

*Sowing the Seeds of Innovation in Child Protection
10th Australasian Child Abuse and Neglect Conference,
Wellington, New Zealand, February 2006*

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Tena Koutou. Tena Koutou. Tena Koutou Katoa.
He aha te mea nui o te ao?
He tamariki. He tamariki. He tamariki.

What is the greatest treasure in the world? It is children. It is children. It is children.

I wish to acknowledge the Maori, the indigenous peoples of this land and to thank them for my safe journey to their shores. I also wish to thank the conference organisers for the honour of participating in this important conference.

Our current child protection systems are unsustainable and harmful to children and their families. We are at the crossroads in the history of child protection. Having come into existence as a result of a fundamental shift in the relationship between the State and the family which began well over a century ago, most of the child protection systems in the English speaking world have shifted from their traditional responsibility. That was the care of children for whom they had statutory responsibility, not screening the population for children who might be “at risk”. Most child protection services in countries such as Australia and New Zealand have become demoralised, investigation-driven bureaucracies which trawl through escalating numbers of low income families to find a small minority of cases in which statutory intervention is necessary and justifiable, leaving enormous damage in their wake. The point has been reached in many places where we are exceeding the use of the State’s coercive powers to protect children without causing further harm.

We need to turn with the tide toward a whole-of-government, population-based public health approach to child protection, and resist the currents carrying us toward an overwhelmed legalistic and reactive system. Child protection policy needs to be based on knowledge. A central strategy in a knowledge-based reform agenda in child protection is to tap the exemplary policy and practice innovations occurring in some places and to sow their seeds in systematic and sustainable ways elsewhere.

To turn with the tide, we need to do four things:

1. *Understand how the past shapes present policies*
2. *Implement a public health model*
3. *Translate research into policy and practice*
4. *Transplant successful innovations*

Understand how the past has shaped present policies

The history of child welfare is paved with good intentions. At times it has been successful in reducing the harm inflicted on children. At other times it has itself caused immense harm, usually only visible to those other than the children and their families, a generation later. The worst example of this in Australian history is the large scale removal of children of mixed indigenous and European descent from their families and communities. This is a source of shame to my nation. Its legacy lives on. Indigenous people in other countries, including New Zealand, have also suffered as a result of past child protection policies.

We need to have the courage to ask ourselves “what is it that we are currently so confident about doing in the name of protecting children, without any empirical evidence of its benefit, that in a generation we may be too ashamed to say we have been part of?”.

While the history of child protection varies from place to place in its contextual detail, the differences are variations on wider historical themes. The first wave of the child protection movement, or what was originally called the child rescue or child saving movement, began in the late nineteenth century. It led to legislation to protect children from what was called “cruelty” and gave rise to statutory intervention in the lives of

families by government and quasi-government organisations such as the Societies for the Prevention of Cruelty to Children. Prior to this there had been organised government and charitable responses to orphaned and destitute children, but not to children subject to ill-treatment by their parents and guardians.

Here is a photograph from the Victorian Society for the Prevention of Cruelty to Children in the late 1890s. This organisation was modelled on the NSPCC, the National Society for the Prevention of Cruelty to Children in the UK, which in turn was modelled on the New York Society for the Prevention of Cruelty to Children. We can see Inspector Noble, the uniformed child protection worker or what in the slums they called “the cruelty man”, and a young boy called Leslie who was repeatedly found with his sister scavenging on a rubbish tip and begging for food in the Melbourne suburb of Hawthorn (Scott & Swain, 2002).

This photograph was taken in a local studio months after he came into care, Leslie being put back into his rags for propaganda purposes. The photograph was used to stir the conscience of the community. The trial of Leslie’s father and stepmother was widely reported by *The Argus* and *The Herald* in 1898, the latter carrying the headline “CHILD LIFE FRAUGHT WITH HORROR, STARVED AND FILTHY, TWO LITTLE SUFFERERS. TWO PARENTS PROSECUTED”. The headlines have got shorter over the century but the impact has not. The press has always been a powerful force in child protection in English speaking countries - for better and for worse.

Leslie and his siblings had suffered over a long period and the Magistrate was initially reluctant to use his powers but eventually did so. The stepmother, who had an alcohol problem, was sentenced to six months imprisonment and the children committed to the care of the Neglected Children’s Department, later being transferred to mental hospitals where they remained in their adult years.

The newspaper reported that “The mother was much agitated on hearing the decision, and was led out of the court weeping piteously, with the children holding on to her skirts” (*The Herald*, 1989). The powerful paradox captured in this scene speaks to us today. The State, albeit reluctantly, uses its coercive powers to protect children from parents who harm them yet the parents are typically the children’s primary figures of

attachment. The State then becomes the legal parent but the structure of the State is such that it cannot perform the function of a family. The State is *inherently* a cold breast and dry nipple. The best it can do in loco parentis is to draw on the resources within the extended family or wider community to find people who might genuinely care for the child. Some of us fear this to be a diminishing resource. The State cannot enable the child to find the answers to the questions which are central to each of us: where do I come from; who do I belong to; who am I; and do I matter?

The equivalent today of the State's inevitable failure in emotional loco parentis is not institutionalisation but the appalling instability of out-of-home care – two thirds of children in care in some Australian jurisdictions, those with the courage to count, have had four or more previous placements. I understand that the situation in New Zealand is no different. Such a system corrodes to the very core the capacity of the child to love and to be loved, that is, the very essence of a child's humanity.

The second wave of the child protection movement occurred in the 1960s with the discovery of previously undetected fractures in infants resulting from non-accidental injuries. It is exactly 40 years since the paper, "The Maltreatment Syndrome in Children" by the Victorian police surgeon Dr John Birrell and his paediatrician brother, Dr Robert Birrell, was published in the *Medical Journal of Australia* (Birrell & Birrell, 1966). The Birrells documented the undiagnosed fractures and non-accidental injuries of children admitted to the Royal Children's Hospital in Melbourne, following the classic US study, "The Battered Child Syndrome" published by Henry Kempe and his colleagues in the *Journal of the American Medical Association* four years earlier (Kempe, Silverman, Steele, Droegmueller and Silver, 1962). In the same issue of the MJA appeared Dr Dora Bialestock's paper on her examination of 289 babies consecutively admitted to the care of the State which revealed significant developmental delay associated with child neglect, the major reason for admission (Bialestock, 1966). Child neglect has continued to receive far less attention than physical or sexual abuse, despite neglect being the single largest reason for children coming into State care and it being the cause of at least half of child maltreatment fatalities (Smith & Fong, 2004).

The evocative term “the battered baby syndrome”, coined by Kempe, caught the attention of press, public and professionals alike and led to legislation such as mandatory reporting of suspected child maltreatment throughout the United States and eventually in Australia. Significantly, and in my opinion fortunately, New Zealand, the United Kingdom and most of western Europe did not follow the American policy path.

Young children suffering severe physical abuse constitute a very small proportion of child protection cases, thank goodness, yet the laws and policies developed in the aftermath of the discovery of the battered baby syndrome, *specifically designed to identify clear cases of serious physical abuse and bring these to the notice of statutory authorities without delay*, have, over time, come to be applied to a much broader group of acts of omission or commission which *may* result in child abuse and neglect.

This net widening is influenced by the two powerful historical drivers of child protection over the past century: the notion of the child as a holder of human rights and the notion of the child as a psychological being.

(a) The notion of the child as a holder of human rights

As the view of the child as the property of parents diminishes, and the view of the child as a holder of human rights gathers force, the pressure on the State to use its coercive powers to defend the rights of the child vis a vis their family, and to assume the role of loco parentis when parents are deemed unfit, has increased exponentially. In western Europe, the State’s responsibility has focussed less on the use of its coercive powers than on its responsibility to provide health, education and social services for all citizens, including children. Obviously these are not mutually exclusive but relying primarily on the State’s coercive powers in child protection, the approach most exemplified by the United States, is akin to building more prisons rather than preventing crime.

(b) The notion of the child as a psychological being

The nineteenth century understanding of child physical abuse was extreme cruelty resulting in serious bodily harm, and the understanding of child neglect was the

serious failure of parents to provide for the most essential needs of shelter and sustenance. These acts of commission and omission were not seen in terms of psychological harm. What now constitutes child abuse and neglect has been massively widened to encompass an ever-increasing range of behaviours which are seen as psychologically harmful to children. Some acts now regarded as child abuse and neglect were actually normative childrearing just a generation or so ago. For example, physical discipline that was routine punishment in schools and homes is now seen by some as child abuse.

Similarly, leaving children in the care of older children which was normative in earlier times in Australian and New Zealand society, and still is among some cultural groups in our counties, is now regarded by many as neglect. And while what constitutes child sexual abuse has not changed significantly over time, how child sexual abuse is understood has shifted dramatically from that of “moral danger” to that of psychological harm.

These two parallel historical currents, the notion of the child as a holder of human rights and the notion of the child as a psychological being, both of which are still gaining momentum, are both doubled-edged swords.

On one hand, they have enabled us to recognise the very existence of child abuse and neglect. On the other hand, in some socio-political contexts, including New Zealand and most States of Australia, they have led to child protection systems which are like a giant Casualty Department required to respond to a flood of patients, the vast majority of whom do not require hospitalisation and would be much better managed by the local GP.

The over-extension of the child protection system is evident in the escalating number of unsubstantiated child protection notifications in New Zealand and in Australia, doubling over the past few years. Only 1 in 5 of the approximately 222,000 notifications in Australia in 2004 was substantiated. The overextension of the child protection system has reached an extreme level in some parts of the US, such as Cleveland, Ohio, where 49.1% of all Afro-American children and 20.7% of all white

children will at some stage in their childhood be the subject of a child protection notification (Sabol, Coulton & Polovsky, 2004 cited by Jill Korbin, 2005).

Child protection systems which catch large numbers of children in their nets are dangerous systems. While comparative policy analysis in this field is complex, and little research has been done to date, it is interesting to note the differences observed between the United States and the United Kingdom. According to a comparative review by the UK Department of Health in the 1990s, "...the USA has more reported cases (three times that for the UK) and more child abuse deaths (four times that for the UK. It also has twice as many children in state care" (Department of Health, 1995, p. 95).

New Zealand and some parts of Australia now have notification rates much closer to that of the US than the UK. In New Zealand the rate is escalating very rapidly. Such a scenario is like the Titanic heading toward the iceberg at increasing speed. It is illusory to think we protect children by extending the reach of the statutory child protection system yet in the wake of child abuse tragedies that is exactly what tends to happen – a vicious negative feedback loop is established.

An overloaded child protection system, like an overloaded Casualty Department in a hospital, is very dangerous - for children at high risk, for children at some risk, for children at low risk, for children already in care, for other parts of the service network and for those who work in the child protection system.

- ❖ An overloaded system is dangerous for the most vulnerable child who needs to be removed from a high risk situation, as identifying them becomes akin to searching for the proverbial needle in the haystack. An overloaded system has only three ways of avoiding implosion. It is either too slow in its response time, too hasty and superficial in its risk assessment resulting in poor decision making, and/or too quick to close cases. Response times are a very measurable performance indicator and are usually achieved for cases deemed high risk. Far more common and very evident in recent child death inquiries in some Australian States are instances of both hasty and superficial risk assessment and premature closure.

- ❖ An overloaded system makes it more difficult to assist families where children are at risk but not at a level that could justify statutory intervention. For example, in NSW, when the number of notifications doubled in 12 months from 55,208 in 2001-2002 to 109,498 in 2002-2003 (coinciding with the introduction of a centralised intake system and an increase in criminal penalties for failure to fulfil mandatory reporting obligations), the number of referrals to family support services actually decreased. This was because of the incapacity of the system to make referrals (Fitzgerald, 2002). The paradox of this is that families are denied the very assistance that may prevent abuse and neglect from occurring.

- ❖ An overloaded system hurts those at low risk. Given the scale of child protection notifications now received, it is hard to exaggerate the extent of rage, humiliation and intense fear felt by many parents who are subject to child protection investigations where the concerns are not substantiated. Paradoxically, and tragically, this is very likely to reduce the coping capacity of parents by causing high levels of stress, and by reducing their informal social support and their use of services, as parents are left very suspicious about who in their kith or kinship circle, or who in their local service system, may have notified them to the authorities. Parental stress and low social support are two of the strongest correlates of child abuse and neglect. While this is an area in which it is hard to conduct research for ethical and privacy reasons, it is very likely, in my view almost certain, that our current unsubstantiated child protection investigations are actually increasing the risk of child abuse and neglect for many children. For this I believe we will one day be rightly held morally responsible, as the capacity of current policies and practices to cause further harm to families on such a massive scale is so self-evident. We have become so concerned about the “false negatives” in child protection that we ignore the adverse effects of the “false positives”. It is wrong to frame this as a “child versus parents” dilemma in child protection – in most cases what hurts the parent will harm the child. I have spoken with families who have been deeply traumatised by child protection investigations which have ultimately been assessed to be unfounded. It concerns me why we

have become so desensitised to their pain. Is this because we, like our predecessors in the history of child protection, cannot allow ourselves to acknowledge that we could cause such suffering when our intent is so well-meaning? Is it because we prefer to engage in self-protective “defensive practice” regardless of the cost to children and their families? Is it because we do not readily identify with the anguish of parents because they are mostly “other”? If this happened to middle class families on the scale it is happening to indigenous and non-indigenous working class families, the pain would not be inaudible.

- ❖ An overloaded system hurts children who are already in care as they receive far less attention, reducing their opportunity to reunite with their families where this is viable or secure a timely permanent placement where this is not possible. Poor case management and the neglect of the health and educational needs of children in out-of-home care is pervasive. The imperative of investigation, even if only a tiny proportion of those cases justify statutory intervention, takes precedence over those children who have been legally found to be in need of statutory protection - an example of extreme goal displacement.
- ❖ An overloaded child protection system also hurts other parts of the system, causing redirection of resources. In one Australian jurisdiction with which I am familiar, school counsellors and visiting child health nurses were retrenched so that more child protection positions could be created. Overloaded systems also lead to corrosive relationships between organisations as dynamics such as “gatekeeping” and “poison ball” in relation to resource-hungry cases become common survival strategies.
- ❖ Finally, overloaded child protection systems hurt those who work in them, leading to low morale and high staff turnover which further weaken the system, leading to an increasingly stigmatised and deprofessionalised field which is unattractive to qualified personnel. Measures such as importing child protection workers from other places are like blood transfusions – they have a positive short term effect but in the longer term they cannot compensate for

staff attrition and increasing demand for more positions to deal with more notifications.

We have to recognise that like nurses in our health system, child protection social workers are internationally a scarce resource. We are wasting this precious resource and hurting committed and skilled practitioners in the way we are currently using - and in some places, abusing them, for example, when they are scapegoated when things inevitably go wrong in overloaded systems. Unless we change the way we do child protection and do so very soon, some of our systems will implode.

Child death inquiries have often made matters worse as they typically focus only on the last link in the chain of events which could have avoided a tragic outcome. It is like building a system of road safety only on an analysis of factors impairing driver-decision making immediately prior to a fatal accident when paying attention to factors such as car and road design is also vitally important.

Members of a child death inquiry committee in Australia to whom I recently spoke asked me “so are you saying that our recommendations are making things worse?”. I replied – “if your recommendations are likely to lead to an even bigger and more proceduralised child protection casualty department, then yes, you are putting more children in danger. If however, your recommendations strengthen the capacity of the child protection ‘primary care system’, then you are likely to be reducing harm to children”.

We have to accept that there is no system which has yet been able to prevent all child abuse and neglect fatalities or injuries, and while this is what we should aim for, the way to reach that goal is to choose the type of system in which the overall level of harm is reduced.

So, what can we do to reform systems which are harmful and unsustainable?

Implement a whole of government, population-based public health model of child protection

The way forward is a public health model of child protection with research providing an empirical basis for policies and services, and with a careful and systematic approach to “taking to scale” strategies which have been shown to be effective elsewhere. It will not happen overnight but it needs to start soon or it will be too late to turn around as other parts of the service system will not want to become part of it. It will take political courage and a high level of professional leadership. It is not easy but it can be done.

A public health approach to a social problem is population-based rather than case-based. That is, public health strategies measure their success by the prevalence of a condition or problem rather than by the number of reported cases, especially when the latter is not a good indicator of the former as in the field of child protection. (When it comes to child abuse, the incidence data or the number of child protection notifications, tell us very little indeed about the prevalence or the extent of child abuse or neglect. Not all child abuse cases are reported and not all reports are child abuse cases. Data on reports, much of which relates to the same children given the very high rates of renotification, tell us more about reporting behaviour than about the well-being of children).

A public health approach to child protection would measure its success by indicators such as the number of hospital admissions for non-accidental physical injuries per 1000 children in particular postcode areas per annum, or for rare occurrences such as child abuse or neglect fatalities, the number of deaths per 100,000 children across a State or country over a longer period. Other measures could be the number of infants and young children per 1000 identified by universal maternal and child health services as suffering from non-organic failure to thrive – this is a very good measure of physical neglect. These are “hard” indicators of physical abuse and neglect which in most health systems can be readily collected *on a population basis* to assess the efficacy of our child protection strategies.

“Softer” measures which do not specifically measure child neglect but which may be indicative of neglect, could include the proportion of children in an area who do not meet “school readiness” criteria or the level of primary school absenteeism etc. Of course, it is hard to develop measures of this sort in relation to child sexual abuse and

so one measure of this, albeit delayed, is representative survey data of adults on their childhood experiences. (New Zealand has the advantage of the best baseline data on women's experiences of child sexual abuse in the world as a result of the research done by Professor Paul Mullen et al).

Public health strategies, such as those for skin cancer, encompass primary, secondary and tertiary prevention, tackling underlying causal and contributory factors as well as facilitating early treatment. Child abuse and neglect do not exist in isolation. They are strongly correlated with low birth weight, child behavioural problems, low literacy levels of children, non-completion of school, juvenile crime, drug use, teenage pregnancy etc. A meta analysis of prevention programs for this range of problems suggests that those that are multi-faceted and address the underlying risk factors are more effective than those that are single issue focused (Durlak, 1998). These problems all share a common set of risk and protective factors: the quality of early parent-child attachment; peer and school connectedness; the availability of social support for families; and parental poverty (Durlak, 1998).

This means that strategies for the prevention of child maltreatment need to be part of much broader strategies aimed at addressing social disadvantage. Thus a whole of government approach is required, with strong inter-sectoral collaboration across health, education, housing, employment and social services. There is growing recognition of this and there are some encouraging attempts in a number of jurisdictions, including in Australia and New Zealand, to achieve this at a high political level as well as at the local service delivery level.

In some places universal child health and education services are becoming much stronger vehicles for reducing the risk factors and strengthening the protective factors in relation to child abuse and neglect and related psycho-social problems. For example, Victoria's maternal and child health service which serves 98% of all infants, was once focused almost exclusively on weighing, immunizing and screening for developmental problems, but now provides much broader psycho-social interventions aimed at strengthening families and communities as well. Nurse-facilitated parent groups, for 8 or so sessions, are offered to all first time parents in the State, and are taken up by two thirds of families. Two years later, 80% of these groups are still

meeting of their own accord and have become self-sustaining social networks (Scott, Brady & Glynn, 2001). This service has also become an unstigmatised platform for reaching out to those vulnerable families who might otherwise have been referred to child protection. It is strategies such as this which have enabled Victoria through its Innovations Initiative to hold its notification rate very steady for the past four years.

The sustained nurse home visiting program in South Australia, which is built upon a universal service, is another excellent example of primary and secondary prevention, with a particularly encouraging high take up rate by indigenous mothers. (It should be noted that Australia's maternal and child health programs were modeled on the visionary New Zealand Plunket nurses which was established almost a century ago).

The same approach can be applied to schools. We have some wonderful examples of schools as the nucleus of their neighbourhood – vehicles of community building, which strengthen all families. In some places schools are very effective in reaching out to marginalized families, and can be the location from which a range of child and family services can be delivered. Vivienne Watts and Louise Laskey (2002) have written about the untapped potential of teachers to be what they call “real partners” in child protection. If we add to this the roles of school nurses and counselors, then we can see the school as the core service in the lives of children of school age.

We can go much further than use universal health and education services as vehicles of child abuse prevention. Why not see these services as the GPs of the child protection system, and build their capacity to assess child abuse risk as part of their comprehensive service *and* manage the majority of cases currently being referred to statutory child protection services? These services are usually known to the family already, they have a good understanding of the child's circumstances, they are better connected with other local services, and they have greater capacity to reduce the risk factors for child abuse and neglect than statutory child protection services. Yet in many jurisdictions we give these services no choice, and, under threat of criminal penalties, make them refer cases of suspected child abuse and neglect to child protection authorities, often resulting in the family becoming alienated from the very services which can help them most.

There is no reason why maternal and child health nurses for children under school age, and a school nurse, counselor or social worker for school aged children, cannot be supported to undertake a holistic assessment of the child and family in most cases of alleged emotional abuse and neglect, which constitute the clear majority of referrals in most child protection services. Such an assessment could have built into it validated indicators of child abuse and neglect to assist consistent decision-making in relation to statutory notification.

Child protection services in this model would provide consultation to these primary care services, and such consultation could be deemed to satisfy mandatory reporting requirements where these exist. Cases where it is likely that the protective concerns are at a level that warrant a forensic approach and statutory intervention, including cases of suspected physical abuse, sexual abuse, and serious physical neglect, are obviously better managed by police, statutory child protection services and specialist paediatric services.

Thus statutory child protection services could focus on those children who need statutory protection and those who are already in care. Some will recognize that this is similar to the two tiered response systems but there is a key difference – what I am proposing does not require families to go through the stigmatizing child protection portal to reach the service they require. In that sense what I am outlining is a move closer to the Confidential Doctor Program operating successfully in countries such as the Netherlands where only those cases proceeding to court are managed by statutory child protection workers.

Other parts of the service system would need to complement the role of the core universal child health and education services:

- Early childhood education and care services have the capacity to provide high quality care, cognitive stimulation and good nutrition to children, all of which are vital for vulnerable children, especially those subject to neglect. It has been demonstrated by SDN Children's Services in NSW that early childhood staff can also be trained to engage parents such as those with a substance dependence, to minimise the harm to their children. Yet in some jurisdictions

such children are the least likely to be receiving these heavily government subsidised early childhood services – another policy paradox.

In Canada and the UK, and now in South Australia, early childhood education and parenting centres, a new service hybrid, are being established in local primary schools in highly disadvantaged communities.

- In this model NGO family service agencies would provide similar services as they do now, including in-home family support, financial counselling, etc but would be more closely connected with the universal services than they currently are in most places.
- Specialist child and adolescent mental health services also have the capacity to work with parents where child abuse and neglect concerns exist, under a court order if necessary.
- Specialist adult services in the fields of drug treatment, mental health, intellectual disability and domestic violence, as well as primary care practitioners such as general practitioners, all have the potential to offer a more child-sensitive and family-centred service, again in consultation with a statutory child protection services where necessary. The very high proportion of child protection cases in which parents have a mental health and/or substance dependence problem makes this a high priority. There are some inspiring, but as yet isolated examples of mental health services and drug treatment services doing this very successfully in Australia.

Translate research into policy and practice

I have long been fascinated by how research can be translated into child protection policy and practice. My first experiences as a social work student and as a new graduate in trying to put into practice the attachment research of John Bowlby taught me a lot about the organisational factors which can facilitate or inhibit research utilisation in child protection.

There is now research on research utilisation, especially in the health field and it shows us that both practitioner and organisational factors are important. The same factors apply to the uptake of innovation as well as the uptake of research. Fundamentally it is about change management. According to Greenhalgh et al (2004), the important factors relating to practitioners and organisations are:

Practitioner Factors

- *links between researchers and practitioners*
- *participation in post graduate study*
- *practitioner involvement in research*
- *support from colleagues*
- *autonomy*
- *practicality*
- *ease of use or 'effort'*
- *conformity with status quo*

Organisational Factors: Absorptive Capacity:

- *existing knowledge and skills base*
- *related technology*
- *learning organization culture*
- *proactive leadership focused on sharing new knowledge*

Organisational Factors: Receptive Context for Change:

- *strong leadership*
- *clear strategic vision*
- *good managerial relations*
- *visionary staff in pivotal positions*
- *climate conducive to risk taking*
- *effective data capture systems*

A strong research underpinning of policies and programs can help counter the retreat to a more centralised and bureaucratic statutory child protection system in the face of highly publicised cases where the system is seen to have failed.

Research therefore needs to have a more central place in child protection policy and practice, just as it does in the field of health. This is not easy for the relationship between researchers, policymakers and practitioners is a complex one. Shonkoff (2000) has written about them as “three cultures in search of a shared mission”. New ways of working together are now being developed and this is most encouraging.

The UK has shown wonderful leadership in providing sustained funding for child protection related research and for disseminating the research in ways that are accessible to policy makers, managers and practitioners. For example, “What Works for Children” is an impressive initiative which uses “knowledge brokers” to work alongside practitioners in order to help them utilise research. It is the result of a consortium of Barnardos, University of York, City University and the Economic and Social Research Council. Such models are worthy of replication in Australia and New Zealand.

It is encouraging to see greater use of research in child protection policy and practice, especially research undertaken internally by Departments made possible by the increasingly sophisticated data bases we now have, and which in some places are now linked to those in education and health. It is also very encouraging to hear the voices of children, and to a lesser extent their families and carers, coming through in the qualitative research in recent years.

Whether we can achieve, or indeed should aim for “evidence-based practice” in child protection however, is an interesting question. Perhaps evidence-informed practice is the best goal given that children and families have unique situations and live in complex social ecologies which defy the simple application of evidence-based rules, especially in a field which is so values-contested as child protection.

The same applies to program evaluation. Lisbeth Schorr, Director of the Pathways Mapping Initiative of the Project on Effective Interventions at Harvard University, has

argued for a pluralistic approach and has developed tools for mapping the knowledge pathways of multi-determined problems such as child abuse. She says "...it is the very nature of the most promising responses to persistent social problems that makes them almost impossible to evaluate by the methodologically elegant ways in which we evaluate drugs or electric toothbrushes" (Schorr, 2003).

The same applies at the clinical or case level. Donald Schon, author of the classic work, *The Reflective Practitioner*, speaks of some areas of professional practice as being beyond the application of technical solutions based on science.

In the varied topography of professional practice, there is a high, hard ground, where practitioners can make effective use of research-based theory and techniques, and there is a swampy lowland where the situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or the larger society while in the swamp are the problems of greatest human concern. (Schon, 1983).

Child protection belongs in the swamp. This should not deter us. The swamp is a very fertile place. We need to be methodologically pluralistic in our research in order to add value to child protection. We also need policy and practice-informed researchers as well as research-informed policy makers and practitioners.

It is vital that we respect practice wisdom in situations requiring sensitive and nuanced judgements such as child protection. Practice wisdom is still a relatively untapped resource for research.

Child protection research to date has tended to be fragmented. The way forward is through working collaboratively across different jurisdictions to develop common research priorities and pool our resources in studies using larger samples and be able to test interventions under different conditions. Australia and New Zealand would be natural partners in such an approach.

There are many research questions worthy of investigating but I cannot think of one that is more important than how to reduce demand on the statutory child protection system and enhance the well-being of children and their families by tapping the potential of the child protection “primary care system” to prevent and respond to child abuse and neglect.

For children who need to be in the statutory child protection system, I see the key priorities as being:

- How to prevent children being placed in care while ensuring safety at home
- How to minimise multiple placements for children who are taken into care
- How to achieve successful reunification of children who have been removed with their parents or extended family
- How to facilitate timely placement in a permanent substitute family when reunification with the biological family is not possible.

In relation to all of these questions, the issue of parental substance dependence looms large. Enormous amounts of money have been spent on alcohol and drug related research but very little on parenting in the context of substance dependence. We are facing a time bomb in our societies in relation to the impact of alcohol and drugs on children, including unborn babies at high risk of the devastating and irreversible effects of foetal alcohol syndrome.

As well as applied research on such topics, we need to use basic research from the biological, behavioural and social sciences such as that on early brain development, attachment, resilience and vulnerability, risk and protective factors, social networks and social capital. We have more knowledge than ever before and we must work hard to close the gap between what we know and what we do.

Transplant successful innovations in policy and practice in a sustainable way across our service systems

Some of the answers to our problems already exist – in innovative policy, program and practice developments that are beacons for the whole field if only we can understand and adapt them for other contexts.

There has been little attention in the child protection field to the systematic diffusion of innovation, an area pioneered by agricultural scientists, sociologists and market researchers and recently taken up by those in the health and educational fields. In the diffusion of innovation literature in the health field it has been said that: “The challenge is to promote uptake of innovations that have been shown to be effective, to delay spread of those that have not yet been shown to be effective, and to prevent uptake of ineffective innovations” (Haines & Donald, 2002, p.4).

This is important to heed as not all innovation is worthy of transplantation and the first principle should be “do no further harm”. Naturally occurring innovations in professional practice, programs and policy development occur all of the time in the human services, including child protection. If we are rigorous and systematic in the way we tap this potential, it can provide us with a solution-focussed strategy for going forward.

A good example of this is the Family Group Conferencing in both child protection and juvenile justice, first developed in New Zealand. Enshrined in legislation here, this model of working with families has had an impact well beyond New Zealand (Connolly, 2004). In fact, its implementation beyond New Zealand makes an interesting case study of the diffusion of innovation – why a model is introduced, how for better or worse it is adapted, and whether it is marginalised and withers on the vine or becomes embedded in a new system and even helps to transform the culture. How well it is sustained in its native soil is also an interesting question here in New Zealand.

A rigorous process of *‘innovation, evaluation, dissemination and transplantation’* is required.

- ***Innovation***

Find the seed of innovation that addresses a key issue and nurture it in good soil - committed, skilled people in a strong organization which is willing to be a mentor in helping others to learn from their work if it proves successful.

- ***Evaluation***

Build in rigorous evaluation to find out whether and how the innovation works, paying particular attention to

- effectiveness
- efficiency
- transferability
- sustainability

Only if all of these conditions are present can the investment in widescale transfer of innovation really be justified. The cost, the level of organizational change required and the staff retraining to make it work may not justify introducing it otherwise. We will never have enough resources to allow a thousand flowers to bloom and plant all of their seeds elsewhere. Equally, it is a very wasteful investment in innovation if all we end up with is a paddock full of petals. Too often I see in our field a politically-driven plethora of pilots with no sustainability strategy.

- ***Dissemination***

If an innovative approach meets the stringent criteria of effectiveness, efficiency, transferability and sustainability, then it needs to be disseminated in ways that communicate effectively with a range of stakeholders.

- ***Transplantation***

Transplantation is a better term than replication as the innovation may need to be adapted to fit different conditions. It is akin to growing a plant in a new climate where one may need to compensate for low rainfall or poor soils. While this may be necessary it is also risky and needs to be done in a very systematic and rigorous manner, maintaining the core elements of the innovation. It is easy to throw the baby out with the bathwater, and often one finds an innovation becomes so diluted and modified that it is hard to recognize it as the innovation it was intended to be. Program integrity, while allowing for some flexibility, is crucial.

Hope

Sowing the seeds of innovation is one of the greatest sources of hope in the history of child protection, and hope itself is as important as research and innovation. As our knowledge in child protection has increased greatly over the past generation, I wonder if our reserves of hope may have diminished? Perhaps hope is the most precious resource in an era in which the spirit of the age is one of fear and despair.

The children and families with whom we work have often lost hope, as have the communities in which they live. Those who work in child protection as policy makers, managers, practitioners or carers, sometimes lose their hope too and when this happens it is harder to nurture hope in the children and their families.

People are starting to research, write and talk about hope. Valerie Braithwaite (2004) from the Australian National University has recently written about what she calls “institutions of hope ... which not only dream the extraordinary but do the extraordinary.” Let us hold in the light those who lead our organisations so that they may nurture institutions of hope.

What nurtures hope within each of us, I wonder? I expect we have many different sources of hope, but for those of us called to work in the field of child protection there is probably one source of hope we have in common - a deep belief that each child born into this world is a harbinger of hope.

I would therefore like to end by sharing with you a true story that speaks to us as adults of the hope and the courage of children. It is about a 12 year old boy called Stephen Nona, a Torres Strait Islander, a descendant of the people whose long ancestry links the indigenous people of Australia and the Pacific. Stephen received the Australian Bravery Decoration in 2005 for saving his sisters' lives.

In mid 2004 Stephen and his family were in their fishing boat en route to Thursday Island when the boat was swamped. His parents, struggling to save their four year old nephew, urged Stephen and his sisters to swim to a rocky outcrop. The parents and the little boy were never seen again. Stephen and his two sisters reached the rocks, where there was no water and little shelter from the sun. On the third day he said to his sisters “ We have to swim – or we'll die”. His sisters were not strong swimmers and

they were daunted by what seemed an impossible swim. He urged them “to swim with one heart and one mind” and as the tides turned in their favour, he led them into the water, telling them “to swim quietly not to attract sharks”. Later he said “When they got tired, I swam behind, pushing them along”. They swam all day and eventually reached an island where they were found by a search party led by their uncle.

In the field of child protection we now need the hope and the courage to swim with a new tide rather or we will wither on the rock. We need to push one another along from behind when it looks like one of us is about to go under. Above all we need to remind one another that the greatest treasure in the world is children.

Kia ora koutou. Kia ora koutou. Tena tatou katoa.

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