haugeard, 2004).

Translation of neuroscientific and attachment research into practice and policy: Boundaries and blind spots

The association between early childhood environments and later outcomes is robust (Shonkoff, Boyce & McEwen, 2009). Scientific consensus is emerging that early experiences and exposures carry consequences throughout the life-course. While attachment and neuroscientific research has appropriately focused child protection policy and practice on preventing the accumulation of traumatic childhood events, reducing early toxic stress and intervening early to remedy the harms of maltreatment, there are instances where this body of evidence has been overstated, misinterpreted and misapplied.

Overstating evidence from research

In their rather provocatively titled article 'Blinded by neuroscience' Wastell and White (2012) emphasise that the research literature on the effects of

stress and trauma on the brain is vast, often contradictory and open to question and debate. They took particular aim at claims from a report commissioned by the UK government in 2010 (Allen, 2011a; 2011b), which stated that neglectful and aberrant parenting can *irreversibly* damage the brains of infants and young children. The 'controversy' has since slipped into the mainstream print media, with similar sentiments expressed in a more recent article in *The Guardian* by Zoe Williams (2014).

There is also disagreement among scholars in regard to Bowlby's contention that attachment styles established during infancy have a continuing effect on adaptation (Bowlby, 1973). In his book 'Three Seductive Ideas', Jerome Kagan (1998) argued against the widespread belief that experiences and parenting during the first three years of a child's life are the most important determinants of adult outcomes. To Kagan, this assumption is unproven and perhaps unprovable. In a life course perspective individual lives are influenced by their ever changing circumstances (Elder, 2008).

The idea that experiences that occur early in life influence brain development and later life course outcomes *irrespective of intervening experience* is contentious. Research has shown that children's development and wellbeing can improve greatly, even after the most severe early stresses, adversities and disadvantages (Rutter, 2000).

While the brain is most malleable or 'plastic' when immature (and thus more strongly affected by a certain type of experience than at other times), the negative consequences of damaging toxic stress response can be reversed or reduced through *appropriate and*

timely interventions (McRory, DeBrito & Viding, 2011; National Scientific Council on the Developing Child, 2010). This is especially seen in children under the age of seven years and continues to a lesser degree into the mid-teenage years (Mundkur, 2005).

More work is also needed to understand the experiences of adversity *in a family context* within specific timeframes that disrupt brain architecture. While it is known that an individual's physiological sense of threat develops very early in life, generalisable claims cannot be made about connections between specific forms of parenting and brain development (Belsky & de Haan, 2011; Rose, 2011; Macvarish, 2013). The evidence that certain patterns of attachment have neurobiological effects is also insufficient.

Recent attachment research has also shown that positive shifts in attachment style within existing relationships do occur as conditions in relationships change (Dozier, Manni & Lindheim, 2005). Children who have suffered adversity early in life also show secure patterns of attachment to alternative caregivers if they respond to them with understanding, sensitivity and high levels of cooperation and availability. While new experiences are in part created by prior history of adaptation, in this dynamic view of development, circumstances beyond infancy play an important role in children's adaptation and wellbeing (Juffer & Rosenboom, 1997).

Misapplication of evidence from research

Infant determinism

Exaggerations of the intransience of impacts from adverse early life experiences are concerning because

child protection is vulnerable to what Kagan refers to as the “allure of infant determinism” (1998). Deterministic thinking is attractive because it offers an easy solution to the complexity of child protection decision making.

One risk associated with an overly deterministic view of development is the unnecessary removal of infants and young children in less severe cases where interventions to increase caregiver capacities may be more appropriate. Australian child protection statistics show that infants aged less than one year enter care at disproportionately higher rates than children at older ages (15.5 per cent of all children admitted to care in 2012-13 were less than one year). It is appropriate that infants are viewed as more vulnerable to high levels of stress than older children requiring a more interventionist approach. However, the length of stay of infants in the OOHC system is relatively short compared to older children. When the OOHC population is viewed as a point-in-time “snapshot”, the proportion of infants in State care is much lower (just 2.6 per cent at June 30, 2013) (AIHW, 2014). This suggests the issues that bring infants into care are less severe (or more easily remedied) than what is the case for older children.

While it is unclear whether a deterministic view of child development has led to practices that focus on the “lessening of risk, not the meeting of need” (Featherstone, Morris & White, 2013, p.6), the issues that bring infants into care warrant attention. Especially in the context of diminishing capacity within OOHC systems for stable, caring and socially responsive environments, intrepid exploration is needed of more effective ways of working with highly

disorganised parents to ensure young children are not exposed to strong/frequent and/or prolonged adverse experiences in the home (Shonkoff, 2010).

Deterministic thinking also corresponds with a mistaken view that early intervention is all we need to do to manage threats posed to children. It is ‘magical thinking’, to use Jeanne Brooks-Gunn’s words (2003), to expect that if we take decisive protective action in the early stage of life, no further support will be needed, or that concerns that arise in later stages of development can’t seriously derail future development. Child protection systems must promote wellbeing and manage issues at all points along the developmental pathways of children and young people.

Misuse of attachment concepts

As discussed earlier in the paper, attachment theory and research has had a profound influence on child welfare policy and practice in Australia. Yet, child protection is replete with therapies and anecdotes of judicial decisions and social work judgements about individual cases that are said to be grounded in accepted attachment theory or related research that in fact would not be supported by most researchers in this field.

Research published by McClean and colleagues uncovered a poor level of understanding of attachment theory among stakeholders in South Australia. Several “conceptually unsupported” ways in which stakeholders used attachment theory to guide their everyday practice were identified (McClean, Riggs, Kettler & Delfabbro, 2012). One example of an ill-informed placement and support decision

involved placement of a young person in a residential care setting because of a perceived lack of desire or need for an attachment with a stable caregiver.

In regard to infant contact arrangements, a counterproductive emphasis on frequency rather than quality of contact with parents has been identified in judicial decisions (Humphreys & Kiraly, 2011). This reflects a basic misunderstanding of the conditions under which attachment relationships develop and are maintained. Field practitioners' observational assessments of attachment style are also dubious, given the requirement in most attachment assessments to activate the attachment system to tap attachment-related feelings and behaviours.

Concerns have also been raised that interventions that aim to enhance the wellbeing of maltreated children are too narrowly focused on attachment related factors (Barth et al., 2005). It is unrealistic to expect that attachment-based therapeutic interventions acting in isolation will reduce the adverse biological effects of toxic stress. In the risk and resiliency (Rutter, 1999) and the bioecological developmental systems perspective (Bronfenbrenner, 2005) children's recovery is likely to be connected to a range of positive influences. In addition to the over-emphasis of attachment concepts in remedial therapy provided to children who have suffered maltreatment, some controversial attachment therapies have been identified and the term attachment disorder remains ambiguous (Chaffin et al., 2006).

A framework for using research in child protection

The current discourse surrounding the

use of early childhood development in child protection provides an opportunity to reflect on how research should be used to assist practitioners, judges and politicians to deal with complex issues and questions. This involves an evaluation of research evidence and thoughtful application of knowledge.

Evaluation of research evidence

Scientific claims are rarely unequivocal and more often than not open to question and debate. The fierce challenge to some claims from neuroscience is a timely reminder that with all new learning it is important to have a clear understanding of whether it represents accurately the mainstream thinking of professionals within that field, and where any gaps or methodological limitations result in the need to be cautious about certain findings and conclusions.

Good advice is available from several sources about when science is 'ripe for application'. Gary Banks (2009) offers an Australian public service perspective, highlighting robust methodology, good data, transparency as well as researcher capability and expertise as the key ingredients for evidence-informed policy making.

Scientific peer review is a rigorous and useful criterion to evaluate the strength of research evidence. As academic journal articles are not always open-source, they can be difficult for child protection professionals to access. Frontline workers may also not have the time to read and critique primary research journals. Summaries produced by reputable research institutions (such as the Centre on the Developing Child at Harvard University, USA, and the Centre for Community Child Health in Melbourne, Australia) therefore provide

reliable information that should be favoured over information produced by advocate groups and science journalists. Open forums can also be a productive way to examine the strengths and weakness of research.

In their comprehensive overview of research evidence for family justice professionals concerning child development and the impact of maltreatment, Brown and Ward (2013) suggest quantitative research is best suited to address questions about *what* is happening, whereas qualitative research is can more readily explain *why* events are happening. Thus, it seems reasonable to suggest that complex questions in child protection are best addressed using mixed method approaches.

In evaluating the effectiveness of interventions, a number of scientific organisations subscribe to categorisations of research designs that reflect different standards of evidence, with evidence obtained from randomised controlled trials (RCTs) usually meeting the highest standards of evidence (NHMRC, 2000). It is important to note, however, that there are ethical reasons why random assignment is often inappropriate in evaluating the effectiveness of child protection interventions such as adoption or placement with parents, where receiving the intervention (or not) would have far-reaching implications on children's future lives (Brown & Ward, 2013, p.12).

Thoughtful application of knowledge

While knowledge from research is prone to oversimplification and misrepresentation, much can go astray between lifting findings from scientific journals and applying them in professional practice (Greenhalgh &

Russell, 2006, p.36). As pure or 'basic' research (such as studies in the early childhood development field) have not been specifically designed to inform child protection decision making, research knowledge can easily be *misapplied*.

Translating messages from applied research conducted in jurisdictions outside Australia is another challenge. Investment in child maltreatment research in Australia is small compared to countries such as the UK and USA. Privacy issues and concerns about harm resulting from the involvement of children considered vulnerable presents hurdles for academics and practitioners who wish to research this population. Australia also currently lacks ready access to the neuro-imaging tools of functional magnetic resonance imaging (fMRI) necessary to study neuropsychological development (Delima & Vimpani, 2011). In the absence of a strong Australian evidence base, the application of research knowledge requires particular caution.

Evidence needs to be appropriately distilled to meet the needs of those professionals who seek to use research findings in their day-to-day work. Effort must also be made to ensure the implications of research findings are properly understood by the different professional groups to which they apply. This is likely to involve consistent training and ongoing professional development. Informed decisions based on sound scientific principles also need to be followed with ongoing evaluation to weed out unproven and unimpressive interventions (Shonkoff, 2010).

Conclusion

This paper has used evidence from the fields of attachment and neuroscience

to show how prominent science can ensure child protection decisions or actions promote children's best interests. It also cautions that science does not speak for itself; without proper synthesis and distillation, knowledge from research can be distorted and misapplied. To be positively useful in child protection, scientific claims need to be carefully evaluated and thoughtfully translated through processes that both engage and inform professionals who seek to support the interests of children.

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PRACTITIONER'S RESPONSE: Using early childhood development research in child protection: Benefits, boundaries and blind spots

RESPONSE BY DR SANDRA HERIOT

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I recently saw a quote in an article 'Social Science and Parenting Plans for Young Children' on critical thinking about research. Although the quote was about psychologists, it made me reflect on how well this paper by Wise and Connolly has been able to analyse and critically evaluate several vast areas of child development, neuroscience, attachment and child protection. The quote was from Meltzoff (1998) who wrote: "Research shows" is one of the favourite expressions of psychologists who are called on by the media to express their professional opinions on a wide range of topics, who are asked to consult with or testify before law makers about social issues that affect public welfare, or who are relied on to give expert counsel to other health service providers or to educators. Research psychologists carry a heavy burden of responsibility for assuring the accuracy of their claims about their results. In turn, psychologists who cite or apply the research findings of others share their responsibility. They have an obligation to use their critical reading and evaluation skills in reviewing a study before they cite it as evidence that supports a point of view and before they apply the findings in their clinical work (p.9).

In this paper, Wise and Connolly have provided a balanced view of the research and how we might apply such knowledge more carefully to practice in child protection. Attachment theory, and its application to decisions in child protection, is so important. We are often asked to consider a whole range of related issues such as placement options, restoration versus long term care arrangements, psychological impacts on the child to change carers once final orders have been made, consideration of family contact if the child is not restored to the birth family, impacts of moving to another placement and undergoing another change in primary caregiver. As practitioners we try to weigh up and balance stability of current placement, instability in early life, current care, development of social skills, emotional and behavioural regulation and a coherent sense of self in terms of the decisions we make with and for children and families. Alongside these considerations are the impact of trauma and our current understandings of the interconnectedness and interdependences of child development, attachment and neurobiological functions.

Wise and Connolly make a bold but fair claim when they write, "deterministic

thinking is attractive because it offers an easy solution to the complexity of child protection decision-making” and they warn against “systemic level interventions that are short-term or only focus on one aspect”. While we strive to make decisions that are in the best interests of the child, we also need to ensure that those decisions are not inadvertently harmful. So how are we to make good decisions in our work? Decision making in practice requires a consideration and coming together of several elements including the best available evidence, client characteristics, resources (including practitioner expertise) and the environmental and organisational context. The authors give guidance in this area and provide a framework for using research in child protection to assist in dealing with the complex issues faced by practitioners, judges and politicians.

The paper considers two important areas: evaluating the research evidence and thoughtful application of knowledge. In considering the former, they point to scientific peer review, and using different types of research to help answer ‘what and why’ sorts of questions. The paper is a good reminder for us as practitioners that different issues require different sorts of methods, and care must be taken not to misapply our research knowledge.

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PARENT RESPONSIBILITY CONTRACTS: THE EVIDENCE

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Introduction

This paper reviews research on and around the use of Parent Responsibility Contracts (PRCs) over the past 10 years. It explores parental responsibility in the child protection and juvenile justice contexts, the arguments for and against PRCs within both contexts and gaps found in the literature. The paper discusses the conditions within the different statutes of parental responsibility in the Australian states and territories with a primary focus on New South Wales (NSW). The paper concludes with a short discussion on the key factors which need to be considered for parents who are engaged in statutes of parental responsibility.

In the NSW context, a Parent Responsibility Contract (PRC) is a voluntary written agreement between NSW Family and Community Services (FACS) and one or more parents/primary carers (hereon referred to as parents) of a child or young person. The recent legislative reforms in the state of NSW included an extension of Parent Responsibility Contract duration from six to 12 months, which further enables parents to attend intensive parenting courses or therapeutic treatments. The extension of time within the contract allows parents time to actively engage in parenting support programs by identifying and achieving individually set goals in order to improve parenting skills

and build positive and sustainable relationships with their children. The PRC aims to improve the parenting skills of parents and encourages them to take specific actions such as attending a support service. While a PRC has to be registered with the Children's Court, it is not a Court Order and is therefore not legally enforceable.

A PRC in NSW can include conditions that the parent is required to meet, such as:

- Attend counselling
- Attend courses to improve their parenting skills
- Receive treatment for drug, alcohol or other substance abuse
- Undergo drug testing to ensure abstinence.

If one or both parents fail to comply with the conditions of a PRC in NSW, they are considered in breach of the contract and a contract breach notice can be filed in Court.

In NSW, the government clarified that the contracts are a "means of ensuring that parents meet their obligations when it comes to their children" (Meagher, 2006 in Parada, 2010, p.178). *The Children and Young Persons Care and Protection Act 1998* states that the objective of parent responsibility is to encourage and support parents, with

skills and resources to provide for their children's needs and overall wellbeing¹.

Across Australia there are different legal approaches for Parent Responsibility Contracts:

- Northern Territory (NT): Family Parenting Orders which involve a Court order requiring parents or guardians to contribute to the costs (not exceeding \$100 per week) of putting their children or young people in a youth detention facility².
- Queensland: Compensation payments aimed at parents of children found guilty of a crime. This falls under the Juvenile Justice Act of 1992. Recent amendments (Hutchinson & Lewis, 2007) have placed a greater emphasis towards more punitive measures upon youth, rather than punitive measures on parents (Hutchinson, Parada & Smandych, 2009).
- South Australia: Utilises undertakings by parents and guardians which are court based agreements to participate in a program or activity which enhances parent capacity to be responsible for their children³.
- Victoria: Utilises undertakings by parents and guardians to prevent acts specified in the agreement for a period not exceeding six months or, in exceptional circumstances, 12 months⁴.
- Western Australia (WA): Responsible Parenting Orders. This parenting agreement is similar in nature to the NSW Parent Responsibility Contract where the

parent or parents are responsible, but not required to attend parenting guidance counselling, support groups, or for parents to ensure children attend school⁵ (Hutchinson et al., 2009).

- Tasmania and the Australian Capital Territory have no legislative provisions regarding parental responsibility.

These different types of statutory orders will be explored further in the discussion of PRCs in a child protection context. While PRCs in Australia mostly specify the parents' responsibility to their children, internationally, parental responsibility is often in the context of parents' responsibility for their children's behaviour (Brank, Kucera & Hays, 2005; Evans, 2012; Hutchinson, Parada & Smandych, 2009).

The way forward

Since March 30, 2007, the NSW Children and Young Persons (Care and Protection) Act of 1998 (section 38) includes provisions allowing NSW Department of FACS to enter into a PRC with the primary caregiver(s) of a child or young person. According to a Family and Community Services (FACS) discussion paper, PRCs have not delivered results as expected, because they have not been utilised to the extent originally envisaged, with only 168 PRCs recorded between 2007 and 2011. This analysis found that between March 2007 and mid-June 2009, there were 2327 state wide PRC opportunities, yet only 32 PRCs had been developed and, of those, 18 had been breached (FACS, 2012, p.13). Given the relatively low number of PRCs implemented, PRCs would have limited scope for impact in child protection. The

1 Children and Young Persons Care and Protection Act 1998 Ss38A

2 s133 Youth Justice Act 2005

3 s27 Young Offenders Act 1993

4 s363 Children, Youth and Families Act 2005

5 s11 Parental Support and Responsibility Act 2008

discussion paper (FACS, 2012) revealed a number of reasons for the limited impact or application of PRCs. Some of these reasons included:

- Caseworkers operating in a complex and pressured work environments.
- Lawyers advising parents not to enter into PRCs due to serious consequences which may result from a breach.
- FACS staff, legal representatives, non-government organisations (NGOs) and client support groups are largely unfamiliar with the PRC scheme as a whole and are often unprepared to support parents.

PRCs in a child protection context are usually used to address the parenting responsibilities of families where children are much younger and parents may have more influence on a child's behaviour than in adolescence. PRCs within the juvenile crime context address the behaviour of adolescents where the child's peers are a key source of influence on adolescent behaviour (Burney & Gelsthorpe, 2008). Children are removed from their family and placed in the care of the State. In the juvenile justice context, parents may be required to pay a fine for their children's antisocial behaviour. This is probably due to age of criminal responsibility being over the age of 10 years in Australia and in other countries, including the United Kingdom. Where the child is of a younger age, there is more time for change within families with respect to building skills in parenting. At the same time, younger children face greater developmental risks due to their age. The age of the child, usually younger in the child protection context and older in a juvenile crime context, can be both an advantage and a disadvantage. An advantage

could see the parents improving their approach to supervision and communication with their children to correct antisocial behaviour (Hutchinson, Parada & Smandych, 2009). Disadvantages may involve the rights of the child being compromised. In the event that the behaviour is not suitably addressed, parents are penalised for their antisocial behaviour. This inability to regulate behaviour may be due to a number of socio-environmental factors such as economic disadvantage or substance dependency. With access to support programs and therapeutic treatments, parents will be much better equipped to improve parenting skills. Most importantly, they will establish more positive and sustainable relationships with their children. Measures to address antisocial behaviour in children should be in place to enhance outcomes and quality of care for developing children rather than to punish adverse behaviours or responses. As Hollingsworth (2007) reflected, whilst parents have responsibilities to their child, it should not be used "as a mask to control and police their children but to support them" (p.212).

PRCs are described as a primary intervention strategy when dealing with families to enhance and enable skills to provide effective care to their children. In the context of juvenile crime, Parada (2010) observed that there is a responsibility attached to raising children and young people and imposing PRCs reinforces the role of exercising that responsibility. Hutchinson, Parada and Smandych (2009) observed that focusing on the actions of the parents in juvenile crime prevention misinterprets the origin and nature of the problem, whilst also dismissing the socio-economic impact that legal proceedings

have on families. Parents are required to re-evaluate their own behaviour and adapt new skills to exercise appropriate control over the behaviour of their children. When extending this to the NSW context of PRCs, effectiveness can be optimised through greater clarity around specific government and non-government agencies' roles and responsibilities in providing appropriate access to services to parents and their families (Hutchinson, Parada & Smandych, 2009; Burney, 2006 in Parada, 2010).

However, the concept of parental responsibility with respect to juvenile crime has dominated much of the research around PRCs. There are negligible studies on the impact of PRCs in a child protection context. This may relate to the fact that the contracts have been under-utilised in case management with families. The two contexts are significantly different and therefore make it difficult to assume that PRCs will function in the same way within a child protection context as they do in juvenile crime settings.

Juvenile justice context

Parent responsibility legislation in some Australian jurisdictions is focused predominantly on the juvenile justice context. In this context, parent responsibility is a means of imposing measures upon parents that improve their parenting skills and encourage them to accept greater responsibility for the child or young person. Alternatively, parent responsibility can involve making parents subject to fines or imprisonment if they or their children commit crimes or are non-compliant to court orders (Children and Young Persons Care and Protection Act, 1998).

In Australia there are a number of different perspectives on how the State should bring about 'good' parenting. WA Parliamentary Secretary Quirk (2005 in Parada, 2010, p.158) stated that:

"Good parenting is a powerful instrument for prevention and early intervention against some of the serious social problems confronting us. The spirit and intent of this bill is to support and strengthen the most powerful institution we have - the family."

It is important to consider the diverse social, economic and cultural contexts of different families in the promotion of good parenting (Hutchinson, Parada & Smandych, 2009). The chief objective of the Young Offenders Act (1994) in WA is similar to NSW legislation in that it aims to "enhance and reinforce the roles of responsible adults, families and communities"⁶ (Parada, 2010, p.66). PRCs from a NSW perspective aim to give parents opportunities to improve their ability to recognise and respond to their children's needs whilst also bringing awareness to the parents that they are at risk of having their children removed if their behaviour is not changed and improved for the children's best interests (NSW Family and Community Services, 2012).

A large portion of international literature around parental responsibility discussed contracts around parental responsibility for adolescent and criminal behaviour. Dimitris (1997) has written that parental liability laws seek to hold parents liable for delinquent acts of their children. Parents can be involved in civil cases brought against them for damages to person or property. Contributing to the

6 (section 6 (d))

delinquent act would entail that the parent was somehow involved in the criminal act as well. The involvement of parents in criminal proceedings pertains to their notification of and participation in proceedings and the possible recovery of court or treatment costs from them.

In the juvenile justice context, parents who have breached the terms of their parent responsibility agreements have experienced negative feelings such as anger (i.e. towards the sentence they were given as a result of their child's criminal act) or felt humiliated (i.e. as a result of being publicly labelled a 'bad parent'). Parada (2010) uncovered an unsatisfied response from parents engaged in parenting support programs and reported limited or no changes in their children's offending or troublesome behaviour. They concluded that despite their supportive aspects, parenting orders fall short, as "using compulsion and the threat of fines and imprisonment is not an effective way to change the behaviour of parents and their children" (Parada, 2010, p.195).

Scott, O'Connor and Futh (2006) studied the impact of parental responsibility orders in the juvenile justice system in England and Wales. They concluded that parenting programs improved the use of effective discipline techniques and those parenting program interventions improved the parent-child relationship at least six months after the intervention had concluded.

A key issue identified with the use of PRCs from both a child protection and juvenile justice perspective was around the integrity of such orders in practice. In the Australian context, Parada identified that there was a low

prosecution rate amongst parents when applying these laws. It was found that few cases actually make it to a courtroom, which prompts questions about the feasibility of enforcing such laws (Parada, 2010).

Child protection context

Whilst the majority of the literature on PRCs draws from the juvenile justice perspective, there is a limited critical literature relating to their application in a child protection context. To establish the efficacy of PRCs we need to understand if and how they motivate parents towards positive behavioural changes in their relationship with their children so as to provide evidence of the role of PRCs in enhancing parenting skills. This is achieved by parents becoming familiar with their own sense of self direction and autonomy. This in turn enables them to realise self-empowerment and competency in their ability to adapt and maintain the skills acquired within the contract guidelines and or relevant support programs (Homel & Ryan, 2010).

Parada (2010) explored political responses to PRCs and their proposed outcomes for parents and guardians. According to MP Kate Doust, a Western Australian Parliamentary secretary, responsible parenting orders were "the first steps in intervening with families and to provide skills to parents to enable them to deal with the behaviours of their children" (2005, in Parada, 2010, p.161). She emphasised that there is a responsibility attached to raising children and that imposing responsible parenting orders reinforces the role of responsibility of parents to exercise appropriate control over the behaviour of their children and makes it clear that the government agencies also have a responsibility to provide the appropriate

service and support. Objectives for the Parental Support and Responsibility Act (2005) in WA were to instruct and support parents in safeguarding and promoting the wellbeing of their children and to exercise appropriate control over their children's behaviour (Quirk, 2005).

Holt (2010) explored parent experiences and responses to PRCs, an area which has not been explored widely from a Federal Government perspective. Responses on the significance of PRCs from Federal Parliament included the "important social justice responsibility of breaking the cycles of dysfunction" (Linda Burney, MP, 2006, in Parada, 2010, p.179). Another response from the Government included acknowledging its responsibility to prevent "major family breakdowns which result in the removal of children from the family" via the utilisation of PRCs (Reverend Fred Nile, 2006, in Parada, 2010, p.179). Holt explored parents' perceptions of the support given to them during the implementation of PRCs. Parents' responses to PRCs included various approaches which sought to prove that they were not to be considered as 'bad parents'. Additionally, there was reflection on caseworkers' ability to effectively assess parents' willingness to change. Similarly, Evans (2012) examined parenting orders in the United Kingdom and critiqued the consistency of support experienced by parents. Evans (2012) confirmed that evidence of the effectiveness and outcomes of early intervention in the family home was limited.

In terms of the political debate on PRCs, from a Liberal perspective WA Member of the Legislative Council, Peter Collier, framed PRCs in a child protection context as a punitive measure against

parents. Collier found that the punitive outcomes of PRCs for those considered poor parents were offensive and not a good method for developing and improving harmonious relationships between parent and child (Parada, 2010). This is supported by Brank, Kucera and Hays (2005), who argued that punitive parental responsibility laws actually "contribute to deterioration of the parent-child relationship" and can propel further delinquency.

PRCs and parenting programs

There are limited studies on the use of PRCs with families in the context of child and family welfare. However there is some evidence that identifies the impact of parenting programs on children's outcomes, especially where parents have been involuntary participants (Smagner & Sullivan, 2005). An evaluation was conducted on the parents participating in the Triple P programs run in NSW. Triple P seminars were found to be effective in improving the behaviour of children (Masters, Gaven, Pennington & Askew, 2011). The voluntary participants of the evaluation of Triple P programs showed statistically significant improvement from the beginning until the six-month mark, whereas the comparison group did not reveal any significant improvements. This shows that attendance at parenting programs such as Triple P when contracted under a voluntary PRC may improve the parent-child relationship through noticed improvements in behaviour and interaction. Masters et al. (2011) found that there is evidence of longer term social benefits and reduced costs from engaging in Triple P, which also reduced numbers of children from the clinical to non-clinical range of need. Although there has only been a single study in the Australian context (Masters et al., 2011),

it supported the capacity for PRCs to improve behaviour and interaction.

Research by Kelleher et al. (2012) highlighted an important downside to client-worker interactions that can occur within therapeutic parenting programs. Therapeutic relationships are characterised by adherence to “strict rules of confidentiality between staff and clients”, and the idea of mandatory reporting runs counter to this (p.108). Clients were observed to be concerned and angered over the mandatory reporting requirements of parenting program staff, and it affected the way they approached and engaged with their therapy.

Cultural considerations

From an Australian perspective, White (1998) has pointed to the difference between Anglo-American and Indigenous communities’ concepts of what parenting or childhood should consist of. White pointed out that Western notions of childrearing are at odds with an “encouragement of self-direction and independent action” (p.128) style that is reflected in some Indigenous communities. His analysis raises the question of the fairness of imposing Anglo-centric parental responsibility laws on Indigenous peoples. We must take into account the differences in socio-economic resources at household level, which has a capacity to influence the way parents bring up their children. For example, it has been argued that the intervention in Aboriginal communities to control and modify Aboriginal family behaviours have done more damage than good, leading to further breakdown and fragmentation due to interventions not taking into account many Aboriginal parents’ poor educational background and socio-economic circumstances which

contribute to poor self-esteem and undermine parental authority (Hutchinson et al., 2009). Additionally, the imposition of Anglo-centric parental responsibility laws on Indigenous families is inconsistent with Aboriginal family traditions. Aboriginal Australian parenting involves not just the biological mother and father. Extended family members such as aunts, uncles, grandparents and Elders from the community also contribute to the child’s upbringing (Hutchinson et al., 2009).

When considering the cause of poor parenting practice, external factors at the family and social level (such as unemployment and poverty) also need to be accounted for (Evans, 2012; Walters & Woodward, 2007). By punishing the parents or imposing parenting classes in cases where the parents are left to struggle in unchanged social circumstances is a stop-gap measure at best. Goldson and Jamieson (2002) observed that parental responsibility legislation involves critical legal consequences underpinned by stigmatising and undermining the constructions of working class families. Rather, we need to promote good parenting by taking into account the diverse social, economic and cultural contexts of parents’ daily lives (White, 1998). When these contexts are considered, the structural problems that parents are battling with, such as poverty or unemployment, are able to be addressed (Holt, 2010).

Conclusion

In balancing the State’s responsibility to support families and encourage parental responsibility with the Act’s spirit of partnership, it is essential to use PRCs in a way that encourages rather than polices parents. PRCs should clearly identify what is required of parents,

provide reasonable requests within a reasonable timeframe and detail the supports that will be provided to parents to help them avoid breaches of the contract. Reforms aimed to enhance the effectiveness of PRCs include extending the maximum duration of a PRC from six months to 12 months (FACS, 2012, p.15). This reform aims to give parents more time to address the identified risk issues and demonstrate a change in their parenting.

The literature explored the significance of time given to parents in order for them to access advice and support from program staff (Evans, 2012; Burney & Gelsthorpe, 2008). Research confirmed that parents are more willing to accept more help from others when they have time to establish close supportive relationships with parenting program staff. Parents need to feel comfortable and reassured in the support environment they are in. In time, confidence and autonomy can grow and prove to have lasting effects on the nature of their parenting skills (Evans, 2012; Kelleher, Cleary & Jackson, 2012). The PRCs should be developed in partnership with parents.

It will be important to evaluate how they are used and the outcomes achieved. Given persuasive evidence on the likelihood of parents achieving behavioural change if they are encouraged, supported and have objectives and interventions tailored to meet their needs, it will also be important for caseworkers to receive training and guidance on using PRCs to improve outcomes for children, young people and their families.

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GETTING MORE BANG FOR YOUR BUCK: WHAT WORKS BEST IN PROFESSIONAL DEVELOPMENT IN THE CHILD, YOUTH AND FAMILY WORKFORCE

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Introduction

Work in the human services, including in statutory and non-government contexts, is demanding and requires skilful practitioners. The child, youth and family services (CYFS) sector works with families with complex needs and therefore requires practitioners with broad areas of knowledge and a diverse mix of skills. The work is underpinned by a range of assumptions and values that aim to make a difference to vulnerable children, young people and their families. It is also a workforce that consists of a diversity of professional and para professional staff who come from different disciplines and experience. Not surprisingly child, youth and family service organisations recognise the need to provide appropriate professional development for their staff as a strategy to provide high quality services.

Over the last 20 years, service delivery and practice has been influenced by a variety of factors including calls for evidence informed or based practice; increased recognition of the complex and co-occurring issues such as family

violence, substance misuse and mental illness; demands for more integrated or joined up service delivery to respond to complexity; and demands for more individualised and culturally appropriate practice - to name a few.

Training and professional development is seen as central to building and skilling practitioners, from core training for new recruits to ongoing professional development for more experienced staff. Ongoing professional development assists to build the capacity of organisations; aims to improve the quality of services provided to the community; and are thought to aid in retaining practitioners (Curry McCarragher & Dellmann-Jenkins, 2005). Various models and pathways exist for workers to engage in professional development activities including workshops and lectures, action learning, and formal education pathways into diplomas and degrees¹. Government and non-government

¹ Although training and professional development is important as a means for workforce improvement it is clearly not the only factor that leads to quality services and retention of staff. It is critical to also attend to the organisational and policy factors that influence workforce stability, quality, and practice.

organisations often spend significant funds on professional development without, it would seem, not always knowing which learning models or pathways are the most effective to facilitate positive practice change.

Although the importance of professional development is recognised by most professions, the literature exploring which methods of professional development are effective is limited (Curry et al., 2005; Davis, O'Brien, Freemantle, Wolf, Mazmanian & Taylor-Vaisey, 1999; Yoon, Duncan, Lee, Scarloss & Shapley, 2007). Research on the outcomes of training and professional development for the CYFS workforce is particularly scant (Clarke, 2001).

One literature review that does exist, on the CYFS workforce in the USA, found that little is known about if, and how, professional development activities in the CYFS workforce result in better outcomes for children and young people. This is due to the paucity of available research (Harvard Graduate School of Education, 2007). Because of this gap, and consistent with previous reviews in this area, this paper draws on the theory and literature on effective professional development from health, education and the broader human services sector. Its findings suggest that effective professional development requires a set of common elements tailored to the specific professional development needs of the individual and organisation. The paper begins with an exploration of these common elements. Secondly, different models of professional development are reviewed and critically appraised. Finally, recommendations from the existing evidence are made to assist organisations to make best use of their

professional development dollars.

Approach to the literature

Various methods for reviewing evidence in a particular field exist, with distinctions made between approaches depending on the purpose and resources available. Some commonly discussed approaches include: systematic reviews where all primary evidence is included that meets a stated inclusion criteria; rapid reviews which review the literature by using methods to accelerate or streamline traditional systematic review processes (see Gannan, Cliska & Thomas, 2010) and more narrative reviews which often do not make clear how and why particular sources and approaches are used (MacDonald, 2003). Collins and Fauser (2004, cited in Scourfield et al., 2013, p.2) note more narrative approaches may have advantages over more systematic approaches as they can be more inclusive, particularly if there is limited evidence to assess.

This paper has taken a narrative approach as we have not followed the full protocol of a systematic review. This was due to the limited evidence base as well as the resources available to carry out the review². Notwithstanding the more narrative approach and speed required, we used several of the techniques of more systematic reviews including; a clear articulation of our aims, research questions, the search strategy and the methods for analysis (Collins & Fauser, 2004, cited in Scourfield et al., 2013, p.2). We have, where available, relied on previous reviews of the literature.

The search was framed by two questions:

2 The project had the primary aim of informing the ACT Community Services Directorate decisions about their professional development budget specifically for the Children, Youth and Family Support program.

- What are the elements of effective professional development?
- What are the main models of professional development activities?

The literature search was carried out over one month in 2012 and a range of international and national databases were accessed including: PsycINFO, Medline, EMBASE, ASSIA, Sociological Abstracts, Social Work Abstracts PLUS, Psychology & Behavioral Sciences Collection, SAGE Journals Online. To access 'grey literature (i.e. government or non-government commissioned work) Google Scholar was also used.

The search strategy included keyword searches that incorporated multiple keywords with the terms 'effective professional development', 'models of professional development', in child welfare/protection/family support services. This resulted in very few relevant sources. The search was extended to include health and education with education providing some useful sources.

Data analysis was carried in a purposive way to answer the two key questions, and in answering each question a number of themes emerged that have structured the findings. No predetermined quality criteria were used for research design, although most sources used in the review were from academic journals. This may be regarded as a limitation of this review. The results of this analysis follow.

Findings

What are the elements of effective professional development?

The literature suggests effective professional activities are those that are ongoing, active, social, coherent, reflective, relevant to practice (Garet,

Porter, Desimone, Birman & Suk Yook, 2001; Michaux, 2010), and exist in a community which promotes learning (Webster-Wright, 2009). In contrast, there is strong consensus that 'training' provided as 'episodic updates of information' delivered in a 'didactic manner, separated from engagement with authentic work experiences' (Webster-Wright, 2009, p.703) is of questionable benefit (e.g. Darling-Hammond & McLaughlin, 1995; Hargreaves, 2003; Lieberman, 1995, cited in Webster-Wright, 2009, p.703).

Three large scale evaluations (Webster-Wright, 2009; Garet, et al., 2001; Yoon et al., 2007) provide valuable empirical evidence of the mechanisms of effective professional development. These studies found several common elements which promote effective professional development and provide empirical evidence for adult learning theory³ (Webster-Wright, 2009). Garet et al. (2001) investigated the effects of different characteristics of professional development on teachers' self-reported improvement in skills and knowledge, as well as change in teaching practice. Yoon et al. (2007) conducted a systematic review of evaluation studies investigating professional development for school teachers and its effect on student achievement. Davis et al. (1999) carried out a systematic review and meta-analysis on effective continuing medical education.

Ongoing

Time-span and total number of hours engaged in professional development activities had separate and significant impacts on active learning and coherence, which in turn contributed to

³ Adult learning theory (andragogy) suggests that adults have particular requirements as learners and that they learn best in an environment that is problem based and collaborative (Webster-Wright, 2009).

enhanced skills, knowledge and change in teaching practice (Garet et al., 2001). Yoon et al. (2007) found that professional development provided to teachers of less than 15 hours had no statistically significant effect on changes in student achievement. Davis et al. (1999) found that multiple or longitudinal professional development was generally more effective than single events. The findings suggest that a 'one off' workshop would be unlikely to lead to measurable change in practice, but that a generous number of hours over a sustained period does increase the effectiveness of professional development.

Active

Effective professional development involves active engagement in meaningful activities (Davis et al., 1999; Garet et al., 2001; Yoon et al., 2007; Harvard Graduate School of Education, 2007). Studies found that activities needed to be relevant to practice and coherent with the content and practice aims of the professional development. Activities included observing practice and being observed, planning implementation strategies for real work situations, presenting, leading discussions and written work. Inherent in these activities is an opportunity for reflective practice and the opportunity to rehearse and problem-solve the integration of new knowledge and skills into practice.

Coherent, social and relevant to practice

Effective professional development needs to form a coherent program, promote communication between colleagues and align with professional standards. Garet et al. (2001) found that these three elements contribute significantly to increased skills, knowledge and changes in practice.

Hoge, Huey and O'Connell (2004) suggest best practice professional development in the human services is competency based, utilises practice guidelines and develops skills to engage in lifelong learning, including critical appraisal of evidence.

Reflective practice

Traditionally, professional development activities used didactic methods aimed at increasing skills and knowledge. However, an increase in skills and knowledge has been found to have a weak link with positive practice change (Garet et al., 2001). Practice change should result in measurable and increased positive outcomes for children, young people and their families (Harvard Graduate School of Education, 2007). It is argued that changes in practice are facilitated by interactive and reflective learning. Reflection has been found to be central to adult learning and the process of bridging the gap between the acquisition of new skills and knowledge and changes in practice (Moon, 1999). Changes in practice can be facilitated through professional development that questions implicit assumptions and challenges taken for granted practice (Antonacopoulou, 2004; Boud & Walker, 1998; cited in Webster-Wright, 2007).

Changes in practice require the learner to accommodate new knowledge and skills to transform practice. Reflection is critical to noticing, challenging and integrating current knowledge, assumptions and practice with introduced knowledge and skills (Moon, 1999; Platzer, Blake & Ashford, 2000).

In the human services field, critical reflection may be viewed as the key theoretical foundation of practice (O'Hara & Weber, 2006) and as a way

of linking the individual with the wider organisational context (Gould, 2004). In child and youth work, reflection has been recognised as core to competent and effective practice (Curry, Eckles, Stuart & Qaqish, 2010). The Benevolent Society of Australia identified providing sufficient resources, including time and experienced supervisors and facilitators for reflective processes, as a key to effective professional development and learning within their human services organisation (Michaux, 2010).

What are the main models of professional development activities?

Professional development activities need to be selected based on the organisation's planning and policy goals and an assessment of the learning needs of the organisation (World Health Organisation, 2005). Effective professional development takes place in a culture which promotes and adapts to learning. Below is a summary of effective professional development activities, including a summary of the learning organisation model. Professional development activities which may complement the activities discussed below include computerised or manual prompts, consumer-mediated interventions, train-the-trainer models and professional reading programs (Hoge et al., 2004; Garrett & Baretta-Hermann, 1995).

Workshops

Research and learning theory suggest that traditional models of professional development, using only brief didactic methods such as lectures and workshops, have a limited impact on changing practice (Garet et al., 2001; Oxman, Thomson, Davis & Haynes, 1995; Webster-Wright, 2009). However, workshops have been found to be effective when they are presented as a

cohesive series focused on implementation of current research, and providing opportunities for active learning and reflection of how to apply the acquired knowledge and skills to real work situations (Guskey & Suk Yoon, 2009).

Workshops may be particularly appropriate for the dissemination of research and training with a specific focus. However, workshops are unlikely to impact practice if they do not incorporate elements of effective professional development. Workshops need to be carefully selected to ensure that the learning which takes place at the workshop is consistent with the practices and procedures of the organisation, or that the organisational structure is flexible enough to accommodate workshop learnings.

Supervision

Supervision may be viewed as core to effective human service practice and professional development (Hair, 2013; Irwin, 2006). As a learning and support activity, supervision that is ongoing, active, coherent, reflective and relevant to practice is well placed to facilitate many of the elements which have been found to contribute to effective professional development. There is some evidence that professional supervision can lead to improved service delivery by developing and improving skills, enhancing ethics and values and providing a buffer to the rigours of practice (Mor Barak, Travis & Xie, 2009).

Supervision generally refers to an ongoing relationship with an experienced practitioner who facilitates reflection, learning and problem-solving of practice based questions (Irwin, 2006). A variety of supervision methods

enhance the effectiveness of supervision. These may include observation, journals, discussion of research/readings, simulation exercises (e.g. role plays) and teaching exercises including, skills training (Irwin, 2006).

The quality of supervision will depend on many factors, including the knowledge, skills and experience of the supervisor, the active participation of the supervisee, the supervisory relationship, the structure of supervision and the environment in which it takes place (Hair, 2013; Irwin, 2006). Supervision is limited by its reliance on a single supervisor and supervisory relationship which exists within a specific context. Other professional development methods are vital to broaden the scope of professional development and buffer any limitations of supervision.

Mentoring and coaching

Disenchantment with the effectiveness of traditional forms of professional development has resulted in increased interest in 'reform types' of professional development such as mentoring and coaching (Garet et al., 2001). Mentoring or coaching involves an experienced person leading, advising and supporting a less experienced person in their personal and professional development (Strand & Bosco-Ruggiero, 2010). In the social work literature, coaching is regarded as a form of professional supervision (Ennis & Brodie, 1999). Extensive literature exists on the value of the mentoring relationship in the corporate world, with more limited literature in the human services field (Strand & Bosco-Ruggiero, 2010).

Mentoring may involve designing and monitoring personal professional development plans, induction of new staff, coaching in the development of

new skills, facilitating reflection and psychosocial support. In the child and youth services sector, both formal and informal mentors have been found to play an important role in worker retention, development, training and coaching in the transfer of learning for new workers (Strand & Bosco-Ruggiero, 2010).

As a professional development activity, mentoring and coaching have the potential to incorporate all the elements of effective professional development model. It may be particularly valuable in providing ongoing guidance in the development of individual professional development plans and in vivo coaching on incorporating acquired knowledge and skills into practice.

Accredited training courses

The merit of the professionalisation of the human services workforce and the relative value of generic and specialised qualifications is an area of contention amongst social work and human service academics and employees (Healy & Lonne, 2010). The Vocational and Education Training Sector (VET) and higher education play a critical role in providing pre-service and in-service education and training for the human services workforce in Australia (Healy & Lonne, 2010). VET and higher education provide a variety of human services qualifications and training including certificates, diplomas, advanced diplomas, bachelor's and master's degrees in areas such as social work, child and family studies, youth work, child protection and disability studies. The diversity in qualifications is also representative of the diversity in formal training needs in the human services workforce. The value formal education will contribute to professional development should be carefully

assessed with reference to the needs of the organisation, the individual and the ability of the specific formal training course to meet these needs.

Accredited training courses have the potential to offer effective professional development by providing high quality, structured and comprehensive education. Qualifications can play a particularly valuable role in developing critical analysis, reflective, research, communication and problem-solving skills as well as providing a broad context and theoretical foundation for human services work. The CYFS sector represents a diverse field in which effective practice requires specialist knowledge and skills. There is some variability in the quality and content of training and qualifications in Australia, particularly in specialty areas, with criticisms from employers that some training courses do not bridge the gap between theory and practice (Healy & Lonne, 2010). Field placements contributing to these qualifications have been found to play an important role in linking academic and practical knowledge, particularly when they take place in the same area of practice as future or current employment (Healy & Lonne, 2010).

Action learning

Action learning is an approach to learning based on systematic questioning and problem solving. It is based on the assertion that individuals develop questions in the course of their work and seek to find solutions. Learning is achieved through the testing and monitoring of solutions and continual refinement of the solution.

Professional development using action learning is used in health and educational settings (Stark, 2006). It

typically involves a small group of individuals identifying work based problems. Identification of problems and solutions facilitates practice-based questioning, insights and self-reflective processes.

Action learning is being utilised by Australian human services agencies to provide professional development for workers and enhance outcomes for consumers. For example, action learning has been a critical element in the development of a model of early intervention for young people at risk of homelessness (Crane & Richardson, 2000). The Father-Inclusive Practice Guide, a guide to promote father-inclusive CYFS, recommends action learning as a method for the knowledge transfer of their guidelines to practice (FaHCSIA, 2009). The Benevolent Society has identified action learning teams as a key foundation to continuous improvement in their service delivery (Michaux, 2010). Their action learning teams have worked on topics including building inter-agency collaboration and strategies for improving the implementation of research within the society.

Learning organisations

Professional development is most effective when it is facilitated by a workplace that supports ongoing learning (Webster-Wright, 2009). The learning organisation model provides principles which promote learning within organisations. It is a flexible model which is sensitive to the contextual requirements of the organisation (Ortenblad, 2004) and therefore may be particularly applicable to CYFS that are required to provide highly contextual and dynamic services. Learning organisation principles are beginning to be introduced in human services and

CYFS (Bostock, Bairstow, Fish & Macleod, 2005; Michaux, 2006). There are four aspects of the learning organisation; organisational learning, learning at work, learning climate and learning structure (Ortenblad, 2004).

- *Organisational learning*

Organisational learning refers to the organisation's structures which ensure that individuals' learning is stored as knowledge within the organisation and used in practice by the organisation. In the social care learning organisation this may involve information systems which effectively facilitate communication, as well as clear policies and procedures which are understood by all organisational members (Michaux, 2006).

- *Learning at work*

Learning at work refers to the learning which takes place 'on-the-job' and is context-dependant. In the social care learning organisation, learning at work may include participation and feedback informing practice, team work and cross organisational and collaborative practices (Michaux, 2006).

- *Learning climate*

The learning climate is the culture of facilitating learning which is fostered by the organisation's structure and customs. Social care organisations may need to foster a shared vision, encourage new ideas and methods and provide open learning environments to reflect on new knowledge and approaches to incorporating these into practice (Michaux, 2006). Human resources practices will need to provide for continuous professional development and have a clear

supervision and appraisal policy (Michaux, 2006).

- *Organisational structure*

The learning structure of an organisation refers to the management of the organisation such that it has the flexibility to continually respond to the learning of the organisation. For social care organisations, this may involve incorporating the principles of the learning organisation at all levels of the organisation through leadership by team leaders, managers and senior managers (Michaux, 2006).

Challenges of learning organisational principles in the Human Services

Issues which have been found to arise when applying learning organisation principles to community service organisations include time and resource constraints, difficulties allowing appropriate time and space for reflective practice, problems promoting collaboration with other organisations due to funding induced segmentation and the rigid nature of hierarchical bureaucratic organisational structures (Michaux, 2006). In addition, a culture of blame and defensiveness about current practices in some child and family service organisations has been found to inhibit open communication about mistakes and therefore opportunities to learn from these incidents (Bostock et al., 2005).

Summary

Although the literature on effective professional development for child, youth and family services is limited, the existing evidence suggests that the development and implementation of professional development activities should incorporate the following key elements found to promote adult

learning and continuing professional education:

- Ongoing (delivered over a number of hours, across a sustained period of time)
- Active (engagement in meaningful activities, such as observing practice and being observed, planning implementation strategies for real work situations, presenting, leading discussions and written work)
- Social, coherent, and relevant to practice (forming a coherent program, promoting communication between colleagues and aligning with professional standards)
- Reflective (providing sufficient resources, including time and experienced supervisors and facilitators, for reflective processes).

Professional development activities should select from models based upon planning and policy goals, and an assessment of the learning needs, such as:

- Workshops (when presented as a cohesive series, that provide opportunities for active learning and reflection on how to apply the acquired knowledge and skills to real work situations)
- Supervision (an ongoing relationship with an experienced practitioner who facilitates reflection, learning and problem-solving of practice-based questions)
- Mentoring and coaching (both formal and informal)
- Accredited training courses
- Action learning (often in small teams identifying work-based problems and solutions).

Professional development activities should be facilitated by a workplace that

supports ongoing learning, through the four key aspects of a learning organisation:

- Organisational learning (organisational structures which ensure that individuals' learning is stored as knowledge within the organisation and used in practice by the organisation)
- Learning at work ('on the job' training which is context dependent)
- Learning climate (a culture of facilitating learning which is fostered by the organisation's structure and customs)
- Learning structure (management of the organisation has the flexibility to continually respond to the learning of the organisation).

Conclusions: Professional development in the CYFS workforce

Literature on what professional development works best for the CYFS workforce is limited. The existing evidence suggests that professional development for the CYFS workforce should incorporate several key elements that have been found to promote adult learning and continuing professional education. These key elements are that professional development is ongoing, active, social, coherent, reflective, relevant to practice and exist in a community which promotes learning. Specific professional development models should be selected to address the needs of the individual CYFS organisation with reference to incorporating these key elements of effective professional development. It is clear from the literature that workshops and accredited training courses can only serve as a foundation for professional development by expanding knowledge and skills. Workshops and training courses must be complemented

by ongoing support to implement changes in practice through professional development models such as mentoring, supervision and action learning all underpinned by critical reflection. In addition, professional development exists within an organisational culture which, through its structure and processes related on learning within the organisation, may enhance professional development.

What is also clear from this review of the literature is the limited attention to evaluating the efficacy or otherwise of professional development activities in child and family welfare contexts. This remains an area where more research is required to: first to identify what the expected outcomes might be that directly relate to children, young people and their families; and second make considered evidence informed decisions as to which of the variety of training and professional development strategies are the most cost effective to contribute to those outcomes.

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EVIDENCE TO INFORM OUT-OF-HOME CARE POLICY AND PRACTICE IN NEW SOUTH WALES: AN OVERVIEW OF THE PATHWAYS OF CARE LONGITUDINAL STUDY

BY MARINA PAXMAN

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About the artist: Billy Black grew up in care and her artwork was commissioned for this study. Billy said the drawing shows many pathways through the care system with a carer or caseworker acting as a guide, ultimately leading to independence for every young person. "Whether we live with family or strangers, study, work, or just try our best, the paths we choose and are guided through in our youth are what we use to prepare ourselves for the happiest adulthood we can achieve".

Introduction

Pathways of Care Longitudinal Study (POCLS) is a new large scale prospective longitudinal study that will follow the pathways and outcomes of children and young people in their first five years of out-of-home care (OOHC)

in New South Wales (NSW). The aim of this longitudinal study is to collect detailed information about the wellbeing of children placed in OOHC in NSW and the factors that influence their wellbeing. It will provide a strong evidence base to

inform policy and practice and, in turn, improve decision making about how best to support children and young people who have experienced abuse and neglect.

The NSW Department of Family and Community Services (FACS) is funding and leading the study, and has contracted a team of experts to provide advice on the study design and undertake data collection and longitudinal analysis. These experts are:

- A consortium of Australian researchers led by Dr Daryl Higgins and Diana Smart at the Australian Institute of Family Studies. The research consortium includes:
 - > Associate Professor Judy Cashmore, Socio-Legal Research and Policy, Law School, The University of Sydney
 - > Associate Professor Paul Delfabbro, School of Psychology, The University of Adelaide
 - > Professor Ilan Katz, Social Policy Research Centre, University of New South Wales.
- Dr Fred Wulczyn, Director, Centre for State Child Welfare Data, Chapin Hall, The University of Chicago.
- Mr Andy Cubie, I-view, a social research data collection agency.

Ethics approval for the study was granted by the University of NSW Human Research Ethics Committee and the Aboriginal Health and Medical Research Council Ethics Committee.

This article introduces POCLS and describes how it will provide a robust evidence base to inform OOHC policy and practice in NSW.

Out-of-home care in New South Wales

Out-of-home care is alternative care for children and young people under 18 years who are unable to live with their parents, often due to risk of significant harm from physical, sexual and emotional abuse, and neglect. Entry into OOHC occurs for a variety of reasons, but mostly because factors such as parents' poor mental health, substance misuse and/or domestic violence impair parenting capacity.

The NSW Children's Court and FACS, (as the statutory child protection agency), are empowered to make critical decisions about parental responsibility and the care plan for children and young people who are at risk of significant harm. Decisions made by both these organisations aim to improve the long-term safety and wellbeing of children and young people and to be evidence informed.

In NSW, 18,300 children and young people were in OOHC at June 30, 2013 (NSW Department of Community Services, 2014). The main placement types are relative/kinship care (52.7%) and foster care (38.7%), with only a small number of children and young people in residential care (2.8%). Aboriginal children and young people are over-represented in OOHC in NSW and make up 35.4 per cent of the OOHC population (NSW Department of Community Services, 2014) compared with only 4.7 per cent of children and young people under the age of 18 years in the population (Australian Bureau of Statistics, 2011).

In NSW, a series of Government improvements to OOHC is being implemented following the release of *Keep Them Safe*, the Government's

response to the Wood Special Commission of Inquiry into Child Protection Services in NSW. *Keep Them Safe* outlines a number of actions to improve OOHC (NSW Department of Premier and Cabinet, 2009). A key reform is the transfer of case management to the non-government sector, improved timing of health assessments, and education plans for all children and young people in OOHC.

The case management framework for OOHC is the NSW Standards for Statutory OOHC developed by the Children's Guardian. The standards aim to ensure that children and young people are safe, developing well in a stable and positive environment matched to their needs and, where possible, successfully restored to their family. The standards set out that children and young people's rights are a primary focus for their care, they have a positive sense of identity and connections with family and significant others, they contribute to decisions relating to their lives, and that carers are supported to raise children and young people (NSW Office of the Children's Guardian, 2013).

Outcomes for children and young people in out-of-home care

For many children and young people, being in OOHC improves their wellbeing (Fernandez, 2009). However, research in Australia has found that children and young people in OOHC fare poorly in comparison to the general population in terms of their physical health, social and emotional wellbeing, and learning and cognitive development (Cashmore & Paxman, 2006; Fernandez, 2009; Nathanson & Tzioumi, 2007; Octoman, McLean & Sleep, 2014; Osborn & Bromfield, 2007; Sawyer, Carbone, Searle & Robinson 2007; Tarren-

Sweeny, 2008; Townsend, 2012; Vimpani, Boland, Barr & Marshall, 2012). While there is evidence that children and young people in OOHC have poorer developmental outcomes compared to those in the general community, it is not clear to what extent this is due to abuse and/or neglect prior to entering OOHC, the experience of OOHC itself, or a combination of both factors.

In the past decade there have been several audits of OOHC research in Australia (Cashmore & Ainsworth, 2004; Bromfield, Higgins, Osborn, Panozzo & Richardson, 2005; Bromfield & Osborn, 2007; McDonald, Higgins, valentine & Lamont, 2011). These audits have found that, while individual studies were of high quality and provide important insights for policy and practice, more research is needed to provide a stronger evidence base. There are a number of methodological limitations to existing research on OOHC in Australia including reliance on cross-sectional designs, single sites, low response rates, small sample sizes and use of non-validated measures.

Bromfield and colleagues (2007) argued there is a clear need for a large scale prospective longitudinal study of children and young people in OOHC to examine developmental trajectories over time in order to identify factors that improve wellbeing.

Pathways of Care Longitudinal Study: Scope and objectives

POCLS is a large scale prospective longitudinal study that has a broad scope and collects detailed information about the characteristics and circumstances of children and young people on entry to OOHC, the experiences of children and young

people in OOHC, and their developmental trajectories in, through and out of OOHC. The key developmental outcomes of interest in this study are physical health, socio-emotional wellbeing and cognitive/learning ability.

POCLS objectives are to:

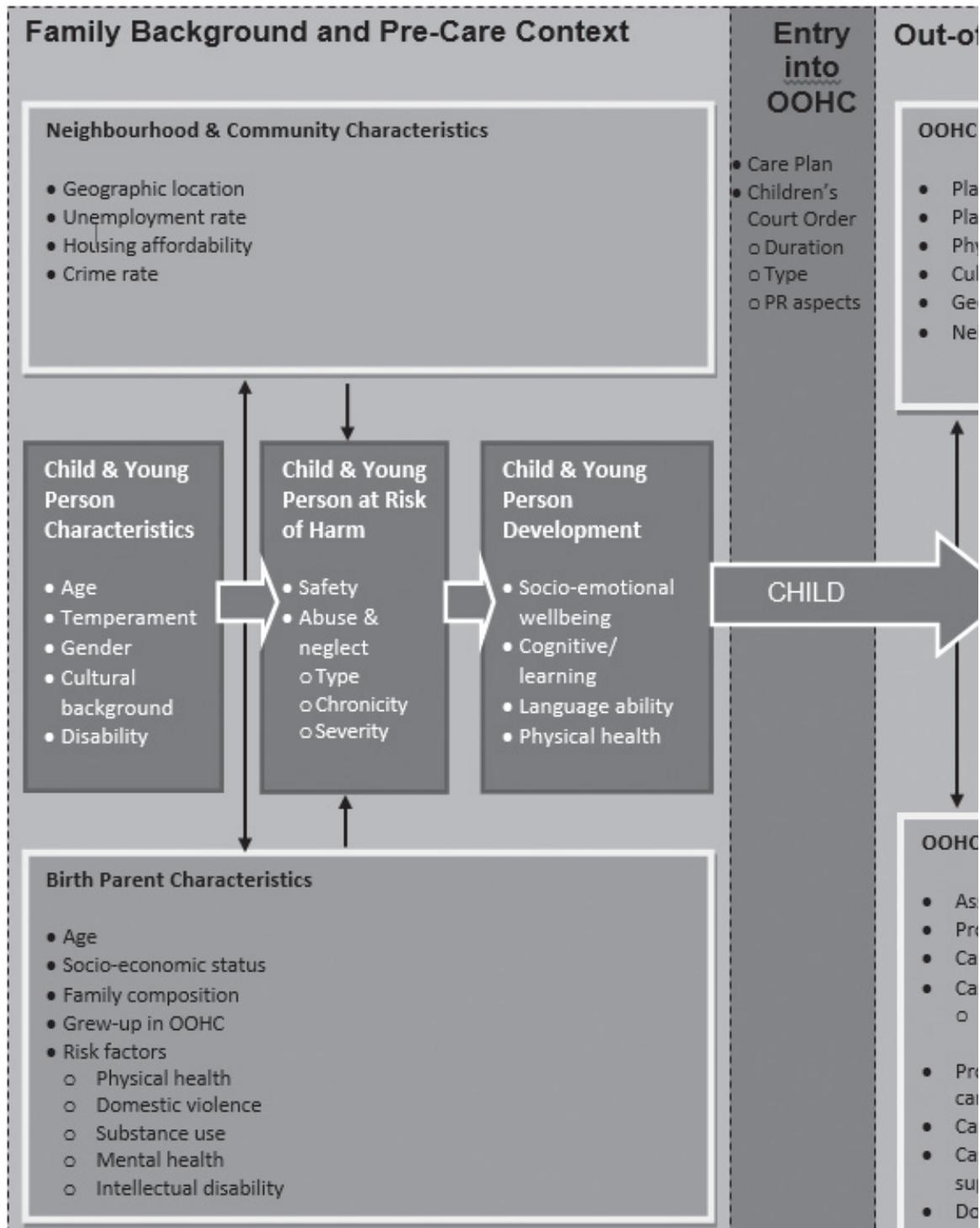
- Describe the characteristics, child protection history, development and wellbeing of children and young people at the time they enter OOHC on Children's Court orders for the first time.
- Describe the services, interventions and pathways for children and young people in OOHC, post restoration, adoption and on leaving care at 18 years.
- Describe children and young people's experiences while growing up in OOHC, post restoration, adoption and on leaving care at 18 years.
- Understand the factors that influence the developmental outcomes for children and young people who grow up in OOHC, are restored, adopted and on leaving care at 18 years.
- Inform policy and practice to strengthen the OOHC service system in NSW to improve the outcomes for children and young people in OOHC.

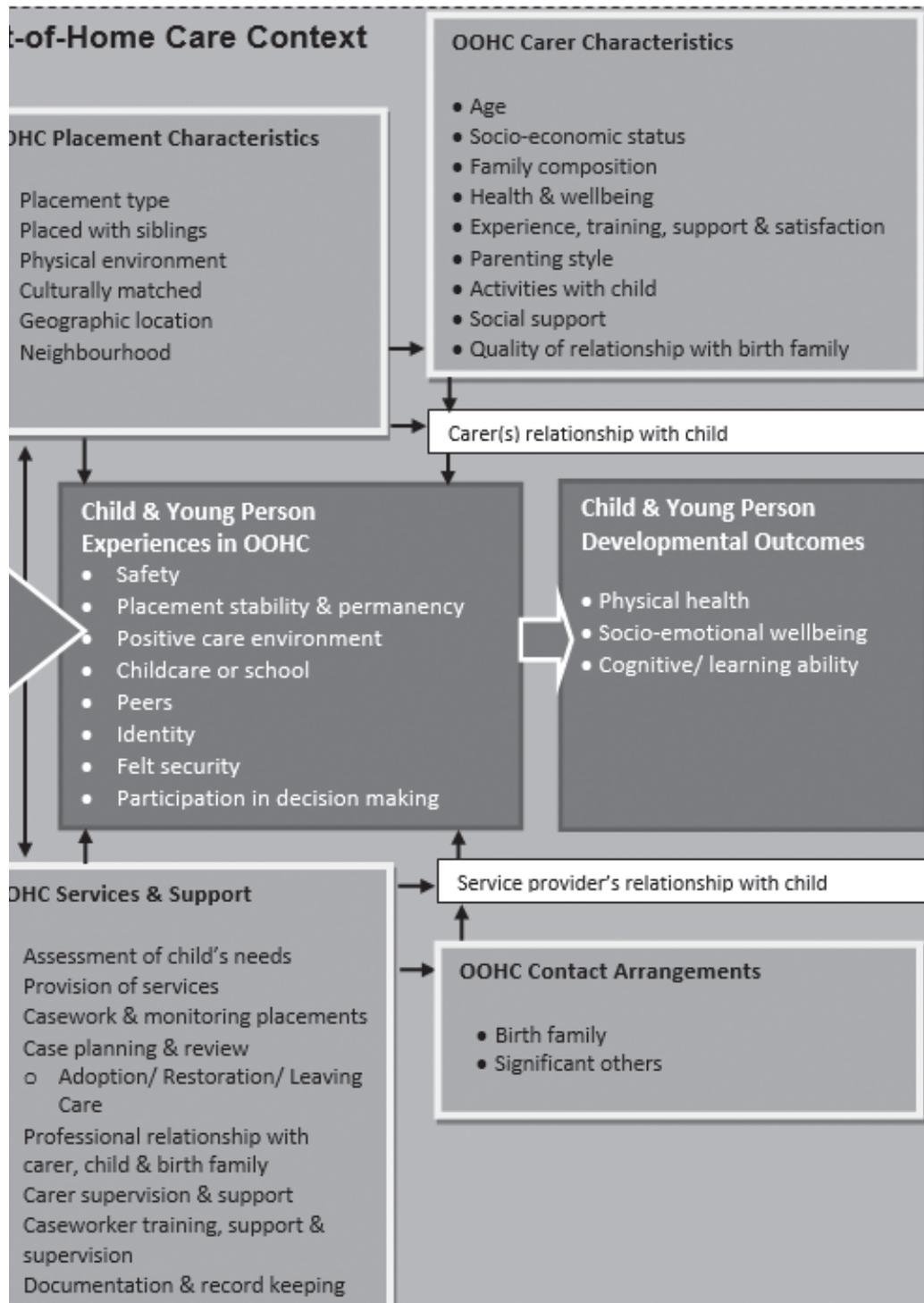
This study aims to measure the key factors associated with children and young people's care and wellbeing as described in the research literature and the NSW Standards for Statutory OOHC. In order to capture the complexity of the factors associated with developmental outcomes for children and young people in OOHC, a conceptual overview was developed. As shown in *Figure 1*, these factors include:

- Family background and pre-care context including birth family characteristics, parental risk factors, and type and chronicity of abuse and/or neglect
- Decisions made by the Children's Court and FACS, as the statutory child protection agency, on entry into OOHC; and
- OOHC service system including a number of factors that may improve or worsen a child or young person's experiences and developmental outcomes while in OOHC.

The risk and protective factors in OOHC include: placement characteristics (e.g. type of placement, if placed with siblings, neighbourhood); carer characteristics (e.g. socio-economic status, health, parenting style, social support); the services and supports provided to the child or young person and their carers; and contact with birth family. *Figure 1* illustrates how these factors may relate to each other to influence a child or young person's experience of OOHC and shape their developmental outcomes.

Figure 1: Conceptual overview of factors influencing outcomes of children and young people in out-of-home care





Pathways of Care Longitudinal Study: Sample and data sources

The sample frame for POCLS is all children and young people aged 0-17 years entering OOHC for the first time on interim orders under the *Children and Young Persons (Care and Protection) Act 1998* across NSW over an 18-month period between May 2010 and October 2011 (n = 4126). POCLS includes children of all ages, all geographic locations in NSW, and all placements with government and non-government agencies. A total of 2827 of 4126 children and young people went onto receive final Children's Court orders. This study is collecting primary and secondary data about the children and young people who received final Children's Court orders.

Three face-to-face interviews are conducted with caregivers, children and young people with an 18-month interval between waves. Carers are invited to participate in the study soon after the final Children's Court order is signed. Standardised measures are administered to children from the age of three years and interviews are conducted with children from the age of seven years. Wave 1 provides baseline data from which to measure how children and young people are faring in Waves 2 and 3. Appendix 1 provides a summary of POCLS questions and measures selected to examine child wellbeing, and carer and placement characteristics.

Brief online surveys of childcare workers, teachers and caseworkers are being conducted in Wave 2 to capture the perspectives of professionals providing education, services and supports for the children and young people participating in POCLS.

Data from the interviews with carers, children and young people, teachers and caseworkers will be linked to administrative data through record linkage in order to provide a broader range of outcome measures for POCLS. As well as FACS administrative data, which will provide information on child protection and OOHC, the study aims to link the following administrative databases to the primary data in POCLS:

- Australian Early Development Census (AEDC) Checklist (Federal Department of Education)
- National Assessment Program: Literacy and Numeracy (NAPLAN) tests for Years 3, 5, 7, 9 (NSW Department of Education and Communities)
- Health records of the child (NSW Ministry of Health)
- Youth offending data (Bureau of Crime Statistics and Research).

Record linkage will enable examination of the outcomes for children and young people in the larger cohort with similar abuse and neglect backgrounds (n = 4126) with those in the study eligible cohort (n = 2827). Record linkage provides the opportunity to compare these two groups of children on school readiness, school achievement, physical and mental health status and offending behaviour as well to compare these children to their age-related peers in the community. It will also enable exploration of how outcomes for these two groups relate to characteristics of the family background and the pre-care context.

Record linkage will also enable researchers to examine the representativeness of the interview sample at each wave of data collection,

which will assist with understanding the generalisability of the results.

A detailed description of the POCLS study design and data collection methods is published in Paxman, Tully, Burke & Watson (2014).

Measuring child wellbeing

To measure the wellbeing of children and young people in POCLS, a range of quantitative and qualitative questions, and standardised measures, are used. The measures were selected based on their psychometric properties, the availability of normative or comparison data, suitability for OOHC populations and acceptability to carers.

Children and young people's physical health is measured by carer-rated questions to determine health conditions of children (including disabilities), services and supports for health conditions, changes in health conditions over time as well as questions about diet, sleep and weight. The carer-rated Ages and Stages Questionnaire (ASQ3: Squires & Bricker, 2009) is also used to measure gross and fine motor skills (as well as communication, problem-solving and personal-social domains) in children aged up to 60 months. The child's NSW Health 'Blue Book' was scanned at Wave 1 if the carer had it to record the health information contained for children in OOHC.

To measure socio-emotional wellbeing, two standardised carer-report measures are used depending on age: the Brief Infant Toddler Social Emotional Assessment (BITSEA: Briggs-Gowan et al., 2004) is used for children aged one to two-years-old and the Child Behaviour Checklist (CBCL: Achenbach & Rescorla, 2000; 2001) is used for carers of children three to 17-years-old. The

CBCL is a gold standard measure of externalising and internalising behaviour problems and interpersonal competencies. Information is also collected on services and supports for mental health problems, behaviour problems in the school environment, and whether or not the child is prescribed psychotropic medication for their behaviour. Children and young people aged seven years and older are also asked questions about their socio-emotional wellbeing, peer relationships, friendships, school, health, carers and caseworkers.

To examine children's cognitive/learning ability, measures include the widely used Peabody Picture Vocabulary Test 4th Edition, reflecting language comprehension (PPVT: Dunn & Dunn, 2007), which is administered to children and young people three years and older. The Matrix Reasoning Test from the Wechsler Intelligence Scale for Children (WISC: Wechsler, 2003), which measures non-verbal reasoning, is administered by interviewers to children and young people aged six years and older. These measures have norms which enable comparisons to children and young people in the general population. Educational outcomes are also examined through questions about school performance, such as grades attained.

Measuring factors that influence child wellbeing

Based on the conceptual overview provided in *Figure 1*, a range of caregiver and placement characteristics known to be associated with the outcomes of children and young people in OOHC were selected for measurement in POCLS. These characteristics include safety, placement type, placement stability, caregiver

physical and mental health, parenting style, difficult behaviour self-efficacy, carer experience, relationship with partner, support network, and caregiver household and socio-demographic characteristics. Questions also capture services and supports provided to the child or young person and their carers including casework and monitoring of the placement; case planning and review; the level of contact the child or young person has with their birth family and significant others; caregiver training and support; and satisfaction with support and services.

Discussion: The potential for the Pathways of Care Longitudinal Study to inform policy and practice

As POCLS is a large scale, prospective longitudinal study, it will provide a solid evidence base to inform OOHC policy and practice and potentially improve wellbeing of children and young people. The study will examine how child protection history, parental risk factors, system response, type of court order, placement and carer characteristics interact with each other to influence child and young person outcomes over time.

The scope of POCLS is broad and there are many possibilities for analyses of the data to inform policy and practice. For the purposes of this paper, we have selected four key areas of decision making, policy and practice that are likely to be informed by POCLS findings. These include:

1. Critical decisions by child protection workers and the Children's Court professionals
2. Policy and practice around placement in relative/kinship care
3. Policy and practice around service provision; and

4. Policy and practice around contact with birth family.

(1) Improving critical decisions by child protection workers and the Children's Court professionals

POCLS has the potential to improve decisions by child protection workers and the Children's Court professionals, by comparing outcomes for children and young people who went on to receive final Children's Court orders versus those on interim orders who were returned to their families. Approximately one-third of the children and young people (n =1299) in the POCLS sample who received interim orders returned home and the remainder went on to receive final Children's Court orders (n=2827). Most previous research studies investigating the effects of OOHC have compared outcomes of children and young people in OOHC with age-related population norms. Given that one group of children has a child protection history while the other does not, it is not surprising that there are marked differences in developmental outcomes between the two groups. The design of POCLS enables a unique comparison of these two groups of children, both of whom have been exposed to child abuse and neglect, which will examine how returning home versus staying in OOHC influences child outcomes. While there may be differences in the characteristics of these two groups, they will not be substantial in comparison to children and young people with no child protection history.

These analyses will help inform decisions made by child protection workers and Children's Court professionals by gaining a better understanding of outcomes of children with abuse and neglect backgrounds

who return home compared to those who remain in OOHC.

(2) Improving policy and practice around relative/kinship placement

Despite being the major component of home-based OOHC placements in NSW, relative/kinship care is under-researched. National and international studies suggest that the types of children and young people placed in relative/kinship care may differ from those in other types of OOHC, such as foster care and residential care, and different developmental trajectories may result (Paxman, 2006). Children and young people in relative/kinship care are generally more stable in their placements and are also less likely to be restored to their birth parents (Winokur et al., 2009; Delfabbro et al., 2013). Given that there is widespread discussion on the impact of parenting responsibilities on grandparents (Brennan et al., 2013), POCLS will provide a much-needed profile of children and young people placed in relative/kinship care and how these compare with those in foster care, and the characteristics of the pre-care context. The study will also provide a comparison of carer characteristics and demographics and how these factors influence child wellbeing. Research shows that casework and service use may differ between kinship, foster and residential care, and that kinship carers in particular lack access to support services (McHugh, 2013).

The findings of this study have the potential to improve policy and practice around what placement types lead to positive outcomes for which children, and what services and supports are needed.

(3) Improving policy and practice around service provision

Other than the OOHC placement, the provision of services is the most important resource provided to children and young people in OOHC and their carers. There is a lack of research on the contribution of various services and interventions to wellbeing in different care settings. This study has the potential to improve service provision in OOHC by identifying which services or interventions improve wellbeing for different groups of children and young people. POCLS will examine the link between services and interventions received at Wave 1 and developmental trajectories for children with health problems and/or physical disability; those with emotional or behavioural problems in the clinical range; and those with below average cognitive development. It is expected that POCLS will improve our knowledge about the services, supports and interventions that are likely to improve outcomes for children and young people, and any gaps in service provision that need to be addressed.

Caseworkers play a key role in facilitating access to appropriate services for children and young people and their carers. POCLS will examine the perceived quality of the caseworker-child and caseworker-carer relationship, the consistency of casework provision, including changes in caseworker and frequency of contact, and the links between casework provision, service access and child wellbeing. The findings of this study will inform caseworker training, supervision and quality assurance.

(4) Improving policy and practice around contact with birth family

Children and young people's

relationships and contact with birth family and significant others are understood to be important elements of their experience in OOHC and may be associated with placement stability, restoration and wellbeing. There is evidence that good quality contact with birth family, along with appropriate services and supports, may promote positive outcomes for children in OOHC, however, research also suggests the poor quality contact may be harmful for children (Sen & Broadhurst, 2011). Overall there is a lack of robust research on contact, particularly on sibling contact, and the impact of contact on child wellbeing (Sen & Broadhurst, 2011). POCLS will examine many factors related to family contact, such as the type and frequency of contact with different family members, barriers to contact, the role of the carer in maintaining contact, the quality of children's relationships with family members and others who are significant in their lives, and children's perceptions of 'felt security' in their first years in OOHC.

At present, there is considerable policy and practice debate about the amount of contact children should have when they are in OOHC, with whom, at what ages and under what circumstances. POCLS has the potential to inform policy and practice around contact with birth family and significant others.

Conclusion

This article describes POCLS and the potential for the study to inform OOHC policy and practice in NSW. Children and young people's trajectories in the first five years in OOHC are captured in POCLS. Wave 1 data collection provides comprehensive baseline data on children's experiences and development at the commencement of

OOHC on final Children's Court orders. Monitoring children's wellbeing across waves of data collection will enable researchers to examine the factors that influence a child's experience of OOHC and that shape their developmental outcomes.

A series of reports will be published after each wave of data collection. From the end of 2014, a collection of policy and research reports based on analysis of Wave 1 data by the expert academics and researchers will be available.

For more information about the study visit the study webpage www.community.nsw.gov.au/pathways.

Acknowledgements

We would like to acknowledge the leadership provided by the POCLS Chief Investigator Marilyn Chilvers (FACS) and the contributions to the study design by previous colleagues: Peter Walsh, Margo Barr and Matthew Gorringer (FACS); Carol Soloff (AIFS) and Michelle Ernst (University of Chicago). We would also like to extend our thanks to Toulia Kypreos (FACS) who enthusiastically recruited 1788 caregivers to this study and Rachelle Brown (I-view) who has managed the fieldwork.

We would like to make a special mention of the contributions to this study by the late Professor Jacqueline Goodnow, Macquarie University, who was a member of the Department's Research Advisory Council. Jackie's leadership at the inception of the study and during the study design phase was invaluable. We appreciate the exceptional experience and knowledge Jackie brought to the study.

Appendix 1: POCLS questions and measures for carers, children and young people to examine child wellbeing; and carer and placement characteristics

Domain	Questions and standardised measures	Respondent
Children's Wellbeing		
Physical health & development	Ages and Stages Questionnaire (ASQ3; Squires & Bricker, 2009) (study age: 9 months-5 years)	Carer
	Questions about health conditions, services received, immunisation, height, diet, weight, sleep	Carer
	Questions about health concerns; smoking, alcohol, drinking; services and support	Young person 12-17 years
Child socio-emotional development	Short Temperament Scale for Infants, Toddlers and Children (STSI; Fullard, McDevitt & Carey, 1984) (study age: 9 months-7 years)	Carer
	School Aged Temperament Inventory (SATI; McClowry, Halverson & Sanson, 2003) - short form (study age: 8-17 years)	Carer
	Brief Infant Toddler Social Emotional Assessment BITSEA; Briggs-Gowan et al., 2004) (study age: 12-35 months)	Carer
	Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2000) (study age: 3-17 years)	Carer
	Ages and Stages Questionnaire (ASQ3; Squires & Bricker, 2009) (study age: 9 months-5 years)	Carer
	School Problems Scale (Prior, Sanson, Smart & Oberklaid, 2000)	Young person 12 years plus
	School Bonding Scale (O'Donnell, Hawkins & Abbott, 1995)	Young person 12 years plus
	Short Mood & Feeling Questionnaire 13-item scale (Angold et al, 1995).	Young person 12 years plus
	Self Report Delinquency Scale 10 item scale adapted from (Moffitt & Silva, 1988)	Young person 10 years plus
	Felt Security activity to show who they feel close to (adapted from the Kvebaek Family Sculpture Technique; Cromwell, Fournier & Kvebaek, 1980)	Child 7 years plus
	Questions for carers about family contact, services and supports for child emotional and behavioural problems, problems at school, child psychotropic medication	Carer
	Questions for children and young people about peer relationships, friendships, bullying, number of schools attended, feelings, services, relationship with carers and caseworkers	Child 7 years plus

Domain	Questions and standardised measures	Respondent
Cognitive/ Learning & Language Ability	Communication and Symbolic Behaviour Scale Infant and Toddler Checklist (CSBS ITC; Wetherby & Prizant, 2003) (study age: 9-23 months)	Carer
	MacArthur-Bates Communicative Developmental Inventories (MCDI-III; Fenson et al., 2007) (study age: 30–35 months)	Carer
	MacArthur Communicative Development Inventories—Short form (Fenson et al., 2000) (study age: 24–29 months)	Carer
	Peabody Picture Vocabulary Test (PPVT-IV; Dunn & Dunn, 2007)	Child 3 years plus
	Matrix Reasoning Test from Wechsler Intelligence Scale for Children (WISC-IV; Wechsler, 2003)	Child 6-16 years
	Questions for the child are about access to a quiet place to study; support; identity; participation in decision making; bullying, awards. For young people 14 years and older further education and training, living skills, aspirations	Child 7 years plus
	Questions about current schooling (usual grades at school, changes in schools, repeated years, school problems), services, support. For children aged 15 and older, questions on work and further education, life skills and plans for leaving care	Carer
Carer and Placement Characteristics		
Services and support – child view	Questions about caseworkers, feel listened to, involvement in case planning, access to services and support	Child 7 years plus
Services and support – carer view	Questions about the availability of caseworkers, case planning and review, casework & monitoring, carer training and support, family contact	Carer
Parenting practices/ style/ self- efficacy	Parenting Warmth (Paterson & Sanson, 1999)	Carer
	Parenting Hostility (Institut de la Statistique du Québec, 2000)	Carer
	Parenting Monitoring (Goldberg, Spoth, Meek & Moolgard, 2001)	Carer
	Difficult Behaviour Self-Efficacy Scale (DBSES; Hastings & Brown, 2002)	Carer
	Questions about relationship with carer; how happy you are in the current placement; if carers are helpful, listen, spend time with you, praise you	Child 7 years plus
Carer psychological distress	Kessler K10 (Kessler et al., 2003)	Carer
Carer satisfaction with services & support	Satisfaction with Foster Parenting Inventory (SFPI) – Social Service Support Satisfaction Scale (Stockdale, Crase, Lekies, Yakes & Gillis-Arnold, 1997)	Carer
Carer characteristics	Questions about socio-demographic characteristics; relationship with partner; relationship with study child; carer experience and training; family activities; support network; carer physical health; cultural background and cultural activities	Carer
Social Cohesion	Social Cohesion and Trust Scale (Sampson, Raudenbush & Earls, 1997)	Carer
Placement characteristics	Questions about household composition, size, location, neighbourhood	Carer

Note: Other data sources for POCLS are record linkage to government data, caseworker survey and teacher survey.

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PRINCIPLES IN PRACTICE

BY KERRY LANE

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Introduction

In late 2011 the New South Wales (NSW) Department of Family and Community Services (FACS) began the roll out of a new service model titled 'Practice First'. The model was developed in response to growing concern about how practitioners respond to reports about the safety of children. What was worrying was the amount of time practitioners spent behind their computers rather than with families. Their work was dominated by administrative tasks, procedures and tools. Work with families was often forensic and at times adversarial. These problems were not unique to NSW, and most statutory child protection systems worldwide have faced similar challenges where the management of risk has resulted in burdensome administrative requirements that have inadvertently deskilled the workforce. In addition, FACS data highlighted system weaknesses and unmet demand within NSW including an over-representation of Aboriginal children, limited capacity to meet demand, timeliness of response and a high number of children in care.

The design of Practice First was influenced by a broad range of research and practice initiatives in other jurisdictions (Munroe, 2012; Sawyer & Lohrbach, 2005; Hackney, 2008). The focus of Practice First is on changing

the practice culture across the spectrum of work with families: assessment, intervention and collaboration with partner agencies. The model operates under the clear mandate established under the Care and Protection Framework¹ which is to understand each child's experience, build relationships with families and communities using collective wisdom, skills and courage to achieve change. The three essential components of Practice First are culture, people and systems. These elements aim to develop a child protection culture founded on 10 principles of practice, where casework is delivered in teams, risk is shared and systems are supportive of and give legitimacy to spending time working with families.

Implementation of principle based practice

Following a pilot of Practice First in Mudgee and Bathurst, FACS rolled out Practice First in December 2012 to 15 centres including the Gosford Community Service Centre (CSC). The idea of principle based practice was warmly accepted at Gosford CSC and the Practice First model was viewed as a vehicle that provided workers with the permission to question current practices

¹ The Care and Protection Framework articulates the mandate, values and principles that underpin child protection practice in NSW.

and the freedom to craft its own solutions to casework challenges. It was decided by the Gosford CSC that applying the 10 practice principles to the Children's Court arena would be a good litmus test of the veracity of a principle based approach and of staffs' commitment to such an approach. While the team acknowledged and discussed all 10 principles in relation to their work with the court, the following focuses on some of the major changes implemented and highlights the principles on which they are based.

Building relationships

There is consensus in the literature that the quality of the relationship between professionals and family members is key to achieving successful change (Ashley & Nixon, 2007; De Boar & Coady, 2007; Turnell & Edwards, 1999). Principle 9 of Practice First states that the quality of relationships makes a significant impact on effectiveness. Relationship based practice relies on caseworkers and families investing themselves in the relationship. This 'investment' and the partnerships formed with families is a key driver of change. Helfer and Kempe (2008) argue that building a relationship with abusive and neglectful parents is one of the most difficult to establish. In Gosford, such challenges are most evident when Community Services is required to exercise its most intrusive statutory powers.

At the beginning of implementation, caseworkers were worried that removing a child from a family that they had been working with would mean the end of their positive working relationship. This worry did not however translate into reality. Caseworkers reported that despite the fact that they have had to remove children from the care of their

parents, they observed parents' willingness to continue to engage in casework with them. This is due to the relationship that was developed between the caseworker and the family prior to the removal, and the level of honesty and transparency that existed in these relationships. Caseworkers were observed to be more open and approachable during their work, and put a greater amount of thought and energy in preservation casework prior to any entry into out-of-home care. Even though parents, naturally, are not happy with decisions that involve the removal of their children, practitioners found that more parents conceded to Long Term Orders, either at Dispute Resolution Conferences or prior to a final hearing and cross examination. This has resulted in less hostility and ultimately enhanced opportunity to negotiate good contact arrangements and re-negotiate a meaningful future role for parents in their children's lives that goes well beyond the historically standard four times per year supervised contact. The team also learnt that relationship based practice was more than just getting along with parents. It was about altering their own perceptions about parenting capacity and seeing them as being more cooperative, engaged and willing to make or agree to changes in the interest of their children.

Respectful and accessible language

Group supervision is an integral part of Practice First and has been the major vehicle or space for a change in practice to commence. Lohrbach (2008) describes group supervisions as "a place where emotional support is available, questions can be responded to, professional development and leadership skills can be honed and where social work knowledge, research and skills can come alive and have

meaning in the field.” The instigation of group supervision in Gosford meant that decisions about the lives of children and their family were talked about, challenged, supported and scrutinised by colleagues within and outside of the department. One session that proved to be pivotal to the start of a new way of working in the court arena and maintaining our integrity and relationship with parents was the case of ‘Jeremy.’

Jeremy had been removed shortly after birth and an Application for Assessment Order was sought. During group supervision, the group decided to write the Application for Assessment in a ‘Practice First’ or principled way. Jeremy’s father was only 16 years of age and his mother was slightly older but had a significant developmental delay. A draft of the Clinic Assessment terms of reference had been completed prior to the group supervision session and was drafted in the professional language that we had become accustomed to in the court. It read as follows:

Assessment of the Natural Mother's cognitive ability and current mental health status and the impact on same on her parenting capacity and coping skills. Including an assessment of:

A The Natural Mother's intellectual capacity and executive functioning skills.

When this was discussed in group supervision and viewed from a parent’s perspective, the team quickly decided that neither parent would understand what was being assessed and thus gaining their consent to any Assessment Order would be considered tokenistic. With the input from the psychologist, the terms of reference was rewritten in a

language the parents could understand as detailed below:

You will meet with someone who will get you to do activities such as blocks or puzzles. They will show you pictures and will ask you questions. Some questions will be easy and some will be harder for you to answer. We want this done as it will help us and you see how you think and how you feel and how well you remember things, how easy or hard it is for you to learn new things and how easy or hard it will be for you to plan and do things for Jeremy.

Someone will also be asking you some questions. They will ask you questions about what it was like for you growing up and how you were looked after and things that happened to you. They will ask you what your life is like now and your relationships with Jeremy's dad and grandmother and other people in your life. They will watch you with Jeremy just like when you are at contact. This will help us figure out if you can look after Jeremy and keep him safe and away from people and things that might hurt him.

Once developed it was apparent that the language was so basic that it would not be acceptable to the Children’s Court Clinic, and so the original terms of reference was lodged with the Court (for the eyes of the professionals) and the alternate terms of reference (which mirrored the original but in basic language) was provided to the parents. The caseworker took the alternate terms of reference out to Jeremy’s family to discuss and then wrote an affidavit outlining her conversation with the parents. This affidavit clearly demonstrated that the parents

understood what would happen to and be expected of them and their agreement or consent to such an assessment.

This example reflects the importance of Principle 4, that language impacts on practice. Consistent with the importance of respect, the language used to talk with and about parents models the culture and values of the organisation. This simple change in language shows caseworkers' capacity to view things from the parents' perspective, to be open about pending procedures and decisions, and makes processes such as consent meaningful.

Respect for families and context

The success of using group supervision to write an Assessment Application naturally led to group supervision being used to develop the Care Plan for Jeremy's family. The Care Plan template is such that the final order being sought is outlined at the beginning of the document. Experience has shown that when the first thing parents see is 'Parental Responsibility to the Minister to 18 Years', they become either too angry or too upset to continue reading. It has an immediate and alienating effect. The group restructured the Care Plan. Background information was placed at the beginning of the plan and outlined the parents' own experience of being parented and how this might have impacted on their ability to parent, and the supports that were or were not available to them. It also described their relationship with their children, acknowledging both their strengths and limitations. The narrative then flowed seamlessly onto the restoration section and whether this was a realistic possibility. Also included in the Care Plan was a section on what the parents would need to do in the future for a

Section 90 to be considered. Setting such targets or benchmarks means that both families and workers are clear and open about what needs to change and what such change looks like. It creates visible actions and expectations.

By making these very little changes, the parents are left with a more comprehensive understanding of why their child came to be removed from their care and roots this decision firmly in the context of the family's past and present life. Parents are transformed from 'bad people' to people who face many challenges that impact on their capacity to keep their children safe. It describes and evaluates the actions, not the person, and in doing so enacts Principle 2, that families have a right to respect. When parents can see that the order sought is not about a government agency saying that they don't love their child, but rather that despite their best intentions they simply aren't in a position to implement safe parenting, they are much more accepting of the decision. This change is a simple example of narrative therapy - of challenging someone's dominant story. It also exemplifies Principle 3, which requires an appreciation of context to strengthen practice. This helps practitioners identify strengths on which they can build. Being curious and writing holistically about a case also allows the practitioner to remember that, despite the efforts of parents and caseworkers, it is in the best interest for some children to be placed in out-of-home care.

Respectful writing in which the family is viewed as the primary audience has led to other benefits. Care Plans are now more 'child focused', outlining what the children need now and in the future rather than just focusing on negative information about their parents. When

these children eventually read their Care Plans, they will get a better sense of why the decision was made and how much their parents cared for them, wanted them, and fought for them.

Challenges

While the story of 'Jeremy' illustrates the success of a principle based approach, implementation was not always simple. One of the key challenges was tension between the other arms of the agency such as Legal Services, that had not been exposed to the Practice First model and associated principles at the same time as Gosford Community Service Centre. This resistance was however useful as it was a test of practitioners' and the agency's commitment to this new way of working and the integrity of the model. With Legal Services' subsequent endorsement of these changes, Community Services is now one step closer to making this way of working in the Court arena a statewide practice.

Conclusion

It is early days for Practice First and principle based practice, and further robust enquiry is required to determine if this approach is as good as initial feedback would suggest. These examples of small but significant changes in practice show how a shift in culture can begin. The promotion of principle based practice was supported by efforts to increase staff competency through supervision, coaching and training. Leadership at the local and system level was important for managers at various levels of the organisation championing change and looking for ways to align everyday practice with the organisational principles. Administrative supports and the overarching Care and Protection Framework also provided organisational

impetus and permission to develop principle based practice. There is still much to be done and much to learn. But the combination of small changes, quick wins and positive feedback from families has created an eagerness, hope and inspiration among practitioners about the possibilities for their own practice and the outcomes for children, young people and families.

Standing steadfast to the Principles has proved necessary to shift practice in a domain that is so strongly governed by legislation, policies and an investigative and forensic culture. Practitioners at Gosford Community Service Centre had to follow the words of Thomas Jefferson and "On matters of style, swim with the current, on matters of principle, stand like a rock." 'Standing like a rock' could arguably be the 11th Principle for Practice First.

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A REVIEW OF PRE-BIRTH CHILD PROTECTION PLANNING IN A TERTIARY MATERNITY HOSPITAL: ENGAGING VULNERABLE PREGNANT WOMEN

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Data collected by the Social Work Department at King Edward Memorial Hospital (KEMH), the tertiary maternity hospital for the state based in Perth, Western Australia, between 2005-2006 and 2007-2008 revealed a doubling of newborns entering the care and protection system (Harrison, 2009), turning attention to the inter-sectoral relationships between maternity hospitals and child protection services. This paper describes (1) the context for the development of policy and child protection based practice at maternity services; and (2) the process of Inter-Agency Early Intervention Pre-Birth Planning based at KEMH.

In a summary of child deaths from abuse and neglect, the Australian Institute of Family Studies stated that, in all jurisdictions, infants accounted for a large proportion of all registered child deaths from abuse and neglect (AIFS, 2014). Child death reviews in Australia also drew attention to the high representation of these infants who were already known to child welfare authorities or whose siblings had been notified previously to child protection authorities. These reports highlighted

the fact that the circumstances leading to abuse or neglect were pre-existing and identifiable before the birth of that child (Child Deaths and Critical Reports Unit, 2006; Child Death Review Committee, 2007; Report of the Queensland Ombudsman, 2003; Victorian Child Death Review Committee, 2000). In 2007-2008, the Australian Institute of Health and Welfare (AIHW, 2009) reported that nationally 44.7 per cent of all verified cases of child abuse and neglect and 42 per cent of all children admitted into out-of-home care were under five years of age; 39 per cent of these children were under 12 months. In the following year, Child Protection Australia 2009-2010 (AIHW, 2011) reported that the concerns of harm to children aged less than one year of age were most likely to be substantiated, at the rate of 13 per 1000 children. The reports of the deaths of infants drew the attention of the media and politicians. For example, in Western Australia the issues arising from the death of 11-month baby Wade Scale, found drowned in the bath, was discussed in the West Australian Legislative Council on 38 occasions for two weeks in the month of August 2006

when the Coroner's findings were first reported in the newspapers (Hansard, 2006).

Against this backdrop maternity hospitals and child protection agencies developed reciprocal agreements, the aims of which were to (a) intervene early to reduce the need for infants to be taken into statutory care, (b) facilitate and encourage vulnerable women to participate in health care critical to their own health and the health of the developing fetus, and (c) facilitate a less crisis driven and traumatic process when statutory care is needed.

Pre-birth child protection planning: Context for the development of policy and practice

In all the Australian States and Territories, legislative reform placed the responsibility on maternity services and child protection authorities to develop early identification and screening tools and to facilitate information exchange to strengthen referrals and follow up (Gallagher, 2006; Jacob & Fanning, 2006). In Western Australia the *Children and Community Services Act 2004* was amended in 2010 to enable exchange of information between services and for the Department for Child Protection (DCP) to be able to provide services and support to the pregnant woman (Hansard, 2010). In Western Australia, as in the other jurisdictions, the legislation is enabling in that the consent of the woman for information about her to be shared and her voluntary participation in the meetings aimed at providing her and her family with support and to engage in services are required. Child protection authorities have no statutory authority over the child until after birth (Department for Human Services, 2011; Department for Communities, Child Safety and

Disability Services, 2007; Meagher, 2006).

Nationally, hospital clinical guidelines to notify and involve child protection agencies were crafted to reflect principles promoting respect for the need of pregnant women to have a say in their treatment and care, to be informed of decisions that affect them, and to have a say in how those decisions are made in the best interest of the child. Studies have shown that, in spite of the fear of child protection involvement, the main concern of drug using pregnant women is the health and safety of their unborn child, strengthening the perspective that early intervention is feasible (Dawe, 2007; Dowdell, Fenwick, Bartu & Sharp, 2007; Hidden Harm, 2003; Ministerial Council on Drug Strategy, 2006; Phillips, Thomas, Ricciardelli, Cox, Ogle, Love & Steele, 2007).

Practice framework for pre-birth child protection planning: Western Australia

In 2008, a key partnership formed between KEMH, Legal Aid Western Australia (LAWA) and the Department for Child Protection laid the foundation for a process involving the family and key agencies in collaborative information sharing and decision making (Unpublished document, DCP and KEMH). When women attend the hospital for their antenatal care, they are screened by the midwives who make a referral to the hospital social workers if there are concerns about domestic violence, drug and alcohol use, serious mental health concerns and other social factors that suggest that the woman is vulnerable or that there could be concerns for the child when born. The social workers conduct a comprehensive psychosocial

assessment in an interview with the woman and form a judgment about what might be needed to provide a safe and stable environment for the mother and baby and about the level of risk which may result in a referral for child protection input. There may be instances when DCP alerts the social worker on learning of the woman's pregnancy and of concerns that they have for the welfare of the yet to be born child.

Referral process

Reasons for referral to DCP are: a previous child notified to DCP or taken into care due to harm or risk of harm; a family member who has been convicted of an offence against a child; concerns about parenting capacity associated with drug and alcohol use; serious mental illness; family and domestic violence; young age of the mother; cognitive impairment; transience or homelessness; and/or the pregnant woman is herself in care. The hospital social worker informs the woman of the referral to DCP, provides her with the reasons for this referral, informs her of the process for pre-birth planning, and with her consent arranges for a legal aid lawyer to meet with her. The role of the hospital social worker and the legal aid lawyer are to enable the woman and her family to have a voice at the ensuing child protection meetings and to support her so that she continues to remain engaged in the process and remains connected to her healthcare. The DCP child protection worker has statutory obligations in relation to the child's safety.

Meetings

The meetings are usually attended by the hospital social worker, the pregnant woman and any family or supports in her network of her choosing, the DCP case worker and team leader, her legal

aid lawyer and relevant community based agencies that have been involved in providing counselling or other services. The meetings adopt a questioning approach to risk assessment, allowing the participants to describe the risks, strengths and solutions that will be implemented by them. During the meeting, a map of the child's and family's circumstances is made, and an assessment and plan regarding the safety of the child. The final judgment about what is required to keep the child safe is made by DCP. These meetings are scheduled to occur during the pregnancy at 20 weeks, 26 weeks and 32-34 weeks. The guidelines specify that by 36 weeks gestation a decision about the extent of the involvement of DCP is made and that this is communicated to the hospital and the woman, especially if statutory action is to be taken. Such statutory action may involve applying to the Children's Court once the child is born to: have him/her taken into protection and care, removed from the mother and placed in alternative care with a registered foster carer or a relative, or an order enabling the child to remain in the care of the mother and/or the father under certain conditions addressing safety concerns. If the woman is late in commencing antenatal care, the meetings occur within constricted time frames. The model for the meetings applies the Signs of Safety framework of assessment developed by Andrew Turnell and Steve Edwards (Turnell & Edwards, 1999). This framework is a strengths based approach based on solution focused therapy; it uses a meeting process to map concerns regarding past harm or future danger to the child when born, the strengths that may contribute to safety and what needs to happen to meet the standards for the safety of the child (Department for Child

Protection and Family Support, 2013). The meetings are facilitated by a DCP team leader who is not involved in the decision making process so as to be seen by the woman and family as a fair and independent facilitator. The following case study illustrates the application of the model.

Case study

This case study was presented to the International Marcé Society conference (Addy, Harrison & Nguyen, 2011). The mother was a 34-year-old woman pregnant with her third child. The concerns were: her other children were in care; she was homeless at the time of referral; she had a major mental illness and had been in care herself as a child. The strengths identified included her attendance at antenatal care, her willingness to be engaged with services and treatment facilities and her demonstrated attachment to her pregnancy and child. Three Signs of Safety meetings were held between 24 and 35 weeks gestation. The meetings were attended by: the woman, her partner, the woman's grandmothers, a community mental health social worker, her treating psychiatrist, the hospital social worker, a facilitator and a DCP child protection worker. The safety plan, which was completed by 35 weeks and included an admission to a Mother-Baby Unit and on discharge a roster of family and services to assist with and monitor the baby's care, facilitated a safe discharge home for the mother and baby.

Summary of outcomes

The following section will discuss what was achieved in the three years from the commencement of the Pre-Birth Child Protection Planning process in 2008.

Numbers of infants entering care

Clinical data maintained by the KEMH Social Work Department demonstrated a 25 per cent decrease in newborns taken into statutory care from the hospital in the year 2008-2009 compared to the 12 months prior to the start of the trial of the pre-birth planning protocol (Hall & Harrison, 2009).

Feedback from women

One hundred and sixty pregnant women participated in the pre-birth planning meetings during the period August 2008 to June 2011 (Harrison, 2009; Harrison, 2011). The pre-birth planning meetings were one of the initiatives subject to an independent evaluation commissioned by the Legal Aid of Western Australia. Howieson (2011) concludes that families were attending, engaging and feeling supported and that meetings were procedurally fair. These results were similar to the findings of the evaluation of the West Berkshire Signs of Safety Strengthening Families Framework that used a semi-structured interview format with both families and workers (Griffiths & Roe 2006).

Hospital based outcomes

An aim of the pre-birth child protection protocol was to enable access to appropriate antenatal care and the safe delivery of a healthy baby. In the 12 month period 2008-2009, 36 women were informed during the pregnancy that their babies would be subject to a court order giving DCP statutory powers to make all decisions about their child's care when born. All attended the hospital for the delivery of their babies (Harrison, 2009). Women who had participated in the meetings and knew ahead of delivery that their baby would be placed in care were reported by hospital staff to be calmer at delivery, the process was smoother and less

traumatic and there was a clearer pathway with legal representation and support of family or support agencies.

Broader application

In 2010 when the amendment to the *Children and Community Services Act 2004* was introduced to the Parliament of Western Australia, the Minister Hon. Robyn McSweeney said that the amendment was necessary so that other hospitals in the State could incorporate pre-birth planning based on the successful implementation at KEMH (Hansard, 2010). The pre-birth planning protocol has been rolled out statewide and the official memorandum of understanding endorsed by the Directors General of the Departments of Health and Child Protection (personal communication). Legal Aid WA has committed resources to continue their participation in pre-birth matters.

Implications for practice, policy and further research

The experience at KEMH suggests that there has been much progress in breaking down the barriers to vulnerable women seeking health care, and has also provided opportunities to link the women and families to community based health and social service support agencies such as the Family Inclusion Network. More research needs to be undertaken over the whole course of the pre-birth planning process. While participatory structures and fair procedures are necessary for effective interventions with vulnerable families, it is not sufficient. Evidence that pre-birth planning processes are based on meaningful and empowering relationships between families and practitioners is required in order to build a sustainable model of care that is strengths based, family centred and child focused. Beyond operational

structure and process, priority needs to be given to research surrounding the complex and difficult judgements of risk made by social workers in the unique circumstances of a pregnant woman and an unborn child. These judgements have lifelong consequences for children and their families. There are also complexities inherent in the notion of an assessment with child protection ramifications in relation to a pregnant woman. The ethical tensions regarding the rights of the woman and a possibly traumatic intrusion into her life at a vulnerable time may have negative implications for attachment and the healthy development of the fetus. This needs further research and reflection by the profession.

Conclusion

Ultimately, pre-birth planning is derived from sound policy. The procedures and structure of pre-birth assessment and planning provides an unparalleled opportunity for meaningful and sustainable preventative work. Pre-birth is the earliest opportunity for early intervention when the woman is most likely to be motivated by the outcome for her newborn to accept supportive interventions and make positive changes in her life and keep her child out of the child protection system.

Collaboration between the Department for Child Protection, Legal Aid of Western Australia and the Social Work staff of the King Edward Memorial Hospital for Women continues to drive this complex process.

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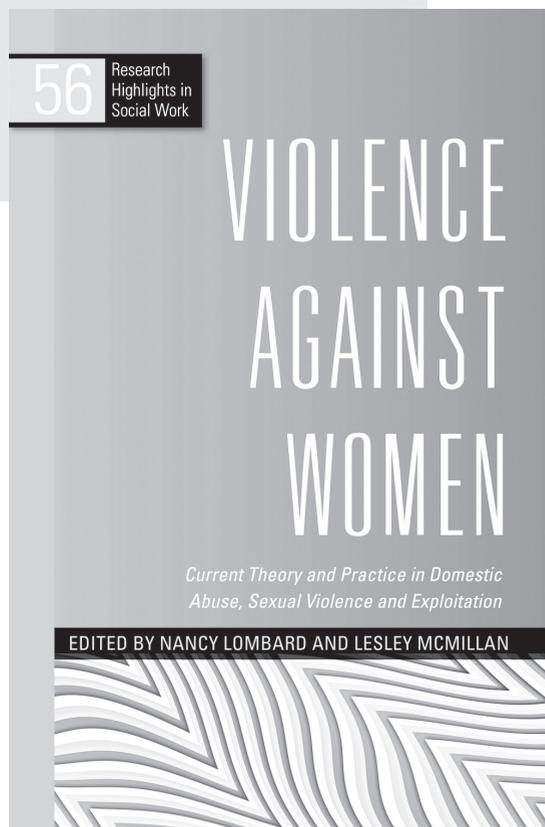
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VIOLENCE AGAINST WOMEN: CURRENT THEORY AND PRACTICE IN DOMESTIC ABUSE, SEXUAL VIOLENCE AND EXPLOITATION

**EDITED BY NANCY
LOMBARD & LESLEY
MCMILLAN**

**JESSICA KINGSLEY
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EDITED BY NANCY LOMBARD & LESLEY MCMILLAN

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I have never been one to read ahead to the last chapter of any book - always trusting the navigational path determined by the author, not needing to take control of the journey myself, and being content to know the end, at the end. When I read '*Violence Against Women*', I followed my usual path of reading from the first to last chapters in sequence. I don't recommend other readers take my rather passive approach to this book. The last chapter is a rich summary of the major themes and content traversed through the preceding 12 chapters, and provides insights and conclusions that provide an entrée to those chapters. By starting at the end, readers will be more proactive in exploring the various chapter content and therefore tailor make the reading journey according to professional interests.

All chapters in this book point to the centrality of gender in any understanding of, and work with, violence against women and children. The last sentence of the book reinforces the message in each chapter: "we must recognise that specific gendered harms occur within a general framework of gender inequality that supports violence against women, and it is only by challenging and

ultimately transforming that framework that we see real and lasting change" (p.242). Busy practitioners will do well to read the last chapter first - it points to the professional obligation we have to work more broadly than on an individual case, and to have both victims and perpetrators in full sight in all our work to address justice and equality for women.

This book has been edited by two Scottish academics, and the chapters have been written with a focus on British and Scottish policy and practice. While reference is made to some international practice and the book draws on a wide research base, it is very British in its language, examples and discussion. However, there is a strong relevance to the NSW Domestic Violence Reform '*It Stops Here: Standing together to end domestic and family violence*'. The essences of the NSW Framework have synergies with many elements of this book in that the NSW Framework establishes a common definition for domestic violence that does include coercion, which is strongly argued by Stark in Chapter One as the new paradigm.

In Chapter One, Stark challenges

practitioners to think beyond physical abuse and, through his tracking of transformative thinking about domestic violence from the 1970s, reaches the new paradigm of coercive control. Stark argues that there is “now compelling evidence that combination of coercion and control is the most devastating form of abuse, as well as being the most common” (p.18). I was challenged by his statement that “some of the most fearful and subjugated clients have never been assaulted” (p.18) and his assertion that “a screen that assessed seriousness by level of injury will miss 95-97% of all cases”(p.20). Read this chapter to learn more about the tactics of coercive control: violence, intimidation, isolation and control, and extend your thinking past physical violence as the main informative of safety planning and risk management.

I recommend that readers move from Stark’s Chapter One to Whiting’s Chapter 11, where the author takes the reader to the challenges experienced when translating theory and research into practice-driven training. Experiential learning techniques and activities which are underpinned by Stark’s coercive control paradigm are described. This is an exciting chapter that acknowledges gender analysis is complex and can be hard to bring to life in a training room. Whiting acknowledges that “in the face of hostility or apathy when people want to know ‘what to do’ when faced with disclosure or how to ‘fix’ a broken client”(p.198) gender theory may seem abstract or irrelevant. I was really attracted to Whiting’s thesis that a theoretical perspective provides a framework for safer practice and I was confronted by the somewhat obvious statement that “put simply, if one doesn’t understand the dynamics of an issue, one is unable to practise safely and

indeed might inadvertently make a client’s situation less safe” (p.203), and this is labelled ‘professional dangerousness’. I urge practitioners to read this chapter and the author’s examples of ‘professional dangerousness’, which is underpinned by practitioner values. The equally challenging notion in this chapter is the “idea that risks can be service-generated” as well as created by individual perpetrators or victim’s vulnerabilities.”(p.204). The elaboration of Stark’s coercive control paradigm by Whiting extended my understanding. I was confronted by the idea that domestic violence doesn’t just happen in the home. The power of perpetrator words that stick in the heads of women and children and intrude in all other contexts is detailed in this chapter. I came to understand that an incident-based mindset will inherently undermine a professional’s ability to understand the depth of fear and the deep loss of autonomy and sense of potency for those victims.

Radford’s chapter on child contact in the context of domestic violence was another thought provoking read, her thesis that there is an expectation that children should have contact with both parents post separation and this assumption camouflages the risks for children and their mothers. This chapter quotes research that has articulated the reasons why women who have experienced domestic violence support the child’s continued contact with the father. These reasons are mirrored by views held by child protection practitioners, and which are also reflected in current NSW legislation. I found this chapter provocative in terms of thinking through safe contact for violent fathers and the conflicts the system can create for mothers. The

chapter makes a compelling argument for talking more with children and young people about their experiences of the coercive controlling behaviours and the impacts on them and their non-offending parent.

As part of the '*Research Highlights in Social Work*' series, every chapter in the book relies on a strong evidence base to support its central thesis. There is considerable relevance to the NSW Domestic Violence reform framework, and to practice in NSW. Discussion on the continued invisibility of violence, the differential experiences and impact of violence, and the need for sensitive and safe interventions that include a dismantling of values, attitudes and beliefs that underline and allow violence to occur, are all pertinent to the development and implementation of the NSW Government's Domestic and Family Violence Framework for Reform. Although I have not provided a detailed account of all chapters in this book, I can say that, as a social worker with 34 years professional experience, this book provided new stimulus for looking at this important area of practice, and each chapter provoked me to critique my own understandings and explore the new paradigms.

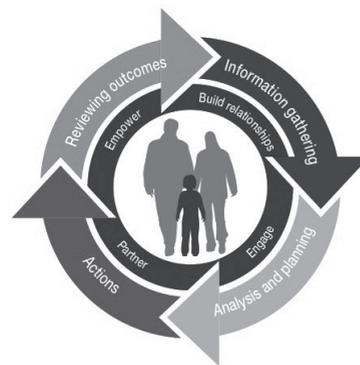
The various chapters would provide a great stimulus for group discussion around specific client groups as well as this broad area of practice. As I read this book I was thrown back to feminist readings that I did as an undergraduate in the 1970s when feminist practice theory was less nuanced than it is now - I found the experience required persistence to stick with the intellectual demands of the academic writing, and stimulating, as I could draw parallels between the UK context and NSW and as light was shed on my own blind

spots. I would recommend this to practitioners as a new reference point for practice with clients who experience coercive control.

WORKING WITH FAMILIES WHERE AN ADULT IS VIOLENT: BEST INTERESTS CASE PRACTICE MODEL SPECIALIST PRACTICE RESOURCE

**VICTORIAN
GOVERNMENT
DEPARTMENT OF
HUMAN SERVICES
(2014)**

human
services



Working with families where an adult is violent

Best interests case practice model
Specialist practice resource



WORKING WITH FAMILIES WHERE AN ADULT IS VIOLENT: BEST INTERESTS CASE PRACTICE MODEL SPECIALIST PRACTICE RESOURCE

VICTORIAN GOVERNMENT DEPARTMENT OF HUMAN SERVICES

'Working with families where an adult is violent' is a specialist resource published by the Victorian Government Department of Human Services (2014) that provides guidance for child protection workers when working with families and children impacted by family violence. It defines family violence as "behaviour that controls or dominates a family member and caused them to fear for their own or another person's safety and wellbeing" (Victoria Department of Human Services, 2012). Although developed for the Victorian workforce, this resource will be of relevance and use to any practitioners involved in preventing and responding to family violence.

The first half of the resource explores the prevalence and gendered patterns of family violence, highlighting that more than half of Australian women experience some form of physical or sexual violence in their lifetimes. The research presented reminds readers of the heightened and specific risks faced by women of Aboriginal and Torres Strait Islander background, women of other culturally and linguistically diverse backgrounds, and women living in rural areas. The resource includes research showing the correlations between the presence of family violence and other forms of abuse and the ways in which

children are exposed to, and affected by, violence. It advocates for an integrated approach to family violence and emphasises the need to keep the perpetrator and the perpetrator's behaviour at the centre of any risk assessment. Particularly helpful are the inclusion of several conceptual frameworks to help make sense of and guide practice, the key practice points emanating from the research, and links to other resources.

The second half of the resource focuses on practice skills and strategies. It provides guidance for workers when gathering information, analysing, planning and intervening with families where an adult is violent. It reminds us that from the very first contact, child protection workers have the opportunity to intervene and stop family violence. The practice section includes tips for practitioners about how to engage perpetrators and non-offending parents and how to explore and consider the lived experience of children. It cautions against relying on interviews alone and promotes the collection of information from multiple sources. It provides practitioners with strategies for analysing complex information in a way that supports sound decision making - with or on behalf of families. It highlights the equal importance of good

information gathering and clear thinking and analysis. The resource concludes with a call for practitioners to critically reflect on their assumptions, to remain curious and to be open to the ideas and feedback from others.

The resource can be accessed from the following website: www.dhs.vic.gov.au/__data/assets/pdf_file/0003/874704/Working-with-families-where-an-adult-is-violent_SPR_WEB.pdf

Alternatively, contact the Victorian Government Department of Human Services Office of the Professional Practice on (03) 9096 9999 or email: officeofprofessionalpractice@dhs.vic.gov.au

