Keeping Children Safe, Together: A Child Protection Symposium

Child Protection is Everyone’s Business

Professor Fiona Arney
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Keeping Children Safe, Together Symposium
Today’s presentation

• Challenging assumptions upon which our current systems are built
• Supporting evidence based alternative approaches for generational and intergenerational change
• Promising approaches to support children, families and communities
Every child deserves a Champion

www.youtube.com/watch?v=a1WvRsnEOY8
Our CP systems are based on 1960s knowledge and 1950s family structures

- Henry Kempe and colleagues – Battered Child Syndrome – nuanced paper, but research translation..
  - Serious physical abuse
  - Detectable through broken bones, failure to thrive
  - Parental psychopathology
  - Infants and toddlers
  - Intergenerational, lower SES

- Relatively uncommon in the population, reported incidents and investigative process to substantiate and then decision making about children’s living circumstances and protective factors – policing...

- Assumptions about family structure, family and gender roles that have changed significantly over time
How do we know it’s the wrong model?
What hasn’t changed as a result of inquiries?

- The system is based on assumptions that are not supported and have not been challenged.
- We still have faith in form rather than function – fear of innovation.
- We still have an *incident based* system of *responding* to child protection.
- Demand reduction is about the child protection system not violence prevention.
How do we change the approach?

• Joint approach based on excellence and common understanding
• Compare the assumptions upon which our child protection system is built and the evidence base
• Implications of treating violence against children as a disease – public health approach
Assumption 1

That child abuse and neglect is relatively rare in Australia

This assumption is not supported
Prevalent and pervasive

• Child physical abuse: 5-10% of adults
• Child sexual abuse: 4-8% of males and 7-12% of females
• Witnessing domestic violence: 12-23%
  – (Price-Robertson, Bromfield & Vassallo, 2010)
Table 3.1: Leading causes of burden (DALYs) by sex, Australia, 2003

<table>
<thead>
<tr>
<th>Rank</th>
<th>Males</th>
<th>DALYs</th>
<th>Per cent of total</th>
<th>Females</th>
<th>DALYs</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ischaemic heart disease</td>
<td>151,107</td>
<td>11.1</td>
<td>Anxiety &amp; depression</td>
<td>126,464</td>
<td>10.0</td>
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<tr>
<td>2</td>
<td>Type 2 diabetes</td>
<td>71,176</td>
<td>5.2</td>
<td>Ischaemic heart disease</td>
<td>112,390</td>
<td>8.9</td>
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<tr>
<td>3</td>
<td>Anxiety &amp; depression</td>
<td>65,321</td>
<td>4.8</td>
<td>Stroke</td>
<td>65,166</td>
<td>5.1</td>
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<tr>
<td>4</td>
<td>Lung cancer</td>
<td>55,028</td>
<td>4.0</td>
<td>Type 2 diabetes</td>
<td>61,763</td>
<td>4.9</td>
</tr>
<tr>
<td>5</td>
<td>Stroke</td>
<td>53,296</td>
<td>3.9</td>
<td>Dementia</td>
<td>60,747</td>
<td>4.8</td>
</tr>
<tr>
<td>6</td>
<td>COPD</td>
<td>49,201</td>
<td>3.6</td>
<td>Breast cancer</td>
<td>60,520</td>
<td>4.8</td>
</tr>
<tr>
<td>7</td>
<td>Adult-onset hearing loss</td>
<td>42,653</td>
<td>3.1</td>
<td>COPD</td>
<td>37,550</td>
<td>3.0</td>
</tr>
<tr>
<td>8</td>
<td>Suicide &amp; self-inflicted injuries</td>
<td>38,717</td>
<td>2.8</td>
<td>Lung cancer</td>
<td>33,876</td>
<td>2.7</td>
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<tr>
<td>9</td>
<td>Prostate cancer</td>
<td>36,547</td>
<td>2.7</td>
<td>Asthma</td>
<td>33,828</td>
<td>2.7</td>
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<td>10</td>
<td>Colorectal cancer</td>
<td>34,643</td>
<td>2.5</td>
<td>Colorectal cancer</td>
<td>28,962</td>
<td>2.3</td>
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<tr>
<td>11</td>
<td>Dementia</td>
<td>33,653</td>
<td>2.5</td>
<td>Adult-onset hearing loss</td>
<td>22,200</td>
<td>1.8</td>
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<td>12</td>
<td>Road traffic accidents</td>
<td>31,028</td>
<td>2.3</td>
<td>Osteoarthritis</td>
<td>20,083</td>
<td>1.6</td>
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<tr>
<td>13</td>
<td>Asthma</td>
<td>29,271</td>
<td>2.1</td>
<td>Personality disorders</td>
<td>16,339</td>
<td>1.3</td>
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<tr>
<td>14</td>
<td>Alcohol abuse</td>
<td>27,225</td>
<td>2.0</td>
<td>Migraine</td>
<td>15,875</td>
<td>1.3</td>
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<td>15</td>
<td>Personality disorders</td>
<td>16,248</td>
<td>1.2</td>
<td>Back pain</td>
<td>15,188</td>
<td>1.2</td>
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<tr>
<td>16</td>
<td>Schizophrenia</td>
<td>14,785</td>
<td>1.1</td>
<td>Lower respiratory tract infections</td>
<td>14,233</td>
<td>1.1</td>
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<tr>
<td>17</td>
<td>Osteoarthritis</td>
<td>14,495</td>
<td>1.1</td>
<td>Falls</td>
<td>13,269</td>
<td>1.0</td>
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<tr>
<td>18</td>
<td>Back pain</td>
<td>14,470</td>
<td>1.1</td>
<td>Parkinson's disease</td>
<td>13,189</td>
<td>1.0</td>
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<tr>
<td>19</td>
<td>Melanoma</td>
<td>13,734</td>
<td>1.0</td>
<td>Schizophrenia</td>
<td>12,717</td>
<td>1.0</td>
</tr>
<tr>
<td>20</td>
<td>Parkinson's disease</td>
<td>13,664</td>
<td>1.0</td>
<td>Rheumatoid arthritis</td>
<td>12,062</td>
<td>1.0</td>
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</table>


*Improving the lives of vulnerable children*
Fig. 5. Cumulative percentage children with Aboriginal or Torres Strait Islander background with a notification born in 1991, 1998 and 2002.
A public health approach to research, policy, programming and practice – regional differences

- Common definition of the problem
- Common understanding of aetiology and consequences
- Possible interventions
- Test and trial
- Share knowledge
- Embed in systems

*Improving the lives of vulnerable children*
Treating violence and neglect as a health problem

• World Health Organisation and US Centers for Disease Control and Prevention
• Violence as a health problem that has social and societal, political, familial, biological and relational origins
• The health impacts of violence and neglect against children and young people are real, intergenerational, preventable and amenable to treatment
• Understand the aetiology and vectors, provide nuanced responses – develop and test theory
• Inoculation, interrupt transmission, change behaviour, high quality treatment
Preventing youth violence: an overview of the evidence

Preventing violence

A guide to implementing the recommendations of the *World report on violence and health*
Taking a disease prevention approach

• “From a reputation as the most violent country in Europe to the lowest murder rate in 40 years”

Proceed until apprehended | Karyn McCluskey | TEDxGlasgow

• [https://www.youtube.com/watch?v=JbJm8Vo5cU](https://www.youtube.com/watch?v=JbJm8Vo5cU) (6-9 mins)
Assumption 2

That doing nothing costs nothing and harms no-one

This assumption is not supported
Cumulative harm

- We know that a relatively small proportion of the population are the subject of a very large number of notifications
- CP costs of investigating only are approx. $40m
- Children who experience multiple notifications will have poor outcomes, whether a notification is substantiated or not (Hussey)
Neglected children are not responded to by the community

In an Australian sample of more than 20,000 adults, neglect was the form of maltreatment (as compared with physical abuse and sexual abuse) that was least likely to garner any other response by the general public than a child protection notification – i.e. people would make a notification and not do much else (and approx 40% would make a notification)
And they may be left unseen by systems

- Families in which neglect is more likely may be effectively “screened out” of preventive and early intervention services (e.g., nurse home visiting programs)
- Children are unlikely to tell others about neglect (fear, no comparative experiences) and families don’t necessarily know what neglect is
- They are also screened out of child protection intervention - Less likely to be rated as a high response priority when dealt with on incident by incident basis
- When they are “screened in” – screened in as lower risk, less intensive service provision, fewer contact hours – than for physical abuse and sexual abuse
A generation of change

• Children with multiple reports are more likely to be “known” to the system early – targeting preventive efforts in pregnancy and early infancy

• Greatest time for motivation to change, highest risk periods for problems to emerge, greatest preventive potential (e.g., prevent FASD), receiving support is normative – importance of engaging dads
• Families may be screened out of other services, or inappropriate models of care – outreach and excellence

• Leading models for Aboriginal children and families in lower risk circumstances

• Evidence based models for intervention in pregnancy, develop the evidence base for intervention when family violence present
Promise of interventions that focus on the child and target the whole family

- Family group conferencing
- Family by Family
- Kinship care
- Parents Under Pressure
- Building Capacity, Building Bridges
- Regional child safety planning
Assumption 3

Getting the mainstream system “right” will have flow-on effects for Aboriginal families

This assumption is not supported
Figure 5.6: Children aged 0-17 in out-of-home care by Indigenous status, 30 June 2010 to 30 June 2014 (rate)

Notes
1. Rate calculations exclude children whose Indigenous status is unknown.
2. Rates were calculated using revised population estimates based on the 2011 Census and should not be compared with rates calculated using populations or projections based on previous Censuses, including those published in previous editions of Child protection Australia.

Source: Tables A39 and S2.
An alternative evidence base

• Community driven priorities and wisdom
• Alternative approaches – focused on prevention of harm, connection to family, community and culture
• Acknowledge intergenerational trauma
• Address the inconsistent application of the Aboriginal and Torres Strait Islander Child Placement Principle
• Cultural, research, policy and practice partnerships to develop and implement this new evidence
• Making evidence based models readily available – support workforce development and training
Assumption 4

That existing services will reduce demand if only we could get families referred in - doing *something* is always better than doing *nothing*

This assumption is not supported
“any psychotherapeutic intervention is better than none at all”

“home visiting prevents child abuse and neglect”

“We use the [XYZ] approach... It’s scenario-based behavioural management... So parents can be responsible when drinking [alcohol] (i.e. they can slip their kids off to parents or you can drink between 12 and 2, but don’t drink and drive and (make sure you] are sober to pick up the kids). [XYZ] provides a usable model for how functioning families operate.”
## Effectiveness of youth violence prevention strategies, by context

<table>
<thead>
<tr>
<th>Parenting and early childhood development strategies</th>
<th>Home visiting programmes</th>
<th>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting programmes</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Early childhood development programmes</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>School-based academic and social skills development strategies</strong></td>
<td>Life and social skills development</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Bullying prevention</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Academic enrichment programmes</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Dating violence prevention programmes</td>
<td>+/-</td>
</tr>
<tr>
<td></td>
<td>Financial incentives for adolescents to attend school</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Peer mediation</td>
<td>+/-</td>
</tr>
<tr>
<td></td>
<td>After-school and other structured leisure time activities</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strategies for young people at higher risk of, or already involved in, violence</strong></td>
<td>Therapeutic approaches</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Vocational training</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Mentoring</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Gang and street violence prevention programmes</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community- and society-level strategies</strong></td>
<td>Hotspots policing</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Community- and problem-orientated policing</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Reducing access to and the harmful use of alcohol</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Drug control programmes</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Reducing access to and misuse of firearms</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Spatial modification and urban upgrading</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Poverty de-concentration</td>
<td>+</td>
</tr>
</tbody>
</table>

**KEY**

+ Promising (strategies that include one or more programmes supported by at least one well-designed study showing prevention of perpetration and/or experiencing of youth violence, or at least two studies showing positive changes in key risk or protective factors for youth violence).

? Unclear because of insufficient evidence (strategies that include one or more programmes of unclear effectiveness).

+/- Unclear because of mixed results (strategies for which the evidence is mixed – some programmes have a significant positive and others a significant negative effect on youth violence).
Inputs
- 0.5 FTE
- "Caro"

Target Group
- Everyone

Activities/Strategies
- Home Visit
- Conversation
- Meetings

Then...
- The Magic Happens

Outcome
- World Peace

Improving the lives of vulnerable children
Target Group
Theory of Change
Planned Activities
Actual activities
Objectives/Goals

(adapted from Segal, Opie and Dalziel, 2012, p.56)

Improving the lives of vulnerable children
Oh you academic types, but we’re talking about real people…
And that’s why it matters
Review of 52 Home Visiting Programs

Relationship between program success and full, partial or no match for theory, components, population and child abuse objective

<table>
<thead>
<tr>
<th>Match Type</th>
<th>Successful (n=25)</th>
<th>Not successful (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full match (n=7)</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Partial match (n=30)</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>No match (n=15)</td>
<td>0</td>
<td>15</td>
</tr>
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</table>

Adapted from Segal, Opie and Dalziel, 2012, p.85
Target Group

Theory of Change

Planned Activities

Actual activities

Objectives/Goals

Program planning

Implementation

Outcomes measurement

Improving the lives of vulnerable children
Supporting this most complex work

• Design with children/clients – have a theory base and test for intended outcomes
• Implementation support models
• Building on the work of the National Implementation Research Network in the US (Technical assistance)
• Have this support available as a service
  – The Department of Social Services have recently developed an expert panel model to provide resources, technical support and guidance in program choice and outcomes measurement
Conclusion

• Our children deserve the very best we can give them
• Incident based responses will fail when the problem is prevalent and profound
• Tackling violence as a health problem holds much promise
• Working together to develop the new way forward
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