Home-Based Family Assessment And Other Factors Associated With Child Protection Outcome In High Risk Families.

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

(Signed): …….

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ABSTRACT

Families with serious and/or chronic child protection risks often have complex personal and social issues. Statutory child protection services must manage escalating child protection reports with limited resources. Addressing families at immediate risk often takes precedence over comprehensive family assessment and planned intervention, so the child protection issues in the lower priority families persist, and child protection reports continue.

The Montrose Home-Based Family Assessment Program assesses Department of Community Services registered families who are at risk of child removal because of chronic and/or severe child protection issues. Using an ecological perspective, the Montrose team conducts a five day comprehensive assessment in the family's home and community, and develops a caseplan to address child protection risks and family support needs. The assessment is voluntary, and the family is encouraged to participate in identifying the child protection issues and developing solutions.

The primary goal of this study is to compare child protection outcomes, three years after referral, for 100 families who participated in a Montrose Assessment, and 100 Comparison Group families. The research questions also explore the relationship between demographic, family, parent, child and child protection service factors and child protection outcome. Outcome is measured by Family Outcome, Children's Outcome, Legal Status, Children's Placement, subsequent Child Protection Reports and Substantiated Child Protection Reports, and Type of Abuse.

The results suggest that home-based family assessment is a cost-effective model that can measurably reduce the likelihood of further abuse, court intervention and out of home care even for complex, high risk families. The study also identifies specific child, parent and child protection service related variables that are significantly associated with child protection outcome. These findings have major relevance for current child protection policy and practice, and also for broader social policy that impacts on high risk families.

CHAPTER 1: INTRODUCTION AND RESEARCH AIMS

1.1 Introduction

In recent years, child protection in western society has been dominated by a number of significant challenges. Families have become more complex, both structurally and in terms of their life circumstances. Stressful home situations can increase the pressure on parent-child relationships, sometimes precipitating serious concerns for the safety, welfare and wellbeing of the child. Statutory agencies have been overwhelmed by child protection reports, while the current economic climate has forced them to manage finite resources by prioritising responses towards reports involving the most critical immediate risks.

More comprehensive assessment is required for families with complex problems as well as high level child protection concerns. The Montrose Home-Based Family Assessment Program combines safety assessment, risk assessment, and strengths and needs assessment in a consultancy service for DoCS* registered families at high risk of child removal. The Assessment process, described in detail in Chapter 4, involves an intensive 5-day assessment in the family's home and community, culminating in a Report and a recommended caseplan to address both child protection risks and family support needs.

1.2 Research Goals of this Study.

The Primary Research Goal is to evaluate the effectiveness of the home-based family assessment model by comparing child protection outcomes, three years after referral, for 100 Montrose assessed families and 100 equivalent families who met all referral criteria for the Program but did not participate in an assessment.

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* NSW Department of Community Services.

Other Research Goals relate to identifying demographic, child, family and child protection service related factors that are predictive of outcomes for high risk families.

1.3 Outline of the thesis.

Chapter 2 places the study in context, by exploring the social, economic and legislative issues impacting on children, families and child protection in late 20th and early 21st century Australia.

Chapter 3 reviews child protection literature on factors potentially impacting child development, welfare and wellbeing, in the context of Ecological Systems Theory (Bronfenbrenner 1979, 1999). This study supports the view that comprehensive assessment is the foundation for successful interventions with families and should include:

1. The child's developmental needs
2. The parents' or caregivers' capacities to respond appropriately
3. The wider family and environmental factors. *(*Department of Health 2000, p.12*)*

Chapter 4 describes the Montrose Home-Based Family Assessment Program during the period covered in this study (1990-1999). This model is ecological in approach, taking into account the inter-relationship of children, their families and their communities. The Program's *immediate* goal is to prevent family breakdown while maintaining child safely. Its *longer-term* goal is improved parenting capacity, overall family functioning and child protection outcome. It relies on accurate assessment of the risk factors, family strengths and needs, parents' capacity and motivation for change, and the availability of appropriate support services. Parental participation in the assessment process enhances the potential for successful engagement with recommended services.

Chapter 5 outlines the study's research goals and methodology. The study is an outcome evaluation of 200 families referred to the Montrose program -

100 Montrose assessed families and 100 equivalent Comparison Group families. The Research Model is a quasi-experimental design, using secondary analysis data from DoCS computerised individual child protection files. Multinomial logistic regression (Hosmer and Lemeshow, 1989) is used to develop models of the variables most strongly associated with child protection outcome.

Chapter 6 describes the 200 families in the study. Although the Comparison Group was not formed by random selection, its families are sufficiently comparable to the Assessed Group families on demographic, family, parent and child-related variables for it to constitute an acceptable non-equivalent control group.

1.4 Major Findings.

Chapter 7 compares the child protection outcomes, three years after referral, for the two groups of referred families, measured across seven domains: Family Outcome; Children's Outcome; Legal Status; Placement History; Number of Notifications* per family; Number of Confirmed (substantiated) Notifications per family; and Type of Abuse reported.

The findings also identify a number of child, parent and child protection service related factors associated with child protection outcomes. (Fig 1.1).

Chapter 8 investigates the possible role of the Montrose assessment in mitigating the negative impact of the identified predictive factors on child protection outcomes. The findings indicate that participation in a Montrose assessment appears to have a mediating effect with high risk families, even in the presence of factors otherwise associated with negative child protection outcomes.

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* The terms *Notification* and *Child Protection Report* mean the same thing in practice and are used interchangeably in this thesis. The same applies to the terms *confirmed* and *substantiated*.
A *Notification* is the term used during the years covered by this study to describe a contact with the statutory child protection service (NSW DoCS) concerning risk or harm to a child. In NSW, since the Children and Young Persons (Care and Protection) Act 1998, a notification has been called a *Report.*

1.5 Findings of this Study in the Context of other Research, and Implications for Child Protection Policy and Practice.

Chapter 9 reviews the major findings of this study in the context of other research findings, and highlights the implications of these findings for child protection policy and practice.

The study acknowledges some limitations associated with inferences about causality that can be drawn from a research design using a non-randomised Comparison Group and secondary data. However, taking into account these limitations, the results give a strong indication of the value of this comprehensive home-based family assessment model for wider use in child protection practice. The model encourages the family members' participation in identifying their specific child protection issues and support needs, and promotes family engagement with interventions and services, increasing the likelihood of improved parenting, improved family functioning and reduced child protection risk.

The goals and philosophy of the program are clear and accessible, the procedures are transferable and the model is cost-effective. It could be replicated in its current form for use with other families with high level child protection risks, or adapted for other specific client groups and populations,

At a more general level, the study identifies a number of models associated with child protection outcome, the strongest of these containing *combinations* of factors related to the child, the family and the family's interaction with the child protection service system. The results indicate that child maltreatment is associated with a complex interaction between individual and family factors and the wider social system.

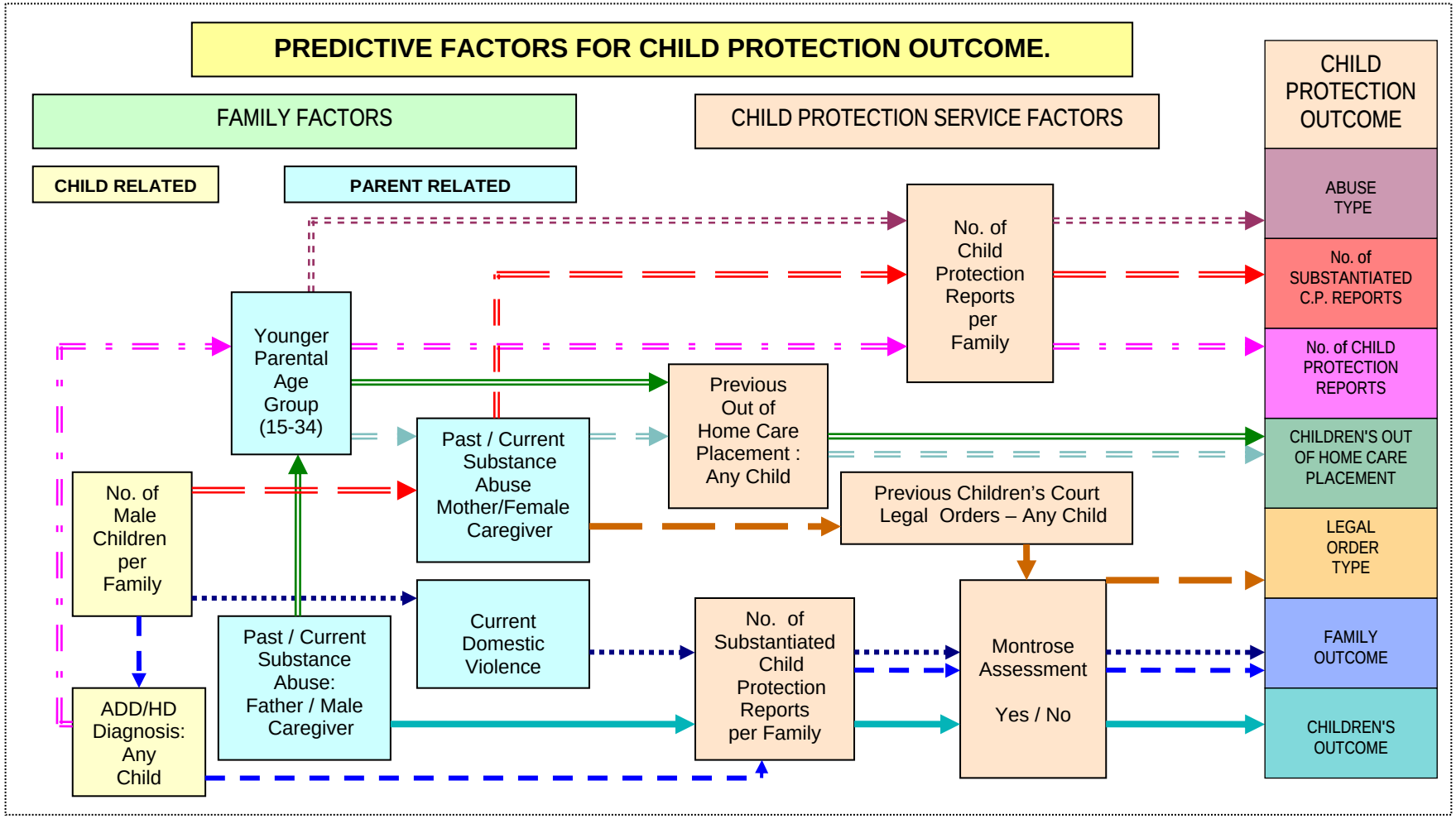
A policy implication for child protection practice involves whether the model could be successfully extended to non-voluntary families, e.g. through the use of Children's Court Assessment Orders. Another policy implication, for statutory child protection services, is associated with the way families are

prioritised for child protection response at the initial point of contact. Current strategies are not dealing effectively with chronic 'lower risk' families, who characteristically make up a large proportion of re-referrals, but who do not currently receive any intervention unless the risk level escalates.

Practice implications are directed towards earlier intervention with a wider range of vulnerable families, to reduce the likelihood that initial child protection risks will escalate and/or become chronic.

Further research suggested by this study involves more detailed understanding of the factors identified in the study as being associated, individually or in combination, with poor child protection outcomes.

Fig. 1.1: Main Effects Predictive Models for Child Protection Outcome.



CHAPTER 2: CHILDREN, FAMILIES AND CHILD PROTECTION IN LATE 20th AND EARLY 21st CENTURY AUSTRALIA.

2.1 The Social Context of the Child in the late 20th Century.

This study relates mainly to the years 1990 to 1999, which covers the period three years before and after the 200 families in the study group were referred to Montrose for assessment, from January 1993 to December 1996. It is important to examine the social context relating to children and families in Australia during this last decade of the twentieth century, before progressing to a more detailed description of the Montrose target group families.

Over the centuries, the question "*What is a child?"* tends to produce highly variable answers, and the social construct of childhood is even more subjective. Aries (1962) contends that childhood is a social invention, that parenting in the Middle Ages focused on meeting only the physical needs of children, and that the vulnerable nature of childhood and children's needs for an affectionate bond with parents is a product of the 15th to 17th centuries.

Wilkinson (1993) summarises the thoughts of a number of authors: "Traditionally childhood has been associated with immaturity, dependency and vulnerability, where it is usual to regard children as bearers of a limited range of rights and where adults are regarded as promoting the child's development or protecting the child from harm." Wilkinson (1993, p.146) cites Franklin (1986), who contends that the concept of childhood is a relatively recent invention and does not describe a single, universal experience of any fixed duration. Franklin suggests that existing divisions between childhood and adulthood are arbitrary, that children are defined in a negative way as 'non-adult', and that the term 'child' has less to do with age than with power.

The Convention on the Rights of the Child was adopted by the United Nations General Assembly in 1989. In its preface, the Convention cites the Universal Declaration of Human Rights (1959), in which the United Nations

proclaimed that "childhood is entitled to special care and assistance." The Convention asserts that as well as being afforded the same basic human rights as adults, the child is entitled to specific additional rights regarding care and protection. Because of the child's physical and mental immaturity and vulnerability, some of these special requirements include care and legal protection, before and after birth.

By 1990 The Convention had been signed and ratified by a sufficient number of nations, including Australia, to come into force. This indicates that childhood is an internationally recognised phenomenon, and in this international context, childhood begins before birth and ends at the age of majority for the relevant signatory country, or at 18 years, whichever is the earlier. In Australia, there is no common legal definition of a child across the states and Commonwealth. Definitions tend to vary according to circumstance and become even more contentious when dealing with the issue of children's rights.

Edgar (1992) examines the roles of the family and the state in the socialisation of the child in the last decades of the 20th century. He asserts that childhood refers to a social status conferred by a society on a group defined by age and dependency upon adults. He cites the findings of Qvortrup (1987) in the European Centre's review of the status of childhood in a number of European countries in 1987. Qvortrup (1987) maintains that childhood must be seen as a social construction, a permanent structure in society whose members are continually being replaced.

Edgar (1992) concludes from the European Centre study that childhood is a concept that States structure according to their individual cultural goals and needs. He states that the legal system defines children's status as 'not-yet-adults', which reflects adult society's view of the child, but disregards children's rights by devaluing their individual capacity for autonomous action. He cautions that the pursuit of children's rights should not deflect attention

away from children's *needs* and adult (not only parental) *responsibility* for children, particularly with regard to socialisation.

Edgar's paper is in part a response concern about the direction of the children's rights movement (with an implied threat to parental rights) which followed the ratification by numerous countries of the UN Convention on the Rights of the Child (1989). The rights afforded to the child under the Convention may be summarised under nine subgroups:

1. The right to life and opportunity for development, free from all forms of discrimination, exploitation, abuse, neglect, and cruel or degrading punishment or torture. *(Articles 2, 6, 19, 32-37)*
2. The child's rights and interests to be given paramount importance and his/her opinions and wishes to be given due consideration in all matters pertaining to him/her *(Articles 3, 12, 21)*
3. The right to grow up in the security of his/her family, with a sense of personal and cultural identity, with minimal state intervention but with access to all state services to support and assist the parents to provide an adequate standard of living for the child. *(Articles 5, 7,8, 18, 26, 27)*
4. If deprived of his/her own family environment, the right to provision of alternative care and protection from the State in a culturally appropriate living situation, with the placement being regularly reviewed. Further, the right to know and maintain contact with non-custodial parents, unless it is not in the child's best interests to do so. *(Articles 9, 20, 25)*
5. The right to state protection against abduction by a non-custodial parent or other party, for any purpose. *(Articles 11, 35)*
6. Freedom of thought, expression, conscience, religion, culture, language, privacy and association. Access to appropriate mass media information and protection from harmful material. The right to participate in play, leisure and artistic and cultural activities. *(Articles 13-16, 17, 30, 31)*
7. The right to the highest level of health care. Provision of free and compulsory primary education and equity of access to a range of secondary

education, aimed at developing the child's personality, talents and mental and physical abilities to their full potential. *(Articles 24, 28, 29)*

8. Special protection and social integration for refugee children and children with disabilities. The right to protection, basic legal guarantees and the goal of social reintegration for young people involved with juvenile justice services. *(Articles 22, 23, 40)*

9. The right to all possible protection from active participation in armed conflict under the age of 15 years, and the right to maximum physical and psychological rehabilitation and social reintegration for all child victims of armed conflict. *(Articles 38, 39)*

Carney (1990) asserts that the UN Convention "reflects a perception which embraces both the vulnerable, dependent child requiring special protection and also the child who is a potential adult, or is adult-like, and thus the rightful recipient of a range of civil, political, legal and social rights similar to those attaching to the status of adult." (Carney 1990, quoted in Wilkinson 1993, p.148)

The Articles of the UN Convention on the Rights of the Child provide a poignant commentary on an international perception of the place and role of the child in the last two decades of the 20th century. Childhood is, it would seem, a time of special needs and privileges, but also a time of particular vulnerability. The child may rightly expect to be nurtured and protected by adults but also requires legislated safety from harm and exploitation from elements of the adult world.

At the most extreme end of the child risk spectrum, studies of homicides in NSW between 1968 and 1981 (Wallace 1986) and in 1986 (Bonney 1987) found that approximately 10% of homicide victims were children under 10 years of age, 96% of these having been killed by a parent or other relative. The National Committee on Violence (1990) found that across all age levels in the Australian population, infants under one year old are the group at greatest risk of homicide (p.20), predominantly from their parents or other

relatives (p.4). Ten years later, the under one year olds had been supplanted by males aged 30-34 years old, but the rates of victimisation for children under one were still described as "high" (Graycar and Mouzos 2002, p.3).

It would appear that even in developed, industrialised nations, the Convention is not a reflection of how children are currently treated, but rather the statement of an ideal, or worse, a set of *minimum* standards against which states may measure themselves.

In 1993 it was revealed that Australia had failed to fulfil its obligation to report back to the United Nations on the status of Australian children two years after ratifying the UN Convention on the Rights of the Child. In reporting Australia's failure to meet its treaty obligations, the Co-ordinator of the Children's Rights Coalition highlighted a number of specific areas where children's status had not changed since the Convention was signed (McNicholl 1993). These areas included community attitudes towards Aborigines and Torres Strait Islanders, child victims of abuse, children with disabilities, and those affected by family dysfunction.

In modern, industrialised society many of the expectations regarding the child's basic rights to life, adequate standard of living, basic health care and freedom from harm and exploitation should be assumed. Western society promotes an idealised, generally privileged picture of the child through the mass media, particularly in advertising. For many children in Australia, this picture is essentially true in terms of their access to nurturance from their family and an adequate standard of living, education and health care. At the same time, many other children are living in quite different circumstances, lacking access to either the benefits or protection of their community.

The standard of care most children receive is ultimately dependent on the nature and quality of their family circumstances. State intervention, when required to address an inadequate level of care and protection, may be tentative or interventionist, but unfortunately, it is often inconsistently applied,

depending of different states' legislative definitions of risk and harm, and depending on the financial and workforce resources available to statutory child protection services.

2.2 The Changing Social Context of Children and Families in Australia.

The Preamble to the United Nations Convention on the Rights of the Child (1989) states some assumptions about children and families on which the Convention is built. These include the assumption that the family is "the fundamental group of society and the natural environment for the growth and wellbeing of all its members, particularly children" and that the child has a need and right to grow up in an atmosphere of "happiness, love and understanding" and should be "fully prepared to live an individual life in society".

The social context of the child varies across cultures and within cultures over time. Elliot (1986) asserts that the view of childhood as a time of dependence and psychological vulnerability is peculiar to, and the product of, modern western culture, and that the antecedents of 20th century changes in the circumstances and social role of children can be traced back to the mid 19th century. The Industrial Revolution, with the exclusion of young children from the labour market and the trend towards compulsory education, marked the beginning of a significant change in the status of children in western society.

Two of the basic tenets of the United Nations Convention on the Rights of the Child are the roles of the parent as the primary caregiver and the family as the fundamental unit of society for the nurturance and socialisation of the child. Yet, the Convention does not define a family, except to concede that it may include extended family members. In fact, the diversity of family structure in late twentieth century western society is the subject of an extensive body of literature (Rapoport et al 1977; Scanzoni 1987,1989,1991;

Anderson and Hula 1991; Gilding 1992; Edgar 1992; Briggs 1994; Skolnick and Skolnick 1994; McDonald 1995).

The changing role of the family has been reflected both in its internal relationships, and its kinship and neighbourhood networks. McDonald (1995) notes that before and after the Industrial Revolution, young couples were expected to set up independently of their parents, and older persons expected to live separate from their children. Industrialisation had the effect of increasing the incidence of extended family households in towns and cities because of housing shortages. This was the case in Australia in the mid 19th century, but by the turn of the century improved transportation and availability of housing led to a decline of the extended family in inner city areas and the return of the nuclear family in the suburbs.

Gilding (1992) documents the changing patterns of family/household formation in Australia from the late 19th to late 20th centuries, using government reports, census data, real estate material, advertising and diaries, letters and autobiographies. He examines the role of social trends, changing market forces and welfare policy on the composition of the family unit within society, and notes that increasingly, the market and state have replaced kinship and neighbourhood relations as primary influences on the family.

Gilding (1992) reports that the structure of the early 20th century Australian family was affected by laws relating to divorce and payment of maintenance for children, married women's rights to own property, the legal right of deserted women to remarry, compulsory primary education, child labour laws, the vote for women, birth control methods, and a resultant decline in the birth rate that continued into the 1920s and 1930s. This period saw the growth of the middle class and middle class family values. Traditional family values were supported by the provision of the "basic wage", introduced in 1906 and deemed to be sufficient to support a man, his wife and three

children at a basic level. This formula continued as the basis for wage-setting policy in Australia until the 1970s.

The Australian family has been greatly affected by the social, economic and political trends of the latter half of the twentieth century. The rapidly changing nature of the family in urban, industrial society, and its consequent effects on the role and status of the child, can be clearly traced over the last half of the 20th century. In the immediate post Second World War decades, more couples married, at progressively younger ages.

McDonald (1995) reports that during the 1950s divorce rates fell and the decade saw both the post war "baby boom" and a rise in the acceptability of "family planning". This era of the modern nuclear family - the father (breadwinner), mother (not in paid employment) and children - was supported by the economic climate of the 1950s, with low unemployment, low interest rates and affordable, detached suburban housing. Families consisting of a woman and children without a male wage-earner were significantly financially disadvantaged. (p.33)

Smaller families permitted a change in childrearing practice, focussing on close affectionate relationships between parent and child with the aim of fully developing of the child’s potential. Bowlby (1953) proposed his attachment theory, where the "significant other" to whom the child could become attached could only be the child’s mother, or mother substitute. The father’s role was to be the income provider and keep the mother financially and emotionally secure.

A longer term effect of this new focus on children was the emergence in the late 1950s of the teenager as a distinct social (and economic) category. Aries (1962) suggests that for every period of history there is a 'privileged age' - youth being the privileged age of the 17th century, childhood in the 19th century, and in the twentieth century, it was adolescence.

Effective birth control coincided with the permissive era of the 1960s, with two thirds of Australian women in their reproductive years in this decade using the contraceptive pill, the highest proportion in the world. (Hugo 1986, pp.45,73). However, despite access to more reliable methods of birth control, between the late 1940s and the late 1960s, ex-nuptial births in Australia more than doubled among women aged 15 -19 years, relative to population (Connell, Francis, Skilbeck et al 1957).

From late 1960s, households became smaller and more diverse. Married couples with children declined in relative numbers, single households, groups, childless (by choice) couples, defacto unions, single parents and blended families increased (Gilding 1992). Another challenge to the nuclear family was the increasing emergence of homosexual relationships in the 1960s. The incidence of same sex relationships was measured for the first time in the 1996 census (McDonald 1995, p.37).

In 1973, social welfare benefits were extended to include unmarried mothers, "deserted wives" and the unemployed, giving women a degree of financial independence from men. The expansion of the labour market and subsequent employment of more married women substantially affected the economic relationship between men and women and the traditional role of women in the family. By 1971, 32% of married women in Australia worked outside the home (Eccles 1984, pp.80-81). At the same time, the nurturing role of women in the nuclear family was accentuated by child experts such as Bowlby (1969), whose republished work on the theory of "maternal instinct" and the risk of "maternal deprivation" led to increased tension for working mothers trying to balance the demands of work and motherhood.

The emergence of feminism in the late 1970s had a significant and continuing effect on family life in western cultures. It has been associated with later ages at marriage, women’s access to reliable means of contraception, declining birth rates, increasing divorce rates, alternative living arrangements, and increasing participation of women in the labour market.

All of these factors have resulted in a significant redefinition of the roles of women with respect to men and children.

Financial tensions within the family increased with the economic recession of the 1970s and 1980s, as did the rate of divorce and dissolution of defacto relationships. Women's growing financial independence from men, together with the increasing dependence of children led to the one-parent family being the fastest growing household type in the 1970s, most of these families consisting of a mother and her dependent children (Gilding 1992). Over the last two decades, reporting of domestic violence has also increased, with women less willing to tolerate abuse and being supported by welfare services and payments to escape violent partners.

Lack of maintenance payments, increasing childcare costs and the generally lower market value of women's work meant that many single parent families were forced to depend on government or non-government welfare. By the late 1980s, child poverty in Australia was recognised to be at such an unacceptable level that its elimination was a federal campaign issue. Despite the campaign rhetoric, by 1990, one child in eight was estimated to be living in poverty. This figure increased as the economic recession progressed (King 1991).

By 1990, 56% of married women with dependent children were contributing to the family's income on a part or full time basis (ABS 1990). This phenomenon increased the demand for professional out-of-home childcare, and welfare assistance for this service. Another effect of increased employment was that in 1992 over 611,000 Australian families had either the husband or wife, or both, out of work. One third of these unemployed parents were main breadwinners with dependent children, meaning 430,000 children were growing up with a parent out of work (Edgar 1992).

The 1980s saw a rise in the number of de-facto relationships, to the extent that they were legally and socially included in definitions of family (Harrison

1990). By 1986, women in Australia in the age group 20-29 were more likely to live in defacto relationships than be married (Brachter and Santow 1988). Those couples who married tended to do so later, and many then delayed starting a family. Families became smaller, with two children being the ideal, and single children and couples with no children becoming more common (Hugo 1986). In 1986, the Australian Bureau of statistics included couples without children in its definition of family (ABS 1986).

Welfare support and increased public acceptance of single mothers resulted in fewer children being available for adoption. As the number of Australian children available for adoption became almost negligible, interest arose in inter-country adoption, from Sri Lanka, Korea, South America and China. De Vaus (2004) reports that in 1971, 10,000 children were adopted in Australia, mainly placements made by agencies. By contrast, only 561 children were adopted in 2001-02, the majority of these being inter-country adoptions or adoptions of children already known to the adopting parent/s, while less than 20% of the total were children being placed by agencies.

In-vitro fertilisation has created new options for childless couples, and also for women who wished to have children outside a formal relationship, whether marriage or defacto. From the 1980s legal and statistical definitions of family began to accommodate ex-nuptial births (Harrison 1986; ABS 1986 quoted in Gilding 1992).

Remarriage has become progressively more common in Australian society, and there has been a subsequent increase in the number of families where children have step or half-siblings, giving rise to a number of permutations of family structure and the concept of the blended family, which may comprise children from previous and present relationships.

Although the legal age of adulthood was lowered in Australia from 21 to 18 years in the 1970s, extended years of secondary and tertiary education, increased rates of youth unemployment, and limited availability of affordable

accommodation, have extended the period of economic dependence of children on their parents. In Australia, the Year 12 retention rate rose from 41% in 1983 to 77% in 1992, with the trend continuing through the 1990s (Cunningham 2002). The effect of this change is a rise in the incidence of families with dependent older teenage children, extending into the early 20 to mid 20's for young people pursuing tertiary education, which is now subject to tuition fees that preclude independent living for many full time students. The presence of legally autonomous but financially dependent adult children in families can give rise to tensions between them and their parents that were not part of family life in the past when children achieved financial independence at a younger age.

The nature of the Australian family has also been increasingly touched by successive waves of migration. Between 1947 and 1993, the Australian population grew from 7.5 million to 17.5 million, approximately one third of this increase being directly due to overseas migration (Harvey 1994). Price (1993) estimated that in the year 2000, more than 40 per cent of young Australians would be the product of ethnically mixed marriages.

Briggs (1994, p.3) summarises the following ways in which family life in Australia in the 1990s was different from preceding generations:

- An increase in cohabitation with more children born outside marriage;
- More ethnically mixed marriages;
- Later marriage and earlier divorce;
- More and different pressures on children and parents;
- Planned pregnancies, older parents and smaller families (helped by more reliable methods of contraception and the availability of legalised abortion);
- High levels of unemployment affecting children and parents of all ethnic groups and social classes;
- Both parents having to work to meet mortgage and other commitments;
- Women demanding equal rights, equal partnerships and child-care.

The definition of a family in Australia in the late 1990s and the early part of the 21st century is therefore both complex and dynamic. In addition to the traditional nuclear family, a legally recognised contemporary Australian family may comprise:

- a married couple with children
- a defacto couple with children
- a married or defacto couple without children
- a single parent (usually mother) and child/ren, or
- a married or defacto couple with children from either or both partners' previous relationships, with or without children of the current relationship.

In addition to the permutations of family listed above, families may include children adopted in Australia or, more commonly, from overseas. The move to de-institutionalise child welfare residential services in the early 1990s, and the rising rate of child protection interventions has led to a significant increase in the number of children accommodated long-term or permanently in kinship care or with non-relative foster carers.

Thus, within this wide definition of what constitutes a family in early 21st century Australia, children are potentially involved in a range of relationships with primary caregivers that goes far beyond the one-dimensional parent-child relationship. The implications of this increased complexity of relationships will be discussed in more depth in Chapter 3.

Gilding (1992, p.132) argues that there are several reasons behind society's redefinition of the concept of family to include a wider range of relationship options. Firstly, it gives legitimacy to the variety of household types that exist, and therefore appeals to a large part of the community. Secondly, it is partly expedient. Normalising a wider variety of family structures means that there is less call for state intervention to protect the traditional (nuclear) family. Thirdly, it is a cost-effective way of limiting possible claims for welfare assistance. By legitimising a range of relationship options, governments can

cut costs by placing more responsibility on families and communities to care for their members.

Brennan (2005) summarises the major issues for children and families in Australia over the last 40 years, according to papers published in the Australian Journal of Social Issues. She presents a wide range of issues relating to family life and children's life situations, but contends that there are " three major themes that predominate: Maternal employment, child care and work/family issues; divorce, child custody and adoption; child welfare." (p.73)

2.3 The Children's Rights Debate.

The issue of children's rights has highlighted the tensions between the rights of the parent and the child, compounded by the right of the state to intervene in the relationship between parent and child (Brown 1980). These tensions are largely the result of society's wide and varying perspectives on the status of the child. The young child is seen in terms of its need for protection by the parent, or by the state from the parent in the case of abuse and neglect. Older children and adolescents are more often seen as requiring control by the parent, but if this fails, society may require protection from the inadequately socialised child. Children of all ages are affected by the interventions of Family Court legislation. The rights issue in Australia may therefore be debated in a number of legal jurisdictions - the Family Court (federal jurisdiction) and the Children's Court (state jurisdiction) and the Criminal Court (state or federal jurisdiction - depending on the offence and the age of the offender).

The children's rights movement argues strongly for the equality of human rights for the child as a member of the society in his/her own right rather than as an attachment of the parent (Alston 1991). Evatt (1989) described the issue of differentiating between children as dependents requiring protection and as independent individuals as 'perhaps the most difficult and controversial issue in children's rights'. The period of debate which took place

between the adoption of the United Nations Convention on the Rights of the Child and Australia's ratification clearly indicates the continuing conflict between those who would promote children's rights and those who fear that increasing children's rights means a corresponding diminution in the rights of their parents and the state. The children's rights debate included test cases in the U.S. and Australia where children sought to legally dissolve the parent-child relationship because of irreconcilable differences (Brennan 2005, p.85).

The 1980s saw a worldwide movement to recognise the individual rights of the child, culminating in the United Nations Convention on the Rights of the Child (1989). Throughout the 1990s, there was continuing debate between those dedicated to extending the range of rights for children, and those who held a 'protectionist' view of the child who recognised and supported the differences in children's and adults' capacities, and advocated for 'special protection' for children (Wilkinson 1993).

Despite this move for equity and the rights of the child, there are many anomalies, e.g. equality for children under the law, as defined in Article 40 of the United Nations Convention on the Rights of the Child, has been challenged in Western Australia. Legislation in that state allows violent young offenders, or those with long term histories of offending, to be treated more harshly than adults who commit the same offence (White 1992). In highly publicised court cases, inequity has occurred in the way the media has demonised children who have been convicted of killing other children, even though the law has taken their age and capacity into account in sentencing. In the U.S. the death penalty for 15 year-olds was ruled unconstitutional in 1988, but still applies to 16 and 17 year olds. (Harrison 1990).

In a commentary on the *Children Act 1989 (England and Wales)*, Ward (1992) noted the movement in the Act away from parental *rights* towards parental *responsibility*. There is also greater concentration on the welfare and wishes of the child, and greater emphasis on encouraging the family to resolve difficulties as far as possible without external intervention. In addition,

the Act extends the range of possible orders and encourages a less interventionist approach by the courts, so that the court must be satisfied that any proposed order would contribute positively to the child's welfare.

The *NSW Children and Young Persons (Care and Protection) Act 1998* reflects many of the same basic principles as the *Children Act 1989 (England and Wales)*. In terms of statutory child protection legislation in Australia, there has been a general move towards recognising the rights of the child to protection from physical, sexual and emotional abuse, the right to receive a basic level of physical and emotional care (protection from neglect). In addition there is acknowledgement of the child's right to live in safety from exposure to domestic violence and from all forms of sexual exploitation. Children are afforded the right to be informed of child protection interventions that affect their lives and to participate in decision making at a level commensurate with their age and capacity.

Parental responsibility for children's safety, welfare wellbeing are also emphasised in the *Children and Young Persons (Care and Protection) Act 1998,* and are supported by criminal legislation which enables prosecution of parents for failing to meet their parental obligations with regard to child safety, welfare and supervision. The *NSW Children and Young Persons (Care and Protection) Act 1998* will be discussed later in this thesis, although it was not the legislation in force at the time of this study (1990-1999), having been proclaimed (in part) in 2000, after the conclusion of this study.

The process of redefining the status of the child continues with respect to the family and the state. This raises a dilemma for child protection services between balancing the child's right to safety, stability and nurturance with parental rights to be primarily responsible for the care and development of their children, free from excessive external (state) intervention (Smith 1992).

Since the 1990s, this dilemma has been addressed in NSW and some other Australian states by a child welfare approach that is described as "child-

centred and family-focused" practice. It is also underpinned by the concept of "strengths-based practice". According to Tomison (2002), the child-centred and family-focused model: "recognises the mutual significance of the child and family to each other… and promotes the importance of service professionals developing a strengths-based partnership with client families." (p.13) This approach works with the family to improve the life situation for the child and is the model employed by the Montrose Home-Based Family Assessment Program.

2.4 Child Protection Policy: State Perspectives on the Child's Basic Needs for Protection, Nurture and Development.

2.4.1 NSW Child Protection Legislation

This study focuses on the years 1990 -1999, during which time the relevant child welfare legislation in New South Wales *was the Children (Care and Protection) Act 1987*. From the year 2000, most of this Act was repealed and replaced by a new Act, the NSW *Children and Young Persons (Care and Protection) Act, 1998.* Various sections of the *1998 Act* have been operationalised since 2000, and other sections have not been proclaimed at the time of writing of this thesis. There have been some changes to the *1998 Act,* which was reviewed at the end of 2006.

The *Children*[*] *(Care and Protection) Act 1987* (hereafter referred to as the *1987 Act*) and its principles provided the legislative and child welfare professional context for underpinning the period of this study. Therefore, for the purposes of this thesis, in most cases the Act referred to will be the *1987 Act*.

The state's values on what constitutes essential basic needs for a child's adequate development are implicit in many parts of the *1987 Act*, but, in

[*] For the purposes of the New South Wales *Children (Care and Protection) Act 1987*, a ***child*** is defined as *a person who is under the age of 18 years.* ***A parent*** is defined as: *a) a guardian of the child;* and *b) a person who has custody of the child,* but does not include the Minister or the Director General or the father or mother of the child if that person has neither guardianship nor custody of the child. (s.3 (1)).

contrast to some other states of Australia[^], and to the New Zealand[#] and United Kingdom[*] legislation, this *Act* contains no single guiding statement of Objects and Principles applicable to the entire Act. The *1987 Act* does define a number of standards when considering state intervention in respect of children and their families, in Section 12: The Objects - Children's Welfare, and Section 55: The Objects - Children In Need Of Care.

Section 12: The Objects of Part 2 - Children's Welfare

With regard to State's perspective on the *needs* of the child, and of the family in supporting the child's development, s.12 (1) recognises that children may have special needs for services "to promote their optimum development", and also clearly designates the family as the ideal environment for the child's care and development. The state accepts responsibility for assisting families to gain access to appropriate services, to support the child within the family or to enhance the chances of restoration to the family if the child has been removed.

In addition, s.12(2) requires the Minister of the Department of Community Services (DoCS) to provide information about child and family welfare services to the community, and to provide assistance and support to non-Government organisations and persons providing child and family welfare services. The object of this action is to ensure "the provision of any necessary welfare services aimed at complementing the care given to children by persons responsible for them."

While the family is designated as the most suitable place for the child to live, the specific conditions under which a child in need may be removed from his/her family are contained in s.10(1):

[^] *Children and Young Person's Act* 1989, Victoria s.87; *Children's Protection Act* 1993, South Australia s.3.4.

[#] *Children, Young Persons and their Families Act* 1989, N.Z. s.4

[*] *The Children Act* 1989, United Kingdom s.1.

".. a child is deemed to be in need of care if:

a) adequate provision is not being made, or is likely not to be made, for the child's care;

b) the child is being, or is likely to be abused; or

c) there is a substantial and presently irretrievable breakdown in the relationship between the child and one or more of the child's parents."

Abuse is defined as:

a) assault (including sexual assault) the child; or

b) ill-treat the child; or

c) expose or subject the child to behaviour that psychologically harms the child; whether or not, in any case, with the consent of the child." *s.3(1)*

Neglect is defined as the failure to provide children with "*adequate and proper food, nursing, clothing, medical aid and lodging." s.26*

The *1987 Act* is silent with regard to what constitutes a satisfactory relationship between parent and child, or the indicators of a breakdown in that relationship. However, it states that this breakdown must be "substantial" and it may be inferred that such breakdown may be transient (or potentially salvageable), given the phrase "presently irretrievable".

The grounds for state intervention into the privacy of family life are therefore limited to specific instances of physical, sexual or emotional abuse, lack of basic physical care (neglect), or the substantial breakdown of the parent-child relationship.

While the *1987 Act* could be criticised for the vagueness of concepts such as 'inadequate provision', 'ill-treat' and 'psychologically harm', a number of concepts can be seen to be intrinsically valued throughout the sections of the *1987 Act* relating to the care and protection of children:

- The special nature and significance of the *relationship between child and parent* is clearly recognised and its preservation encouraged unless the child

is deemed to be at risk, or in need of care. The role of the family as the primary source of care, protection and nurture of the child is fundamental when considering any court action which may remove the child from his/her family. (s.12, s.55 and s.72).*

- The child has 'special needs' for services "to promote their optimum development", and the state's role is to assist families to access these services, or, in the event of the family's not being able to do this, the state is to provide, or assist non-Government services to provide, these services.

- It may be inferred from a number of sections of the Act that the state accepts varying degrees of responsibility for all children within its borders. At the level of least intervention, the state provides information, advice, support and services "aimed at complementing the care given to children by persons responsible for them." s.12 (2). At the other end of the continuum, delegated officers of the state have the right, under s.57, to make an application to the Children's Court with respect to children in need of care. Such action may result in the placement of the child outside the family's care for a specified period of time. Thus, the child's right to the need for care or protection outweighs the value of sustaining the parent-child relationship, although this relationship is acknowledged as highly significant in respect of the need for ongoing contact between the child in care and his/her parents, s. 72(2)(c).

In the event of the need to consider placement of a child outside the parent's care, s.72 (2) of the *1987 Act* specified that "the Children's Court must have regard to:

a) the need to protect the welfare of the child;
b) the views of the child;
c) the importance of encouraging continuing contact between the child and the persons responsible for the child;

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* The NSW *1987 Act* focuses on the relationship between the *child and parent*, as compared with children's welfare legislation from South Australia and New Zealand, which refers to relationships with other family members in addition to the parents. This perspective was broadened in the NSW *Children and Young Persons (Care and Protection) Act 1998*.

d) the importance of preserving the particular cultural (ethnic, religious, linguistic) environment of the child ;

e) the practicality of services and facilities being provided for the child without the need for the making of an order (of undertakings, supervision order, custody order or wardship order); and

f) the objects of this part."

In relation subsection (f), it is noteworthy that s.72 gives the Court the right to intervene in family relationships, but directs that all such decisions be considered in the context of s.55, The Objects of Part 5.

Section 55: the Objects of Part 5 - Children in Need of Care.*.

The Objects of Part 5 listed the premises on which the provision of assistance and support services to children in need of care are to be based. These values reflect many of the guiding principles of the UN Convention on the Rights of the Child (1989) and are as follows:

"a) the welfare and interests of children are to be given paramount consideration;

b) children are entitled to special protection and to opportunities and facilities to enable them to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity;

c) children, for the full and harmonious development of their personalities need love and understanding and, towards that end, should, wherever possible, grow up in the care and under the responsibility of their parents, but if that is not possible, in an environment of affection and moral and material security and, in the case of children of tender years should not, except in exceptional circumstances, be separated from their parents;

d) continuing contact between children and their parents should be encouraged in situations where, pursuant to legal proceedings, children have been separated from their parents;

e) children should be protected against all forms of neglect, cruelty and exploitation;

f) responsibility for the welfare of children belongs primarily to their parents, but if not fulfilled devolves upon the community; and

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* NSW *Children (Care and Protection) Act 1987.* NSW Government Printer. Sydney

g) *except in exceptional circumstances, or pursuant to legal proceedings, there should be no interruption of relationships between children and their parents contrary to the wishes of children and their parents.*"

2.4.2 Values stated or implied in the Legislation.

An examination of the *NSW Children (Care and Protection) Act 1987* produces a set of values which reflects the state's position from 1987 to 1998 on a child's developmental needs and rights. Some of these values relate solely to the child, but many reflect the special relationship between the child and his/her parents and the right of children to grow up in their parents' care, except where this would be contrary to the child's best interests. In the event of out of home care placement, the *1987 Act* was explicitly supportive of ongoing contact between the child and his/her family, except where this would be detrimental to the child.

The specific rights and values espoused in s.12 and s.55 of the *1987 Act* include:

- The child's right to access necessary services "to promote their optimum development".
- The family's right to access any necessary services and assistance to enhance their ability to meet the child's needs within the family environment.
- The child's right 'special protection' against all forms of neglect, cruelty and exploitation and also against separation from parents, especially for very young children, unless in 'exceptional circumstances'.
- Where out of home placement is necessary for the child's safety or welfare, due consideration must be paid to the child's wishes and needs for ongoing contact with his/her family, and the optimal goal of restoration to the family wherever possible.
- The child's right to 'opportunities and facilities' which will promote their physical, mental, moral, spiritual and social development.

- Children are entitled to 'love and understanding', preferably from their parents, but if not in their parents' care, in a situation that affords them "affection and moral and material security".
- Children's interests and welfare are of primary importance in care and protection matters, and in general, parents have primary responsibility for their children's welfare. In the absence of such parental care, this responsibility devolves upon the community.

In addition, Sections 72 and 73 (Children in Need of Care) require that:

- only the need to protect the child's safety or welfare allows intrusion of the state to override the right of the child to be raised within the family.
- in care applications, the most intrusive interventions can only be made when the Children's Court is satisfied that the less intrusive options would not meet the child's need for care. (s.73 (1) (b)).
- a Supervision Order, Custody Order or Wardship Order can only be made if it is likely to result in a significant improvement in the standard of care being given to the child. (s.27 (1) (c)).
- continuing contact is encouraged between children in alternate care and persons responsible for the child (parents/family/significant others) and due care must be given to preserving the child's ethnic, religious and linguistic cultural environment.

Section 55 of the Act clearly extends the state's interest in the child beyond the areas of physical protection and provision of basic physical needs, into the more abstract concepts of love, understanding, and mental, moral, spiritual and social development. While specifically related to the requirements for children in need of care, s55, contains perhaps the most significant statement of what the state regarded at that time as the values underpinning adequate care, protection and the developmental needs of children.

Section 55 was the touchstone for all interventions of the Montrose team over the years of this study, and until the proclamation of the new *Children and*

Young Persons (Care and Protection) Act in 2000. Montrose family assessment reports and recommendations often quoted one or more of the principles from s.55 as a way of describing the needs of the child and an acceptable standard of parenting.

While many of these concepts have indisputable validity in terms of child development theory, their abstract nature does present major problems in terms of standardised measurement of their degree and quality in practice. Although some areas of abuse may be clearly detrimental to the child's welfare at the time of assessment, the long term effects of other types of child maltreatment, particularly neglect, are much more difficult to predict. In the context of the obvious weight given by the *1987 Act* to the importance of the parent-child relationship, these less tangible forms of abuse were assessed in terms of each individual child and family's particular circumstances when determining if a child was in receipt of *'good enough'* parenting.

Some of the grey areas within the *1987 Act* were explored in the review of the Act undertaken by the Legislative Review Unit of the NSW Department of Community Services (DoCS LRU 1996). In response to criticism of the 1987 Act regarding a lack of Objects and Principles applicable to the whole Act, rather than just parts of the Act, the *Children and Young Persons (Care and Protection) Act* 1998 has included Objects (s.8) and Principles (s.9) that "are intended to give guidance and direction in administration of the *Act.*" (s.7)

The Objects of the *1998 Act* stipulate that:

- *"children and young people receive such care and protection as is necessary for their safety, welfare and wellbeing, taking into account the rights, powers and duties of their parents or other persons responsible for them" s.8(a).*
- *"that institutions, services and facilities responsible for care and protection of children and young persons provide an environment …free of violence and exploitation and …services that foster their health, developmental needs, spirituality, self-respect and dignity" s.8(b).*

- *"that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the performance of their child-rearing responsibilities in order to promote a safe and nurturing environment." s.8(c).*

The Principles applicable to the *1998 Act* include references to:

- The safety, welfare and wellbeing of the child or young person being the paramount consideration in all actions and decisions that involve them. s9(a).
- The views of the child or young person to be sought and to be given due consideration. s9(b).
- Decisions and actions that significantly affect a child or young person must take account of their culture, disability, language, religion and sexuality, and where relevant, that of those with parental responsibility for them. s9(c).
- In legal and administrative interventions to protect the child or young person from harm, the course of action taken must be least intrusive intervention into the life of the child or young person and their family. s9(d).
- If a child is not able to remain in his/her family environment, the child or young person is entitled to special assistance from the State and his/her name, identity, language, culture and religious ties should be preserved. s9(e).
- A child placed in out of home care is entitled to maintain relationships with people significant to him/her, including parents, siblings, extended family, peers, family friends and community, unless contrary to his/her best interests. s9(f).

The Principle of Participation (s.10) directs that children and young people must have access to information about the decisions being made under the *1998 Act* that will have a significant impact on their lives, and must be given the opportunity to express their views and participate in the decision making process in accordance with their age and developmental capacity. They must

be informed of decisions and the reasons for any decisions made about them and given the opportunity to respond.

In Australia, state child protection services have moved towards the provision of both secondary and tertiary level services - through targeted support services for vulnerable families and populations, provided by non-statutory government and non-government agencies, and via more effective investigation of child at risk notifications. The reforms included in the NSW *Children and Young Persons (Care and Protection) Act 1998* reflect this intention in s.20 and s.21, by providing a means for parents, children and young people to request assistance (material assistance, referral or other service) from the Department of Community Services, without the need for a report of risk of harm (s.23 and s.24) being made to DoCS.

2.4.3 New Directions in Child Protection Policy and Practice.

Concurrently with this reform agenda, and challenging the potential for widening the services offered by child protection systems, the number of child protection notifications in Australia has risen exponentially over recent years, reflecting a broader international trend. The rise in the number of reports across Australia may be due to growing public awareness of child maltreatment and the need to report it, or because of the introduction, or extension, of mandatory reporting obligations in most Australian jurisdictions during the 1990s. Whatever the reason, the number of child protection notifications in Australia more than doubled between 1999–00 and 2003–04. (AIHW 2005, p.xiii). By 2003-04, there were 219,384 notifications Australia-wide, with NSW accounting for 52% of these (115,541). The Australian figure was 10% higher than in the previous 12 month period (Commonwealth of Australia 2005, p.9).

The number of substantiated notifications also increased, however, a large proportion of investigated reports were not substantiated. In fact, only one in five notifications was substantiated in Australia in 2004 (Commonwealth of

Australia 2005, p.9; Scott, 2006, p.6). Many child protection reports use valuable resources on investigation, which are not substantiated, or are substantiated but involve transient or chronic low level risk of harm to the child and are referred to a support service or closed with no child protection intervention.

During the 1990s, child welfare reform in the UK, the US, Australia and New Zealand promoted a changed role for the state. In the UK, Children's Trusts were initiated as a framework for operationalising the proposals of the 2003 green paper *Every Child Matters* (National Children's Bureau (2004). The strategy for improving outcomes for children and young people and their families has emanated from "the convergence of two streams of government child and family policy…the first…is focused on the protection of the child's welfare and the provision of services targeting more vulnerable children, young people and families. The second… is focused on the promotion of the child's well-being and the provision of universal and preventative services." (p.1).

The UK *Children Act* 1989, on which the many of the principles in the NSW *Children and Young Persons (Care and Protection) Act* 1998 were modelled, was formulated in a climate of highly publicised examples of failure of child protection systems to protect vulnerable children. Many publications and a large amount of media coverage were devoted to the investigation of child protection systems in cases of child deaths (Reder et al 1994; Goddard and Saunders 2001). On the other hand, child protection workers were also publicly blamed for intervening in a heavy handed way in the lives of children and their families without sufficient evidence, for example in the Cleveland Inquiry (Cleveland Inquiry 1988).

Balancing the role of protecting children from abuse and neglect with that of supporting parents to raise their children with minimum state intervention has been an ongoing challenge for child welfare services. In order to try to minimise errors in professional judgement, risk assessment and risk

assessment tools have become a priority in many child protection services. Although numerous incidence studies (Trocme et al 2002; US Department of Health and Human Services *National Child Abuse and Neglect Data System (NCANDS*) 2005a) have been conducted, and continue to be conducted, there is still little hard evidence of specific factors that will predict with certainty which families may abuse their children, or under what circumstances.

Nevertheless, risk management has become a preoccupation in child welfare services (Walker et al 2002). Based on a statistical model of calculating the likelihood of an event (e.g. child abuse) occurring, risk assessment has become a major factor in child protection intake and assessment procedures. The process involves balancing factors associated with negative outcomes (risk factors) with child, family, community and other factors (strengths) that may ameliorate the risk factors. This appraisal uses all information available to the caseworker or intake worker at the time the risk assessment is made. There is ongoing debate among child welfare professionals, academics and policy makers as to the relative role of professional judgement in interpreting the available information and the success of an analytical process like this as opposed to an 'actuarial' model, such as a risk assessment tool.

The Montrose home-based family assessment process uses the professional judgement of its specially trained staff to analyse the risk factors and strengths in target families, based on a comprehensive information gathering process in the family's home and community. This process has the benefit of time (a period of pre-assessment file review followed by one week in the family’s home location) and multiple sources of information. This enables the assessment team to interrogate the information gathered more thoroughly than a generalist child protection worker can do. Developing a level of trust with the family members often produces more information, a context for family behaviour, and an opportunity to challenge family members that is not available to a local caseworker conducting an investigation with the family regarding a risk of harm report.

In the economic climate of the 1990s and early years of the 21st century, the need to manage finite child protection resources has resulted in the need to prioritise responses to child protection reports. Low level risk reports are ranked below more serious cases at intake and many are closed without investigation.

A growing body of evidence indicates that these chronic, low risk cases are re-reported, often many times over. English et al (1999) note that "prior CPS involvement greatly increases the likelihood of rereferral and… the rate of rereferral increases with the number of prior referrals." (p.302). In NSW, in 1999-2000, 3.6% of children were subject to re-substantiation within three months and 10.2% within 12 months after an initial substantiated report (Child and Family Welfare Association of Australia 2002, p.9.) This process results in a large amount of time being spent on the same families, with no outcome or intervention, placing a considerable burden on the limited resources of the child protection services.

An additional strain on the child protection system has been the steady increase in the number of children on care and protection orders and the number of children in out-of-home care, which increased by 56% from June 1996 to June 2004 (AIHW 2005, p.xiv). At the same time, residential services have all but disappeared in NSW (and in other Australian states) and there is substantial unmet demand for suitable foster carers, particularly for older children and young people, those with challenging behaviour or disabilities and sibling groups. The foster home breakdown rate in the United Kingdom has been estimated at 40% of placements, and one in ten children has 10 or more placements (foster care or residential). (Browne and Herbert 1997, p.145). Foster care placement breakdown is also common in Australia.

In an attempt to deal more effectively with the overwhelming influx of child protection reports, and the flow on to Care Orders and out of home care placements, emphasis in state child protection policy has been placed on prevention of child maltreatment and family breakdown. As Tomison (2001,

p.5) points out, this policy direction is not new. It reflects a broader welfare approach similar to child welfare practice in previous decades, but also reinforces the integral role of the wider (non government) welfare system in providing early intervention services for targeted 'at risk' families.

The New South Wales Department of Community Services, in common with a number of other Australian and international child protection services, has initiated a secondary prevention Early Intervention strategy with targeted families who are deemed to be at risk for child maltreatment, but who are not currently presenting with high risk reports (NSW Department of Community Services 2005). Under this so-called *'differential response'* or *'dual track'* approach, families with child protection reports assessed as low level risk, and who meet other specific program criteria, may be referred to other government or non-government service providers rather than undergoing a child protection investigation. The DoCS Early Intervention Program is being trialled at a number of sites. Its target group is younger families, with children under eight years old, who do not have a significant history of child protection reports, but who have one or more specified risk factors for child abuse or neglect (NSW DoCS 2005).

In differential response type programs, the statutory child protection service is responsible for coordinating preventative and support services that are delivered by other government service providers (e.g. Departments of Health, Housing, Drug and Alcohol or mental health services) or non-government agencies. In addition, there will be primary prevention in terms of community education about the developmental, social and safety requirements of children.

While focusing prevention services on particular target groups, this service model does not address the needs of families with older children, those with more complex problems and those with long histories of child protection contact or intervention. These longer term tertiary level families make up a substantial proportion of referrals to the Montrose Home-Based Family

Assessment Program. The primary research goal of this thesis is an evaluation of the success of this comprehensive home-based family assessment program as an intervention strategy with this group of families at high risk for placement of one child or more in out of home care because of child protection concerns.

The stated goal of the Montrose Home-Based Family Assessment Program is to keep children within their families unless this would jeopardise their safety, welfare or well-being. A successful outcome for a Montrose assessment means that children who have previously been designated as at high risk for out of home care remain with their families, or return to the family's care within the time period covered in the study. This outcome must also result in decreased risk of child maltreatment or compromised development. A successful child and family outcome fulfils the requirements of current child protection policy. It is less intrusive than out of home care placement, the child's need for safety and nurturance is met, the parents' right to be responsible for raising their child is respected and the state's dual role of child protection and family support is fulfilled.

2.5 Summary.

A useful summary of child protection at the beginning of the 21st century is provided by the Center for the Study of Social Policy, Washington, DC (Center for Community Partnerships in Child Welfare 2003). "Regular reviews of child welfare systems reveal that the agencies responsible for protecting and placing children are overwhelmed and under resourced: they … are plagued by high turnover among staff who are inadequately trained to make life determining decisions about vulnerable families. In addition, they are required to focus most of their investment of human and financial resources on investigations to determine blame, punishment and placement rather than on assessment, services and safety strategies for families and children. These systems communicate and coordinate insufficiently with their partner agencies… At the same time, frontline workers are severely hampered by the lack of critical services that troubled families and the

children need, e.g. mental health care or housing, legal assistance or treatment for drug or alcohol abuse, protection and safety for battered mothers or interventions for abusers." (p.5)

This description is entirely accurate for child protection in Australia at the turn of the millennium and in the first years of the 21st century. There has been some progress towards prevention and early intervention by way of community education and support programs for families identified as at risk for child maltreatment. However, the search continues for cost effective interventions with families who are already known to statutory child protection authorities and for whom general casework services have been ineffective, leaving the children at risk of removal due to continuing concerns for their safety, welfare and wellbeing. It is in this climate that the current evaluation of the Montrose Home-Based Family Assessment Program takes place. There is a critical need to identify programs that will engage tertiary level (chronic and high risk) families in making changes, to protect their children and avoid placement into care. In addition, research continues to identify child, family, child protection system and other factors that may predict child protection outcomes for these high risk families.

CHAPTER 3: FACTORS THAT IMPACT ON CHILDREN'S DEVELOPMENT, WELFARE AND WELLBEING.

The physical, emotional, intellectual and social development of children is a process which is vulnerable to the effects of many factors, related to the individual child, his/her family, their immediate neighbourhood environment, the wider social environment and, at the broadest level, the cultural, political and economic context of the society in which the family is living. The dynamics of the interaction between the child, his/her parents, other family members, and the community is the subject of a vast amount of literature related to the normal course of child development, as well as to the etiology of child abuse and neglect.

The literature abounds with information about the factors that may impact upon the child's normal developmental path, from the earliest prenatal environment, through the years of infancy, childhood and adolescence into young adulthood and maturity. At the most proximal level, these factors include the child's health, temperament and intellectual functioning and the effects of parenting in terms of safety, nutrition, physical care, emotional care, intellectual stimulation and social development. Family factors that may play a part in determining the course of the child’s development include family size and structure, ordinal position of the child, cultural background and family history, sometimes over several generations. Extra-familial social factors which also influence the course of the child’s development are peer groups of the child and family, and the social and emotional environment of the local community. At the widest level, the child and family are impacted by the prevailing economic and social influences, such as a secure, stable physical and political environment, and the availability of housing, employment and basic physical, medical, educational and other social resources.

The process of normal child development is impacted by the interaction of numerous personal and environmental factors. If the issue of child abuse and

neglect is added to the equation, the picture becomes even more complex. This chapter deals with the literature that explores the significant factors which may impact positively and negatively on the child during the course of his/her development.

3.1. An Ecological Perspective on Child Development, Welfare and Wellbeing.

Tower (1996) examines many models dealing with the causal factors of child abuse and neglect and lists three categories of causation:

1. the *psychopathological,* including theories that stress the characteristics of the abuser as the primary cause of the abuse (psychodynamic, character-trait, mental illness models)
2. the *interactional,* including models which see abuse emanating from a dysfunctional system, and
3. the *environmental-sociological-cultural*, where the primary contributing factors are stresses from the immediate environment, society, or culture. (p.66)

Bronfenbrenner's (1979) Ecological Systems Theory describes a model of child development in the context of the system of relationships that make up each child's unique environment. The theory defines a series of interrelated layers within the child's environment, each having a unique and interactive effect on the child’s world. Systems theory proposes that there is interaction between structures within a layer and between layers, and that changes or conflict in one layer will have an effect on other layers. Bronfenbrenner (1990) proposes that as a child develops, the pattern of interpersonal interaction within these environments becomes progressively more complex. A child’s development must therefore be studied in the context of his/her immediate environment, and also in the interaction with the layers of the wider environment, also taking into account the context of time.

Belsky (1980) constructed a conceptual framework for integrating the various theories on the etiology of child maltreatment. He used the basic ecological theory of Bronfenbrenner (1979), but added a level that incorporates factors related to the individual - parent or child - (ontogenic development) in addition to family factors (the microsystem), community factors (the exosystem) and cultural factors (the macrosystem). Belsky (1980) describes his model as: "a system capable of integrating divergent etiological viewpoints that stress psychological disturbance in parents, abuse-eliciting characteristics of children, dysfunctional patterns of family interaction, stress inducing social forces and abuse-promoting cultural values." (p.320) It is important to note that due to the era in which it was developed, the work of Belsky was largely focused on physical abuse and neglect. Research into child sexual abuse and emotional abuse was in its early stages at that time.

The specific layers in the Bronfenbrenner (1979) model and in Belsky's (1980) ecological model as applied to child maltreatment are as follows:

- **Ontogenic Development** - individual factors that parents bring to the family system and the parenting role. These may be derived from the parents' own developmental and childhood experiences, and in the case of parents who maltreat their children, may include issues such as inadequate nurturing, lack of positive child-rearing experience, inadequate socialisation or exposure to violence.

- **The microsystem** - represents the immediate surroundings and structures with which the child has direct contact, i.e. that are 'proximal' to the child. e.g. the immediate and extended family system, the school. Relationships at this level have "bi-directional influences," toward and away from the child. Within the microsystem, family influences are strongest and have the greatest impact on the child. Child maltreatment may arise from a process of child-related factors, e.g. developmental factors or temperament, interacting with parent related factors, e.g. maternal competence or spousal relationships, and possibly family structure e.g. large families or families with closely spaced children. Interactions from outer system layers, e.g.

social and economic disadvantage, can have impact on the microsystem. Belsky's (1980) theory describes: "…the multiple contributors to child abuse and neglect that exist within the family…and the complex ways in which these interpersonal and social characteristics of the microsystem … interact with one another and with developmental factors in stimulating child maltreatment" (p.327)

- **The mesosystem** defines relationships between people and settings in the microsystem, e.g. the family and the school or the family and the child protection worker.

- **The exosystem** defines the larger social units, formal and informal social structures with which the child does not relate directly but which may interact with parts of the microsystem. Examples of exosystem structures would be the neighbourhood, informal social networks (or family isolation from them), support systems (or lack of them) and the world of work (or unemployment). This layer may include community-based parent support services, where the child is not directly involved, but the interaction positively or negatively impacts his/her development. Belsky (1980) suggests that in evaluating the role of the exosystem in child maltreatment, two factors must be taken into account. Exosystem influences may stimulate abuse and neglect through the pressures and stress that they place on families. Exosystem influences may themselves be the by-product of changes taking place in the larger social milieu. (p.328)

- **The macrosystem** is the outer layer in the child and family's environment, comprising cultural values, laws and customs which have an influence in all the other layers, e.g. society's attitude to violence, views on corporal punishment and general attitude towards children.

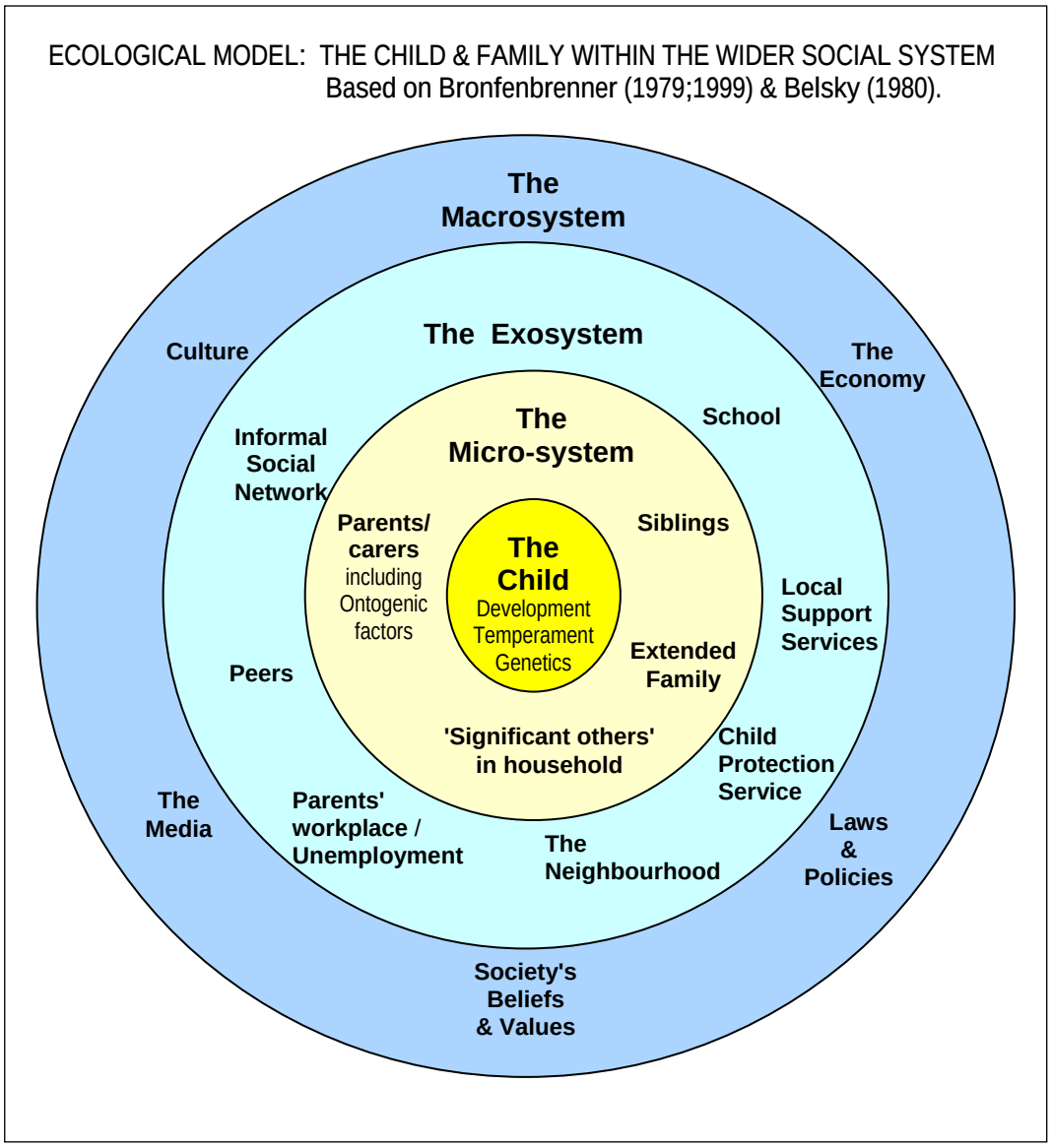
- A final category - **The chronosystem** – relates to the dimension of time within the child's environments, and can be external, e.g. timing of a parent's death, or internal, e.g. physiological changes that occur during the child's development. Bronfenbrenner (1999) modified his original theory by

introducing this additional dimension of time. The revised theory is based on a "process-person-context-time" framework. This proposes that "proximal processes", i.e. regularly occurring reciprocal interactions, over extended periods of time, are critical to effective human development. He states: "in order to develop - intellectually, emotionally, socially and morally - a human being, whether child or adult, requires the same thing: active participation in progressively more complex, reciprocal interaction with persons, objects and symbols in the person's immediate environment." (p.4) "Bio-Ecological Systems Theory" (Bronfenbrenner 1999) includes the role played by the child's individual biology, as well as his/her environment, and the extent to which the two factors interact to impact child development.

The ecological model may be described in terms of concentric circles with the child as the central focus, surrounded by the immediate family (Microsystem), the neighbourhood, the wider community structures and processes (Exosystem) and the economic and political constructs of the wider society (Macro-system). (Fig. 3.1) Some constructs in the exosystem will overlap with the microsystem, to the extent that the child interacts directly with them, e.g. the school, the child's peers.

The debate concerning the etiology of child maltreatment has come from many theoretical perspectives and has cited factors related to vulnerabilities of the individual child, psychopathology within the parent, the impact of dysfunctional neighbourhoods, or the effects of the broader social and economic climate. The ecological model acknowledges the various individual factors, but focuses on the ***interaction*** of the systems and processes in its exploration of the causes of child abuse and neglect.

Fig. 3.1: Ecological Model: The Child and Family in the Wider Social System. Based on Bronfenbrenner (1979; 1999); and Belsky (1980).

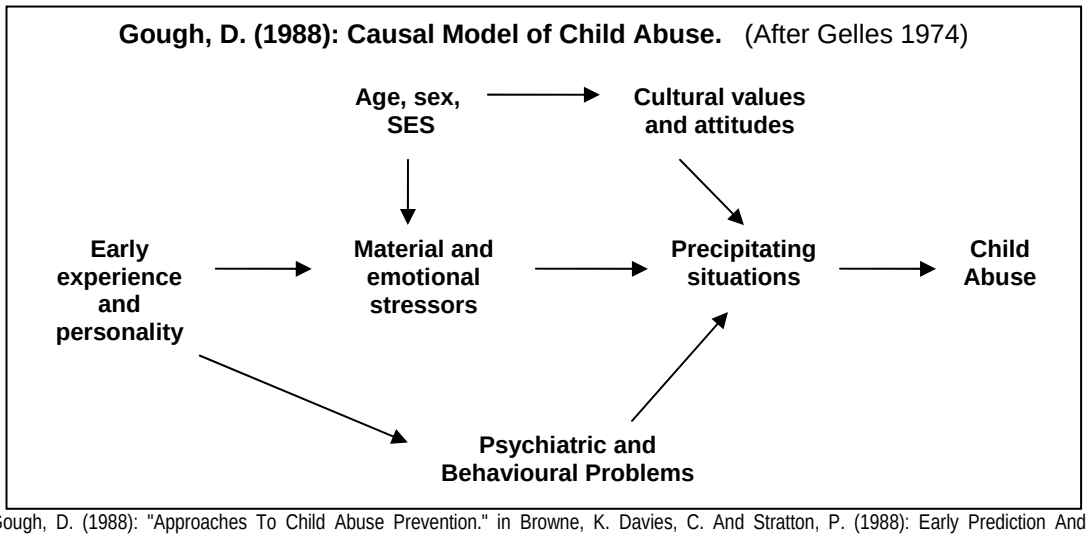


Ambert (1992) examines the interactive effects between children, parents and society and also the role of children on parents' behaviour and circumstances. She nominates demographic and personality features of both the child and parent, as well as social/cultural factors that are associated with the quality of the parent-child relationship, but emphasises that it is the interaction between child, parent and societal factors that finally determines to what extent the child influences the parent, either positively of negatively.

These same characteristics are useful in examining the interactive role of the parent and social and cultural factors on child development, welfare and wellbeing. Ambert's ecological approach to factors affecting the quality of parent-child relationships contains many of the common indicators found in research into the links between child, parent and societal factors and child maltreatment.

Gough (1988) presents a causal model of child abuse, depicted in Fig. 3.2, based on the work of Gelles (1974), which explains the sequence in which the significant variables for child abuse and neglect combine and interact in practice.

Fig. 3.2: A Causal Model of Child Abuse. Gough, D. (1988, p113)



Gough, D. (1988): "Approaches To Child Abuse Prevention." in Browne, K. Davies, C. And Stratton, P. (1988): Early Prediction And Prevention Of Child Abuse. John Wiley & Sons. NY p.113 Copyright John Wiley & Sons Limited. Reproduced with permission.

In a comprehensive review of the international literature, Saville-Smith (2000, p.i) notes a bias in the recent literature away from the search for single factor explanations and a recognition of the complexity of the etiology of child abuse and neglect, where factors associated with individuals, the family, the community and the culture interact with each other.

Prilleltensky, Nelson and Peirson, 2001 conducted a comprehensive assessment of the factors associated with family wellness and child maltreatment, and produced a list of research-based ecological factors associated with child maltreatment. They support the view that child abuse

and neglect is a product of vulnerabilities and protective mechanisms and incorporate previous theories and their own views to produce the following formula (Fig. 3.3) to explain the complex multi-level relationships involved in the etiology of child maltreatment (p.58):

Fig. 3.3: Likelihood of Child Maltreatment Defined by Risk and Protective Factors: Prilleltensky, Nelson and Peirson (2001).

Prilleltensky et al (2001): Probability of Child Maltreatment

$$\textbf{Likelihood of Maltreatment} = \frac{\text{Vulnerabilities}}{\text{Protective mechanisms}} = \frac{\text{Organic causes + Stress + Exploitation + Deprivation}}{\text{Coping skills + Self esteem + Support systems + Opportunities + Adequate living conditions}}$$

Prilleltensky, I. Nelson, G. and Pierson, L. (2001): *Promoting Family Wellness and Preventing Child Maltreatment: Fundamentals for Thinking and Action.* University of Toronto Press. Toronto p.58 Copyright University of Toronto Press. Reproduced with permission

The literature abounds with studies that have identified factors that are associated with child maltreatment. Yet there remains a difficulty in compiling the definitive list of risk and protective factors that could be used in assessment of high risk families or to build a stronger preventative system against child abuse and neglect. Studies differ in terms of whether they are prospective or retrospective, each of these having some problems. Many studies lack randomised control groups or adequate pre-post intervention measures.

Many of the studies are subject to methodological problems - including small or specific samples. Others, particularly those coming out of the U.S. are affected by the racial composition of the USA, with a propensity towards skewed representation of African American, Hispanic and Native American families, which makes it difficult to generalise the results to other countries. Other studies target specific socioeconomic groups, or populations with particular risk factors, e.g. parental drug or alcohol abuse or mental health issues. Faced with an enormous range of factors purported to be associated with child maltreatment, it is helpful to distil a number of factors that appear most frequently in studies, an initial list of factors that professionals

assessing families at risk for child abuse and neglect can use as a starting point to begin understanding the combination of risk and protective factors affecting each particular family.

The following list (Fig. 3.4) has been compiled from the most relevant factors reported by a number of comprehensive literature reviews on child maltreatment by authors from different countries. It is based on*:*

- Ambert, A-M. (1992): *The Effect of Children on Parents*.
- Saville-Smith, K. (2000): *Familial Caregivers' Physical Abuse and Neglect of Children: A Literature Review.*
- Prilleltensky, I. et al (2001): *Promoting Family Wellness and Preventing Child Maltreatment. Fundamentals for thinking and action*.
- National Clearinghouse on Child Abuse and Neglect (2003): *Risk and Protective Factors for Child Abuse and Neglect.*

This is not an exhaustive list, and is subject to the interaction of all the relevant factors for the particular family being assessed, in the context of its culture, its community, its history and its current life situation and the interplay of the specific stress factors that are affecting the family at this time in its family life course.

Fig. 3.4 An Ecological Approach to Factors Related to Child Maltreatment.
From: Ambert, A-M. 1992; Saville-Smith, K. 2000; Prilleltensky, I. et al 2001; National Clearinghouse on Child Abuse and Neglect 2003:

CULTURAL FACTORS (Macrosystem)
• Societies where children are highly valued vs societies that devalue children.
• National and State Child Protection legislation and policy, especially regarding child welfare focus vs non-interference in families
• Society's open acknowledgment of parental contribution vs devaluing of caregivers' roles (including parents, child care workers, teachers.)
• Economic policies - affecting poverty and unemployment
• Income supplements for impoverished families
• Policies governing access to medical care, child care and social services
• Immigration
• Society's acceptance of minority status parents & children vs racism or discrimination.
• Society's fostering of gender egalitarian ideology vs gender stereotyping.
• Societies that reject, rather than tolerate, violence.
• Media that advocates in favour of child wellbeing
• Quality of contents of mass media (including TV, video games and films) Two adverse qualities are media violence and sex role stereotyping

SOCIETAL FACTORS (Exosystem)
• Social cohesion
• Safety of neighbourhoods
• Socio-economic status of the community/neighbourhood
• Adequate housing; low vacancy rate; low level of transience
• Adequate social resources (social capital) of neighbourhoods
• Adequate access to medical, dental and psychiatric resources
• Home & community support for parents with special needs children and parents
• Quality and sufficiency of early day care systems
• Quality of schools; Quality and existence of before and after school programs
• Availability of parenting skills education programs
• Fostering of a positive peer group culture among children and adolescents
• Appropriate recreational facilities for youngsters and families

FAMILY FACTORS (Microsystem)
• Socio-economic status
• Income / Employment status
• Quality of family system
• Connectedness to local community vs isolation
• Family structure -single parenthood, blended families and non-genetic family care
• Family size and child-bearing intervals
• Family stability
• Marital (partner) support
• Domestic / family violence
• Acute stressors
• Patterns of stress management & conflict resolution
• Disciplinary practices
• Family time
• Participation in extra-family activities

Fig. 3.4 An Ecological Approach to Factors Related to Child Maltreatment. (Cont'd)

PARENTAL FACTORS (Ontogenic)	
DEMOGRAPHIC PARENTAL CHARACTERISTICS	PERSONAL PARENTAL CHARACTERISTICS
• Parent age: current & at birth of first child	• Quality of parenting received as children; quality of attachment to own parents
• Sex	• Past exposure to physical abuse and/or neglect
• Adoptive vs biological child	• Coping patterns
• Immigration status /	• Physical health/disability
• Ethnicity/minority status group	• Personality characteristics, temperament, warmth, responsiveness; biological predisposition
• Socioeconomic status	• Psychiatric status; mental health issues
• Income, occupation	• Internal vs external locus of control
• Material resources	• Stress management / Conflict resolution skills
• Education	• IQ; Intellectual disability
• Religion and religiosity	• Substance abuse
• Marital status	• Quality of marital relationship
• Other children, number, spacing & characteristics	• Gender role ideology & implementation (including division of labour)
	• Parenting skills
	• Commitment to parenting
	• Attitudes to children
	• Parenting expectations
	• Perception of the child re parent
	• Social resources (friends, social support)

CHILD FACTORS	
DEMOGRAPHIC CHILD CHARACTERISTICS	PERSONAL CHILD CHARACTERISTICS
• Age	• Premature babies; low birth weight babies
• Sex	• Physical health; chronic illness
• Birth order	• Physical appearance / physical disability
• Single or multiple birth	• IQ; Intellectual disability; Mental health issues
• Child from current relationship or a previous relationship	• Temperament; personality traits, attitudes, affect
• Quality and composition of sib group	• Quality of attachment to parents
	• Behaviour (home, school, peers, neighbourhood)
	• School performance and achievement
	• Performance & achievement in activities
	• Relationship with other significant persons (peers, teachers, siblings)
	• Quality and composition of peer group

Saville-Smith (2000, p.i) notes that there are methodological problems with many of the studies she reviewed and cautions that the findings cannot necessarily be generalised to other situations or populations. She emphasises that the literature has moved to a position of multidimensional explanations for child abuse and neglect that include complex interactions among individuals, families, communities and cultural systems. Her review of the literature concludes that:

" i. the importance of individual and family pathologies as determinants of child abuse and child neglect has been over-stated.

ii. child abuse and child neglect are likely to arise out of clusters of factors involving individuals, family process, the neighbourhood and the cultural system.

iii. three dynamics seem to co-occur with child maltreatment:

- *socio-economic deprivation* - within the family and the neighbourhood and as a contributor to levels of individual stress
- *fragile social networks* - for individuals…dissatisfaction with friends and family relations… for families…lack of reciprocity with family, including isolation from extended family…for neighbourhoods…a lack of formal and informal networks and services.
- *criminality, violence and substance abuse* are important aspects of familial and individual …(association) with child maltreatment….(and) also disrupt and undermine community social structures and formal and informal networks.

iv. the determinants and dynamics of child abuse and … child neglect may overlap at times but are separate phenomena." (p.2)

These findings provide a useful overview of the complexity of the association of parent, child and societal factor with child abuse and neglect. Before considering the interactional effect of these factors, it is useful to examine some of the individual factors that have been seen to play a significant role in children's development, welfare and wellbeing, and in some cases to be associated with child maltreatment.

3.2 The Impact of Cultural, Social and Community Factors on Child Development, Welfare and Wellbeing.

Ambert (1992) suggests a "*multi-causality*" view of child development, where the influence of the parents is mitigated in urbanised society by other factors such as peers, technology, mass media, popular culture, politics and religion. In examining child development in the context of the wider environment, Bronfenbrenner (1999) cites the negative effects on child and youth development of the interaction of significant aspects of western culture, e.g. the growth of single parent families, more parents in full time employment with less time to interact with and mentor children, and less positive role models in children's lives and more negative role models in the media. These factors are impacted by decreased neighbourhood ties, the widening gap between rich and poor and the increasing numbers of children living in poverty. She cautions that "the growing chaos in the lives of our children, youth and families today …pervades too many of the principal settings in which we live … the family, health care systems, child care arrangements, peer groups, schools, neighbourhoods, the workplace…" (p.9) and argues for early, supportive intervention for children and families as a means of combating the effects of the wider social systems.

Bronfenbrenner (1999) argues that the wider environment has a substantial effect on child development, through interaction with the child's individual competencies and the parents' ability to foster positive growth. The same initial competencies in a child may be developed or extinguished, depending on the *'ecological niche'* into which the fate has placed the child. For instance, a child born into an advantaged environment with two parents, including a mother educated beyond high school, and a supportive and motivating school will achieve a more positive educational outcome than a child with the same potential, but a more disadvantaged parental and social environment. Working with a disadvantaged family to enhance proximal processes may alter the life course of the child by reducing the impact of the

environment on his/her developmental dysfunction and simultaneously increasing the child's developmental competence.

3.2.1 Cultural Factors (The Macrosystem)

Cultural beliefs and values may be formal or informal. Formal beliefs and values are defined by the particular society and are evident in the laws of the state and the policies that emanate from those laws. Values or beliefs may be also promulgated by religious, cultural or other bodies. Cultural values may be reinforced or changed by the way the media portrays the weight of public support for or against values and issues.

In the field of child protection, the dominant cultural system of beliefs involves values about childhood, child rights, parental rights, child welfare and child protection. These are reflected in the legislation and the social and economic policies of a country or state, and in its demonstrated support for the intrinsic value of the child, e.g. by having ratified the UN Convention on the Rights of the Child. Such values and beliefs frame the parameters of acceptable practice with regard to childrearing, child welfare and child protection.

Kempe and Kempe (1980) give an example of the way social values affect the issue of child protection. They suggest that to some extent child physical abuse was recognised, but remained unchallenged, throughout much of the 20th century in western cultures because of community belief that children were their parents' property and parents therefore had the right to treat children as they saw fit. Also, because children were the responsibility of their parents, harsh physical discipline was accepted as necessary to maintain discipline. (p.16)

Clashes of cultural values and practices can create conflict in ethnic or indigenous minority group families (Korbin 1980). In the various waves of migration into a multicultural country like Australia, cross cultural issues may be further complicated by a number of factors, e.g. where migrating or refugee families have left supportive networks of family and friends; or

families have come from situations of conflict or social upheaval, where government services are viewed with anxiety or suspicion; or the cultural values around child-rearing and discipline have been eroded prior to migration, or families have come from rural backgrounds and are then located in urban settings in the new country (Goddard 1988, p.32).

In a multicultural society, it is important to clearly define what child care and parenting practices are regarded as abuse or neglect in the dominant cultural group, and to translate the reasons for this to all cultural and religious communities, via public education and through their representative community organisations. Cultural issues are also relevant when dealing with indigenous populations whose cultural beliefs and child rearing practices may be different from those of the dominant cultural group which is responsible for framing child protection legislation.

Different cultural groups may have widely varying values with regard to childrearing practices and expectations of children's developmental tasks at different ages. Different cultural groups may also define child abuse and neglect in different ways, and some practices perceived as abusive in one culture may be viewed as appropriate or even desirable in another culture, e.g. the 'spanking' debate regarding physical discipline of children, where corporal punishment is banned in some countries and regarded as acceptable parenting practice in others.

While acknowledging the role of cultural background and values in families' development of patterns and roles, Tower (1996) also recognises the role of individual differences between families of the same culture, and proposes that the following variables impact on families' behaviour:

- The culture in which the family has originated
- The subgroup of that culture
- The individual characteristics of family members
- The family's method of adapting to the stresses of living within the family unit. (p.27)

Cultural acceptance of parenting practices also changes over time, which means that statutory child protection services must be sensitive to a range of complex issues related to parenting across and within different cultural groups, while still enforcing the values enshrined in the legislation of the time. The media also plays a significant role in defining community standards for acceptable conduct of children, and of parents and society towards children. Many of the major reforms regarding child protection legislation and practice have been precipitated by media campaigns around specific issues – e.g. child abuse prevention, child deaths, child sexual assault enquiries (Calvert 1992; Goddard 1998).

Media scrutiny and campaigns can significantly affect child protection practice (Reder et al 1994; Munro 1999; Goddard and Saunders 2001). At its best, media attention assists by drawing attention to areas of need for change in child protection practice for the benefit of children. On the negative side, it can skew priority for child protection interventions towards investigation of families regarded as being at the greatest immediate physical risk and away from support for families that do not demonstrate immediate risk to the child, but where poor parenting may have a potentially greater long-term negative impact, e.g. chronic neglect. In the latter case, in an economic climate of finite resources, the "less urgent" cases tend to be referred to community resources (at best) or closed without any intervention. The mandate and motivation of child protection services - to protect children from harm - is compromised in this respect by the need to avoid exposure of child protection services or the governments responsible for them to criticism regarding inaction in high profile or high risk cases.

The prevailing cultural belief systems can therefore be influenced or utilised by the media to bring about positive change in services which enhance the safety, welfare and wellbeing of children or can be used in a crisis-driven, misguided and counter-productive way to draw attention (and resources) away from preventive and supportive services that can assist in improving

child protection outcomes. This double-edged sword is not well understood and the outcomes may have greater ramifications than originally anticipated.

A logical extension of the ecological view is to examine the effect of economic policy in general and social welfare policy in particular on the family and on child protection practice. Tomison (2002) notes the effect of the prevailing philosophy of economic rationalism in Australia and many other western industrialised nations has been the expectation on the part of governments that families and communities will take more responsibility for addressing their own needs with less government intervention. In addition, policy and services supporting the child protection system are increasingly driven by the need to demonstrate cost effectiveness and efficiency, which as Tomison points out is "a particularly difficult task when applied to the prevention of child maltreatment and the protection of children." (p.3) The effect of these policies has generally been the reduction in the range of services and interventions available to families who require support in managing social problems, but who are not actually maltreating their children.

Tomison (2002, p.5) describes the effects of the economic climate in the 1990s in Australia and other western countries on child protection policy. In the early years of the decade, scarce resources defined a general move towards a legalistic, investigative and interventionist model and away from a preventative/supportive model. By the late 1990s, following a dramatic rise in the numbers of reported families (many of whom were notified in order to secure access to services rather than because of actual maltreatment), together with some dramatic media coverage of failed child protection cases, there was a re-positioning of policy to once more include the role prevention and early intervention services.

Hence, over the course of a decade, families whose individual circumstances may not have changed appreciably were directly and indirectly impacted by changes in the prevailing economic and social welfare philosophies. Recent changes in Australian social welfare policies, e.g. expectations for single

mothers to take on part-time work when their youngest child reaches a particular age, will have impacts on the social situation of many families, and on the personal stress levels of individual parents, some of whom may in turn maltreat their children. The degree to which the link is direct or peripheral continues to be as debatable as the other complex issues surrounding the etiology of child abuse and neglect, but the role of the prevailing cultural attitudes must be considered as a factor.

3.2.2 Social Factors (The Exosystem)

Over the centuries, the role of the family in western society has changed from being a relatively self-sufficient unit, to being in the position of having to increasingly negotiate with complex social institutions to meet family needs. Unger and Sussman (1990) adopt an ecological approach, citing a body of research that demonstrates the difficulties and the advantages of the interface between the family and the wider community. They assert that the industrial and social changes over the past century have decreased many of the functions previously performed by the family, or have transferred them to the community. They propose the need for policies and programs to support families in a changing social environment where the relationships between families and their communities are becoming increasingly complex. Examples of social changes impacting on families include family breakdown and reformation, more children being raised in single parent families, and increasing numbers of children being raised in poverty. (p.1)

In examining the interaction between the family and the wider community, it is also useful to note that family members may be influenced by intergenerational relationships between their family and the community. Relationships between previous generations of a family and larger social systems (eg social security or child protection systems) may negatively influence the way a family views the system and workers in the system view the family, impeding the development of more positive and productive individual relationships (Imber-Black 1988).

Child maltreatment has frequently been associated with socio-economic disadvantage (Horowitz and Wolock 1981; Pelton 1981; Garbarino 1999; Vinson 1999) and is often related to family structure, particularly single parent households headed by women (Mayer et al 2003). Families living in socio-economic disadvantage are over-represented among the clients of child protection services.

Poverty is frequently associated with other social disadvantage, such as social disorganisation, educational disadvantage, compromised housing, unemployment and social isolation. All these social disadvantage indicators are often co-located in neighbourhoods (Garbarino, 1981; Vinson 1999), by social (political) design or because poor families cannot afford to live elsewhere. This concurrence of social disadvantage, together with the crime, violence, substance abuse and social disintegration in specific neighbourhoods has been described by Garbarino (Garbarino and Sherman 1980; Garbarino 1999) as a 'socially toxic environment' in which to raise children.

English (1998) describes the complex association between poverty and child abuse and neglect as: "The effects of poverty appear to interact with other risk factors such as unrealistic expectations, depression, isolation, substance abuse and domestic violence to increase the likelihood of maltreatment." (p.47). Berger (2004) cites Waldfogel (2000) who is interested in the effects of poverty on parental behaviour (controlling for family characteristics associated with low income status and also for environmental characteristics and public policies that affect family income). Waldfogel proposes four theories regarding the relationships between low income status and child maltreatment.

These are:

" 1. The stress associated with low income status leads some parents to engage in harsh treatment of their children.
2. Poor families are no more likely to engage in maltreatment but are more likely to be reported.

3. Poor families are reported for neglect more frequently because they simply cannot afford to adequately provide for their children.
4. Poverty and neglect are spuriously correlated and some other underlying factor is driving both."

   Berger (2004, p.728, citing Waldfogel 2000)

While not minimising the effects of poverty, unemployment and educational disadvantage, it is essential to also remain aware of the emotional, personality and lifestyle factors that are not necessarily related to social disadvantage and that addressing the problem of child maltreatment within economically disadvantaged communities requires a more broad and holistic social response.

An associated and more widespread socioeconomic factor related to child development, welfare and wellbeing is the impact of parental employment on childrearing practice within the family. In their study *Families in Britain* Rapoport and Rapoport (1982) were interested in the impact on the development of children in families where both parents work. Their study took into account the diversity of family types, including structure, culture, class, life stage and the various permutations of these categories, but is reflective of an era where the two parent (married) family model was more prevalent than it is in the late 1990s and early 21st century. With the vast changes in economic and social conditions over the past thirty years, dual income families have become a normal occurrence in western societies, and access to appropriate childcare facilities has become a critical social, political, cultural and economic issue. Much of the Rapoports' work presents a middle class perspective, where women’s paid employment was mainly a matter of choice about a second income rather than a necessity as it is for many two parent families in today's economy or a choice between a sole income and reliance on Social Security payments for single parents.

Rapoport, Rapoport and Strelitz (1977) pose a rather optimistic view, cited by Morgan (1985) regarding the changing roles of men and women as women

more routinely entered the fulltime workforce: "…both men and women should be able to undertake parenting tasks traditionally allocated to women and that this shared parenting will be of benefit to the individuals themselves, the children and presumably society as a whole." (Morgan 1985, p.124). In fact, the division of household and childrearing tasks has not changed significantly in line with the increased number of women with children in the full time workforce (Hernandez 1997). This has placed additional stress on women trying to balance the roles of family and work has contributed to stressed emotional climates and time constraints in many families that undermine the primary family relationships and also take time away from the informal and formal social interactions that may be supportive to parents in trying to raise their children.

Ambert (1992) refers to the influence of 'extradyadic' influences, such as day care, particularly long day care, since the increased participation of women in the full time work force. Workplace policy on flexibility in working hours and part time work can have a major effect on parents, particularly working mothers. Family members are affected by emotions and demands on time from the workplace, and employee productivity can be affected by a variety stresses associated with family responsibilities (Crouter 1984). The availability of suitable employment can have economic and personal effects on family functioning. Child maltreatment rates have been shown to rise when job availability falls (Steinberg, Catalano and Dooley 1981). Crouter and Seery (1994) note that family response to economic downturn in the wider system may have different effects on the development of children and adolescents, differentiated by gender, social class and developmental level.

The impact of child care on child development, welfare and wellbeing has been a highly controversial issue for over 20 years, and continues to be vigorously debated. In considering the impact of both parents working or a full-time working single parent on the development of the children, it is necessary to bear in mind the age of the child, his/her developmental level

and temperament, and the amount of time spent in child care, the consistency of caregiver and the quality of the child care provided.

Quality child care has been widely promoted as beneficial for many children. On the other hand, some authors (Belsky 1988a; Howes 1989) have expressed concerns about the length time that a child, particularly a very young child, can spend away from his/her primary attachment figure/s without suffering some degree of stress or trauma. In US research by the National Institute of Child Health and Development (2003) and in the UK by Sylva et al (2005), the attachment and socialisation of children receiving high levels of child care was called into question. The studies found indications that children who were in child care for over 30 hours per week, particularly if the child care started from a young age, had higher incidence of behavioural problems - aggression, defiance, unpredictability in some children and withdrawal, sadness and compliance in others.

In child protection services, quality child care has often been seen as a possible avenue for mediating poor parenting practices, especially in families where neglect or emotional abuse, rather than physical abuse, is the presenting problem, or where the primary caregiver has intellectual, mental health or other issues that compromise her/his ability to meet the emotional and physical needs of the child. However, the choice of child care facility is determined by both economic and parental factors. In Australia, the demand for child care places has outweighed supply for over a decade and social service systems have limited budgets for long term child care. It has been suggested that parents who are stressed, lacking in support systems and lacking in knowledge of good parenting practices may be less able to assess their child's needs and more likely to enrol them in lower quality child care, with a greater carer to child ratio, more staff turnover and less individualised care (Howes 1989, p.3). The debate remains whether out of home child care can substitute for parental care or whether children's development, welfare and wellbeing may be damaged by child care if it is "too much, too early and too long" (Biddulph 2006).

3.2.3 Community Factors. (The Exosystem)

A major influencing social factor located the Exosystem is the local community or neighbourhood, which directly impacts the child and family on a continual basis. There is increasing recognition of the impact of the interaction between the *neighbourhood* and the caregiving role of the parent as a factor in the etiology of child maltreatment. Unger and Sussman (1990) cite the critical role of the neighbourhood in giving families a sense of location and belonging. Local communities can be places of safety, security, providing emotional and practical support, and reinforcing positive childrearing practices and beliefs. On the other hand, in neighbourhoods that lack supportive community ties and are affected by crime, substance abuse, violence or youth delinquency, families must struggle against this negative environmental influence on their childrearing practices.

Garbarino (1981) describes the neighbourhood as the "ecological niche in which families operate….where one finds the conditions of life that conspire to compound rather than counteract the deficiencies of and vulnerabilities of parents." (p.234) He refers to the interaction between economically deprived parents with few personal or social resources and neighbourhoods that cannot provide them with the support, encouragement and feedback that they need: "…personally impoverished families clustered in socially impoverished places: high risk families in high risk neighbourhoods." (p.237) Garbarino's (1981) study found that in addition to economic disadvantage, neighbourhoods with high rates of child maltreatment also had social deficits such as "low levels of neighbourly exchange,…residential instability and transience,…deteriorated housing, poor relations with institutions such as schools and by a pervasive pattern of social stress." (p.240)

In a similar social mapping exercise in Australia, Vinson (1999) found similar patterns of co-occurrence of child maltreatment with social disadvantage indicators, including low income households, use of emergency assistance, long term unemployment and court convictions.

Garbarino (1981) cites four working assumptions related to the ecological approach to child abuse and neglect:

"1. Economic forces are significant but not exclusive determinants of neighbourhood character. …. poverty is as much a social concept as it is an economic one.

2. Residential segregation based on socioeconomic factors presents a serious threat to family well-being because it produces concentrations of high-need, low-resource families. …

3. The process by which the neighbourhood's character affects child maltreatment is threefold: the high level of neediness inhibits sharing; the lack of positive models reinforces inappropriate and inadequate behaviour; the lack of intimate and confident interaction inhibits nurturance and feedback. …

4. Values and attitudes that place a family at risk for maltreatment are accentuated by the stresses of social impoverishment. …" (p.241)

Coulton et al (1995) reports parents' responses regarding the major factors in a neighbourhood that assist them to raise their children. These relate to feelings of personal safety, trust in neighbours and connectedness to neighbours and the wider community. Coulton et al believe that the fact that these *social* factors are often absent in disadvantaged neighbourhoods is more potent than the impact of the actual *economic* deprivation.

Garbarino (Garbarino and Crouter 1978; Garbarino and Sherman 1980) developed a map of social conditions associated with risk of child maltreatment, applied to neighbourhoods rather than individual families. These risk factors were able to predict rates of child maltreatment across different communities, even when they were comparable in socioeconomic level and demographic character. The risk factors are:

- low family income,
- presence of female-headed single parent households,
- the number of working mothers and
- transience of residents.

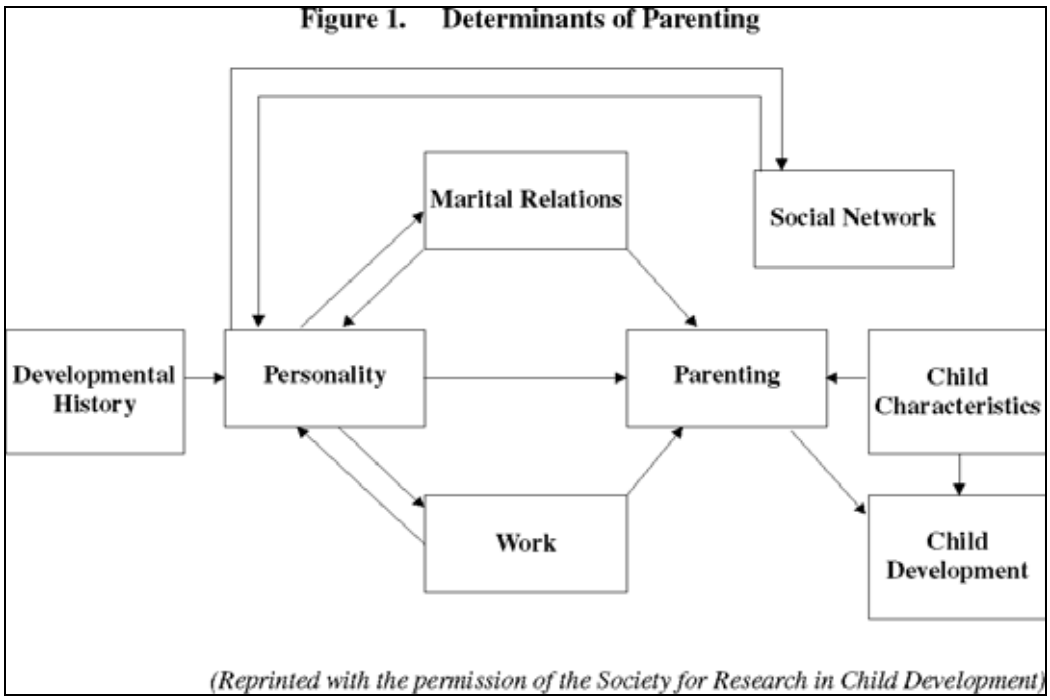
Vondra (1990) extends Belsky's (1980) concept of 'the ecology of child maltreatment' to examine the interplay of risk factors associated with child abuse and neglect within the family and community. She argues that "research has consistently demonstrated that recurrent maltreatment is not the outcome of any single factor - whether parental psychopathology or maltreatment history, child temperamental or behavioural deviance, marital conflict or violence, economic hardship and job stress, inadequate social supports, or socio-cultural mores that encourage punitive, authoritarian parenting." (Vondra 1990, p21). Vondra emphasises the *interaction* of individual and environmental factors in understanding the ecology of abusive or neglectful parenting: "… factors arise from within and outside the family, converging to create a family situation characterised by both extreme need and an inability to develop or maintain the external supports that could help bolster this fragile system." (p21).

Gaudin (1993, p.11) cites Belsky and Vondra's (1989) model for factors that contribute to adequate parenting, including a combination of:

- parents' own developmental history and resultant personal psychological resources,
- characteristics of the family and child, and
- contextual sources of stress and support.

Figure 3.5 illustrates Belsky and Vondra's (1989) model for the inter-relationship of the three factors - parent related, family and child related and environment related. Gaudin (1993) describes the complex and often reciprocal inter-relationships within the model: "The developmental experiences of parents influence their personality and psychological resources, which directly influence both their parenting attitudes and behavior and their ability to develop supportive relationships with others. Parenting behavior influences the child's personality and behavior, which reciprocally influences parents' response to the child. The social context of the parent-child relationship, which includes the marital relationship, social network supports, and work-related factors, is highly influential on parenting..." (p.12)

Fig. 3.5: Child, Parent and Environment- related Determinants of Parenting.
(Gaudin p.12: From Belsky, J. and Vondra, J. 1989)



Belsky, J. and Vondra, J. (1989): 'Lessons from Child Abuse: the Determinants of Parenting.' in Cicchetti, D. and Carlson, V. (1989): Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect. Cambridge University Press. MA. pp.153-202. Image Copyright : Wiley-Blackwell. Reproduced with permission.

Vondra (1990) and Garbarino (Garbarino and Crouter 1978; Garbarino and Sherman 1980) both make a clear link between the socio-economically disadvantaged female-headed household and child maltreatment rates. Vondra sees this as a societal factor, associated with the fact that these families are more often living below the poverty line, with female carers who are in low paid, low status jobs or unemployed. Where there are male carers in the household, there are not the same social expectations as with women that they will provide income, homemaking services and childcare for the family.

Unger and Sussman (1990) acknowledge the work of Vondra (1990) in examining the possible negative interactions between individual and community and determining a number of characteristics which may have a deleterious impact on the family or child. They name the following factors as being associated with child abuse and neglect: "social isolation, lack of social control, economically deprived neighbourhoods, unemployment, inadequate social services, and psychological functioning, poverty, and community

values and norms." These factors may be exacerbated by the absence of family ties and a sense of personal space and personal places when families are transient or homeless (Rivlin 1990, p.39).

Polansky et al (1991) group the causes of neglect under three major theories: "The *economic*, emphasising the role of material deprivation and poverty; the *ecological*, in which a family's behaviour is seen as responsive to the larger social context in which it is embedded; and the *personalistic*, which attributes poor child care to individual differences among parental personalities, particularly their character structures." (p.21). This range of theories could be effectively applied to the etiology of child abuse.

While the negative link between child maltreatment (excluding sexual abuse) and socially impoverished neighbourhoods is often cited, Germain (1991) examines the community's more positive function in the family's interaction with their neighbourhood environment, i.e. its ability to provide practical and emotional support for families in times of stress. Similarly, Cicchetti (2004) proposes the "ecological-transactional" model (Cicchetti and Lynch 1993) to explain the 'potentiating' processes associated with child maltreatment and vulnerability and the 'compensatory' factors and processes associated with child development and that decrease the probability of child maltreatment or increase resilience to its effects. These factors and processes may be located in the distal (community or cultural) level or at the microsystem level of the child's immediate environment (including family), or within the individual child.

3.3 The Impact of Family, Parent and Child Factors on Child Development, Welfare and Wellbeing.

The issue of how parent, child and social factors are linked to specific types of abuse or neglect is the subject of numerous studies. However it is difficult to compile a definitive list of factors involved, owing to the variation of definitions of the types of abuse and neglect, the range of factors examined by the various researchers and many acknowledged methodological considerations depending on the source of the information and whether the study was prospective or retrospective. In addition, there is a growing belief that families that exhibit 'single type' maltreatment are the exception and that children in many families experience different types or multiple types of abuse and/or neglect, in single incidents or over a period of time (Howes et al 2000; Higgins and McCabe 2000).

Vondra (1990a) states that understanding the evolution of child maltreatment involves the integration of knowledge from a number of disciplines: "knowledge from developmental psychology about what children need for healthy psychological development, knowledge from clinical psychology about the origins and manifestations of child and/or adult psychopathology, knowledge from family disciplines about the dynamics that underlie day-to-day family functioning and crisis situations, and knowledge from sociology about social and economic forces that foster or undermine the wellbeing of the family." (p.149). Vondra argues for a *multifactorial* model of causation of recurrent maltreatment, that it is "not the outcome of any single factor - whether parental psychopathology or the experience of maltreatment in childhood, child temperament or behavioural deviance, marital conflict or violence, economic hardship and job stress, inadequate and ineffective social supports, or sociocultural mores that encourage punitive, authoritarian parenting." (p.150). It is the interaction between a number of these factors that, according to Vondra, produce an environment in which abuse and/or neglect may arise.

Crouter and Seery (1994) also take an ecological perspective in examining influences on family and child development. Relevant structures and processes include: "family structure, parents' occupational positions, neighbourhood opportunities and constraints, the quality of key settings such as schools and daycare, and...cultural and subcultural variations." (p.421)

3.3.1 Family Factors (The Microsystem).

As noted by authors cited earlier (Garbarino 1977; Bronfenbrenner 1979; Belsky 1980), the issues of child abuse or neglect cannot be seen as single factors associated with the child or the parent alone. It is critical to place the interaction of child-parent characteristics within the ecological context of the community or society within which they relate, and to consider the extent to which that social context assists or inhibits positive family functioning.

In her review of the literature on child maltreatment, Saville-Smith (2000, p.7) notes a number of family related factors that have been found in some studies to be associated with child abuse and/or neglect. While the list is not definitive, it provides some general factors that need to be borne in mind in the assessment of families with child protection issues. Some of these factors could be grouped as:

a. **family structure** (including single parenthood, blended families and non-genetic family caregivers, family size and child-bearing intervals),
b. **family demographics** (including socioeconomic status, income, employment status),
c. **family functioning** (including familial instability, marital support, patterns of anger and conflict resolution, and disciplinary practices), and
d. **family connectedness to the community** (including access to formal and informal support systems.)

3.3.1 a. Family Structure.

The process of defining 'family' poses significant challenges in the late 20th and early 21st centuries. As indicated in the previous chapter, over the past

half century, and certainly since the development of the Bronfenbrenner's (1979) original ecological model, family structure in western industrialised society has been subjected to considerable social change, producing a wide range of structural options for family units.

Leach (1968) laments the decline of the extended family and the rise of the nuclear family: "In the past, kinsfolk and neighbours gave the individual continuous moral support throughout his life. Today the domestic household is isolated. The family looks inward upon itself; there is an intensification of emotional stress between husband and wife and parents and children. The strain is greater than most of us can bear. Far from being the basis of a good society, the family, with its narrow privacy and tardy secrets is the source of all our discontents." (p.44).

Scanzoni (1987) argues that the family as a concept is not declining, but is changing as part of society's continual evolution and transition and *'the family'* has been replaced by the concept of '*families'*. He urges family policy in the United States to include more forms of families, including single parent and dual working parents, rather than continuing to be targeted at the statistically less common traditional nuclear family.

In exploring the role of family structure in child maltreatment, there is a need to consider the complications that the different family structures now considered to be 'normal' bring to the microsystem layer of the ecological model. McDonald (1995) states that in late 20th century Australia, a child whose parents have divorced, when asked to describe his or her family may include natural parents, siblings, step-parent, step-siblings and half-siblings, although the people named will normally live in two or more different households. As McDonald puts it: "The group described by the child is 'family' for that child and not for anyone else." (p.44).

At the micro-system level, then, the concept of "family" may need to be broadened to "families", to include the range of persons that the child is

relates closely to on a regular basis. For instance, a complicating factor for children whose parents have separated/divorced and re-partnered is the fact that the partner of the parent with whom the child lives may have a much stronger or immediate influence (for better or worse) on the child's development, welfare and well-being than the natural parent with whom the child has less frequent contact. In looking at the parental factors impacting on the child therefore, the ontogenic characteristics of the partner/s of the parents must be taken into account if those persons have an impact on the child's development, welfare and well-being.

Within an ecological model, the micro-system applied to reconstituted families may therefore contain two immediate family units which are structurally quite different but are interactive and impact directly on the child, individually and through their interaction with each other.

Rapoport et al (1977) argue that balancing children's and adults' needs in the context of changing family structures is extraordinarily complicated, and that stresses in relationships are caused by individuals trying to maintain conservative values while behaving in a variety of non-conventional ways. While agreeing that the value of families being child-centred predominates in western societies, Rapoport et al assert that in reality this ideal is a myth, which does not reflect the tensions inherent in trying to reconcile parents' needs with those of their children.

This observation becomes even more relevant in the context of the 21st century family models where reconstituted and blended families place more stress on parents to meet the competing needs of all players - within the child's family of origin and the new family members who are part of the reconstituted families (including four or more sets of grandparents).

Tower (1996) emphasises the importance of the family as a system, with subsystems, boundaries, roles and communication patterns, in recognising and meeting children's developmental needs. She cites the following

examples given by Karpel and Strauss (1983) of different family contexts, noting that these definitions may significantly overlap, and that perceptions of parental function may vary widely, depending on what the particular community or society wants to foster:

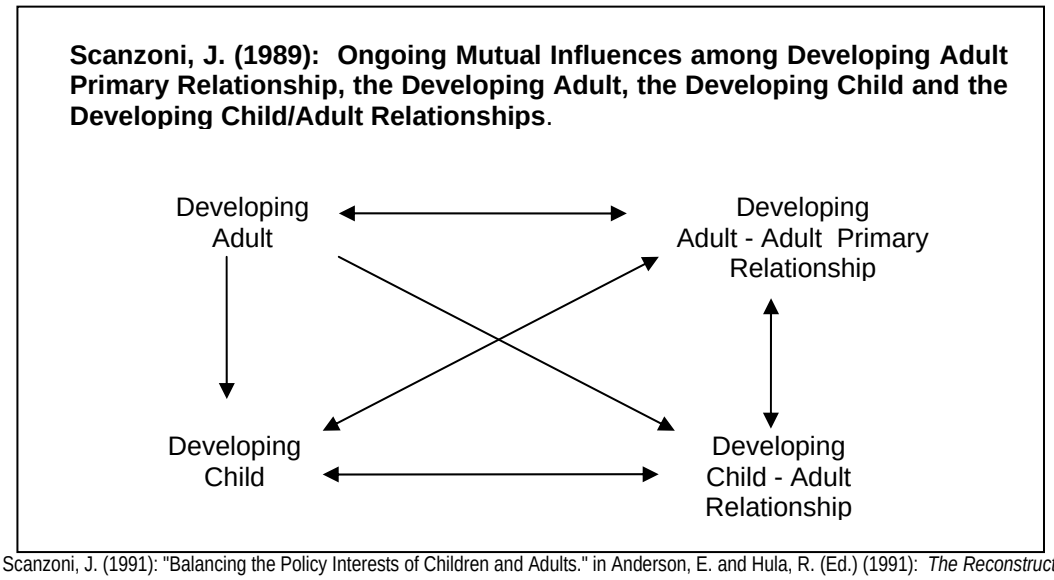
- *The functional family* - members who share household tasks, activities and child care.
- *The legal family* - bound by legal structure and altered by divorce or the legal removal of children.
- *The family by perception* - members see each other as being part of the family, e.g. live-in boyfriend considered to be acting in the role of father and husband.
- *The biological family* - held together by blood relationships.
- *The family of long term commitments* - long term expectations encompassing trust, fairness and loyalty.

Scanzoni (1989; 1991) suggests replacing the idealised concept of 'family' with a more progressive construct of primary or close relationships. Scanzoni's concept is represented by a pattern of mutual inter-relationships between the child, the adult (parent / parent figure) and the adult's primary (sexual) relationship, and allows for a wider range of primary relationship options in a variety of living situations. The construct also stresses the importance of the *developing* nature of the child, the adult, their relationship and the adult's other primary relationship, and the influence of each upon the other. It is a more representative image of contemporary families or close and primary relationships than the conventional image of 'the family', composed of a static structural relationship between a father, mother, and their children. (Fig. 3.6)

Scanzoni (1991) argues that to increase child and family functioning, enhancement must occur not only in the area of child development but also in the three other areas - the developing adult, the developing adult-adult primary relationship and the developing child - adult relationship. He calls for policy that balances adult interests and needs with children's interests and

needs. He further proposes that policy and programs must be aimed at simultaneously enhancing the wellbeing of both adults and children: "…general policy and specific programs need to address the psychological and social wellbeing of adults as well as children if children (and adults) are ultimately to prosper as fully as possible." (p.17). As an example, he cites child care assistance as a policy that assists the wellbeing of women who place their children in day care and also increases the wellbeing of the child.

Fig. 3.6: *Ongoing Mutual Influences among Developing Adult Primary Relationship, the Developing Adult, the Developing Child and the Developing Child/Adult Relationships.* Scanzoni, J. (1991) p16



Scanzoni, J. (1991): "Balancing the Policy Interests of Children and Adults." in Anderson, E. and Hula, R. (Ed.) (1991): *The Reconstruction of Family Policy.* Greenwood Press NY Adapted from Scanzoni, J. et al. (1989): *The sexual bond: Rethinking families and close relationships.* Sage. Newbury Pk Copyright Sage Publications CA. Reproduced with permission.

Some family structures, e.g. single parents and blended families, have been reported to be to be over-represented in child maltreatment reports. The Canadian Incidence Study (CIS) (Trocme et al 2005) reports that of all cases of substantiated maltreatment in 2003, 32% involved children living with two (biological) parents, 43% in single parent families, 20% in blended/step families and 5% with families of "other composition". (p.73) When categories of maltreatment are compared by family structure, single parent families accounted for 34% of physical abuse, 44% of sexual abuse, 47% of neglect, 48% of emotional abuse and 43% of exposure to domestic violence reports (in the latter case, all female headed families). Canadian census figures for 2001, quoted by Trocme et al 2005, indicate that 8% families with children under 17 were headed by a lone female. Lone male parents would account

for a much smaller percentage of families. The Canadian Incidence Study figures for child maltreatment would therefore indicate that single parent families accounted for a disproportionate percentage of all substantiated child maltreatment cases.

However, such structural factors must be examined within their demographic context. Single parent families, particularly those headed by females are often the recipients of social security, are more likely to be in a lower socio-economic group, and are therefore often located in economically and socially disadvantaged communities. As such, they are also open to more scrutiny by various social services, which may lead to higher rates of reporting, sometimes because of actual maltreatment and sometimes to elicit funding or services.

Blended families have also been associated with higher rates of reporting for child abuse. However, this link is highly speculative and may be confounded by other factors, including parental personality factors, and family instability related to the breakdown and reconstitution of the family, rather than the fact that one of the caregivers is not genetically related to some of the children. In the Canadian Incidence Study (Trocme et al 2005), two parent blended/step families account for 20% of substantiated reports of physical abuse, 13% of sexual abuse, 14% of neglect, 15% of emotional abuse and 15% of exposure to domestic violence. (p.74)

Mayer et al (2003) reporting on the results of the Quebec Incidence Study of Reported Child Abuse, Neglect, Abandonment and Serious Behaviour Problems (QIS), supports the findings that single parent, and blended families are over-reported and more likely to be investigated in Canada. In particular they found that neglecting two parent families are often blended families, usually made up of a biological mother and stepfather or defacto. In addition, neglected children in blended families have more behaviour problems, and problems related to hyperactivity and externalisation and are more likely to require social work help. Families headed by single mothers

are more likely to be extremely poor, many of the mothers have not completed high school, are not in the workforce, are socially isolated and have more personal problems. (p.3)

Using data from the US National Longitudinal Survey of Youth, Berger (2004) explored the effects of income and family structure on indicators of child abuse and neglect. He reports that child maltreatment, particularly neglect, is highly correlated with poverty, and that the primary factors associated with child abuse and neglect include unemployment, single-parenthood, limited access to social and economic resources and parental substance abuse. He also notes that low income families and families from low income neighbourhoods are more likely to be reported to child protection services. (p.726)

Berger (2004) found that families with both biological parents had the lowest number of overall risk factors for child maltreatment, and single parent families had the highest number. However, he reports mixed results for mother-partner families, which had higher numbers of overall risk factors than two parent families, but were not significantly associated with a number of the individual risk factors measured, although families with a non-biological father scored lower on emotional support. (p.743)

Saville-Smith (2000) cites three family structure variables from her literature review that appear to be associated with child abuse or neglect, but cautions that the association is complex and mediated by situational and environmental variables. These factors are the number of children by different fathers, younger parental ages at birth of first child (mediated by other stress factors), and combination of number and spacing of children (associated mainly with neglect). (p.20).

3.3.1 b. Family Demographics.

In terms of family demographics, socio-economic status, income and employment status are frequently seen to be associated with at least some

types of child abuse and to play a direct role in the etiology of neglect. Child abuse has been directly or indirectly associated with economic disadvantage, while children living in poverty are 40 times more likely to be harmed by physical neglect than children living at or above the median income level (National Center on Child Abuse and Neglect 1996). However, the association between child abuse and neglect and poverty is complex and highly controversial. Some authors suggest a direct link between poverty and child maltreatment (Pelton 1981; Gil 1981), while others contend that although a disproportionate number of child protection cases are found in areas of socio-economic disadvantage, the association between poverty, socioeconomic disadvantage and child maltreatment is complex (Waldfogel 2000) and most families living in poverty do not abuse or neglect their children (English 1998; Vinson and Baldry 1999).

Horowitz and Wolock's (1981) study, comparing welfare recipients involved with child protection services and a control group of welfare recipients, reports that: "material and social deprivation are central factors leading to child maltreatment…the maltreating families were 'the poorest of the poor'… lived under poorer material circumstances, had more socially and materially deprived childhoods, were more often isolated from friends and relatives and had more children…". (p.138)

In terms of types of child maltreatment associated with income / employment status, the US Third National Incidence Study 1993 (Sedlak and Broadhurst 1996) found that "family income was the strongest correlate of incidence across categories of child maltreatment. Poverty was especially related to serious neglect and severe violence towards children." (p.2) The study reported that abuse is 14 times more common and neglect is 44 times more common in poor families (with annual incomes under $15,000 compared with families with incomes over $30,000), and that the findings cannot be explained only on the basis of the higher visibility of lower income families to community professionals. (pp.2-17)

A direct link is not made between household poverty and child maltreatment in the Canadian Incidence Study (CIS 2005) (Trocmé et al 2005) because specific levels of income were not measured. However, in terms of employment status and incidence of substantiated child maltreatment, the CIS reports that for each of the categories of physical abuse, sexual abuse, emotional maltreatment and exposure to domestic violence, full time employment was the major source of family income in between 60%-70% of the families. In families associated with substantiated reports of neglect, only 41% were in full time employment (p.79). The CIS does not provide figures for the level of income actually derived from the full time employment, however, 39% of the total study group families were headed by single female and this group is often associated with poorly paid employment or dependence on social security. The income of the remaining families was derived from either part-time or seasonal work, or social security. Therefore it is possible to draw a link between social disadvantage and substantiated child protection reports.

Berger (2004, p.742) reports that income plays a part in the quality of caregiving in the home, in terms of lower cognitive stimulation and emotional support, and in addition, lower income parents are more likely to use physical discipline, possibly in response to the stress associated with economic disadvantage. On the other hand, Pringle et al (1966) counsel that effects of family breakdown and social disadvantage must be measured against the range of abuse and emotional stress children may endure while living in dysfunctional, but financially secure, families. They caution that it is important to avoid the temptation to opt for the simplistic solution of addressing only social or economic disadvantage. Waldfogel (2000) suggests that a conclusive link between poverty and child maltreatment is difficult to establish, and it may be that underlying factors such as mental health issues or substance abuse contribute to both poverty and child maltreatment. (p.2)
The characteristics of socio-economic disadvantage are far broader than lack of sufficient financial resources. Social and economic disadvantage substantially increase the stress factors for families and exacerbate the

impact of other risk factors for child abuse and neglect. In addition, disadvantaged families in disadvantaged neighbourhoods are more likely to be isolated from social supports that could mitigate against existing risk factors. As reported earlier in this chapter, research by Vinson and Baldry (1999) indicates that even within groups of caregivers living in disadvantaged situations, the risk of child maltreatment arises from a complex interplay between personal, family and neighbourhood factors, as well as stress factors and support factors.

3.3.1 c. Family functioning and interaction.

This category includes family structural stability, quality of relationship of parental partners, strategies for anger management and conflict resolution, disciplinary practices quality of parent/child bonding and attachment and relationship between the family and its community.

Whatever the structure of the family in which children find themselves, in order to develop into well adjusted adults, they must learn a certain number of skills in relationship building and organising their own lives. According to Helfer et al (1976), these skills include learning to set priorities, plan ahead, trust others, make friends, develop a good self image, differentiate between feeling and behaviour and get their needs met in an acceptable manner. Helfer et al believe that children learn skills by observation, association and through outcome, and that the social unit to assist the child achieve these developmental tasks should ideally include consistency and stability of primary caregivers. The stability of the social unit may in turn be negatively affected by a number of personal and social factors, including parent/caregiver immaturity, instability, overly high expectations of the child, or unmet personal needs. (p.56)

Saville-Smith (2000) reports research that indicates child abuse is associated with families where interactions are characterised by anger and conflict, spousal violence, lack of marital support between the parental couple, coercive punishment, and family members who are involved in aggression or

violence outside the family. In addition, physically abusive families are reported to be more isolated from their extended family, neighbourhood and support services. Families associated with child neglect are more likely to have instability in family structure and have disengaged parent/child relationships and although they may be involved with extended family and neighbours, the relationship is not reciprocal, but one of passivity or dependence, in order to have needs met. (p.22)

Domestic violence, parental anger management and conflict resolution problems are frequently associated with child maltreatment, either by direct physical abuse of children or exposure to parental domestic violence or chronic threat or conflict. Tomison (2000) cites a growing body of evidence that domestic violence may be a predictor of other types of violence, with child abuse being estimated to be 15 times more likely in families where domestic violence is occurring (National Woman Abuse Prevention Project 1989). The association is not limited to the perpetrator of domestic violence, or to physical abuse of children. Straus and Gelles (1993) report that women who are victims of domestic violence are more than twice as likely to physically abuse their children (Tomison 2000, p.6). Goddard and Hiller (1993) conducted a hospital based child abuse tracking study which found that 40% of sexual abuse cases, as well as 55% of physical abuse cases involved families where domestic violence was occurring (Tomison 2000, p.7). It is also now recognised in NSW child protection legislation that children who witness domestic violence or its aftermath are likely to suffer emotional trauma.

Perry (1997) poses the hypothesis that children who suffer chronic exposure to domestic violence may suffer long term harm by virtue of the fear-induced adaptive response they develop in order to survive the conflict in the home, which is maladaptive for other situations where they become hypersensitive and over-reactive to perceived threats of danger. Finally, there is growing support for the view that childhood experience of physical violence or witnessing a significant other be assaulted may increase the likelihood of

later involvement in violence, either as perpetrator or victim (Widom 1989; 1992).

Wolfe (1987) examined the day-to-day interactions of family members that may contribute to the escalation of behaviour into an abusive incident. In addition, *behavioural factors* (low frustration tolerance, social isolation and impaired child rearing skills), may become significant when coupled with *cognitive-emotional factors* e.g. unrealistic expectations of the child, being extremely stressed by the child's behaviour and describing themselves as inadequate or incompetent in their parenting role.

Certain disciplinary practices have been associated with potential for child abuse and differential outcomes for children. Crouter and Seery (1994) cite research by Dornbusch, Ritter, Leiderman, Roberts and Fraleigh (1987) into the effects of three different parenting styles - authoritarian, permissive and authoritative - on child behaviour and psychological outcomes. Authoritarian and permissive parenting styles were generally associated with poorer academic achievement in adolescents, while higher school performance was linked to authoritative parenting style.

Vondra (1990) also explores the relationship between parenting styles and child maltreatment. She links poorly educated mothers, in families where the adults are in low status work or unemployed, with childrearing strategies associated with poorer developmental functioning and lower educational achievement in children. She summarises the research findings as follows: "Economic, sociocultural and interpersonal factors act jointly in these families to create a situation of severe economic stress, hardship and dependency that has been cited as the single greatest threat to adequate family functioning." (p.24). Vondra sees the possible solution to this community problem as requiring cooperative intervention between formal, institutionalised services and informal support from churches and local networks.

Studies have linked parental drug or alcohol use to higher parental aggression within (and often outside) the parental relationship and also to more punitive disciplinary practices, and in turn, behavioural or adjustment problems in children (Ammerman et al 1999; Keller et al 2004).

3.3.1 d. The family's connectedness to the community

This factor plays an important dual role in mediating risk factors for child maltreatment. If the family is well connected to a supportive local environment with positive values about children and childrearing, where other adults model constructive strategies for coping with problems, this link may help to reduce the stress associated with economic or social disadvantage. If, on the other hand, the local community is more akin to the sort that Garbarino (1998, p.10) has described as *'socially toxic'* - i.e. has violence, poverty, crime, substance abuse, disrupted family relationships, paranoia and alienation, then family's connectedness to such a system is more likely to increase the risk of child maltreatment.

In many families where domestic violence is present, family members are disconnected from their local neighbourhoods, either through coercive forces applied by the perpetrator, or fear, embarrassment or lack of self esteem in the (predominantly female) victims. In these cases, even a supportive neighbourhood environment will not mediate against the effects of the abuse, since any informal or formal support links made by the victims are likely to be covert if the woman and children are still living in the family home, and will almost certainly not involve the perpetrator.

Abusive mothers report themselves to have fewer friends, to have less contact with the friends they do have, and to give lower ratings to the quality of support they receive from friends (Bishop and Leadbeater 1999).

In relation to the etiology of *physical* abuse, Crittenden (2000) states that the evidence indicates that families in which children are injured, accidentally or intentionally:

"(a) live in low income neighbourhoods characterised by high rates of crime and violence
(b) have large numbers of children relative to the number of protective and supervising adults
(c) are isolated from nonfamilial supportive networks
(d) move frequently (and are thus often in unfamiliar settings and surrounded by unknown people, and
(e) have relatively young, and often single, parents." (p.14)

The factors cited by Crittenden may apply more broadly, in that parents who are stressed, socially isolated, lacking emotional support and positive parenting models are more vulnerable to additional stress, which may precipitate child maltreatment, compared with parents who are financially more secure, better socially resourced and able to access appropriate support in times of transient stress. In addition, parents living in disadvantaged socioeconomic environments may also have co-existing emotional disturbance and/or substance abuse, the latter possibly being a form of self medication to relieve the anxiety associated with their daily struggle. Both these factors may have the effect of further isolating already vulnerable families from formal and informal supports available in their local community that could potentially mediate against child abuse and neglect.

3.3.2. Parent-related factors.

It is essential when examining individual parental characteristics (including ontogenic factors) associated with child maltreatment, to place them in the context of the social environment of the family (exosystem) as well as the family microsystem where child and parent characteristics constantly interact and impact each other.

From her review of the literature on the etiology of child abuse and neglect, Saville-Smith (2000, p.22) lists some specific parental factors found to be associated with child maltreatment, including parent's past exposure to

physical abuse and/or neglect, substance abuse, psychiatric illness, personality characteristics, parenting skills and parents' attitudes towards children.

Reder, Duncan and Lucey (2003) cite Belsky and Vondra (1989) who produced a list of factors contributing to child care outcomes. The attributes include: parent's childhood history of affectionate parenting in an intact family; mental health that allows warm, positive, parent-initiated interactions in a stable environment; psychological maturity, including having a stable sense of self and an internal locus of control, the ability to show affection and having a variety of coping responses; and sensitivity to and a realistic expectation of the child's developmental needs and capabilities. This list of positive attributes could be seen as the basis for a deficit model for parenting factors in the etiology of child maltreatment.

Belsky and Vondra emphasise the *interactive* nature of all these factors and describe child maltreatment as a consequence of the interaction between *stress* factors (vulnerability or risk) and *suppor*t (compensatory) factors. (Reder, Duncan and Lucey 2003, pp.6-7)

3.3.2 a. Parental childhood abuse or neglect.

The link between parental childhood history of abuse and/or neglect and risk factors for the parenting of their own children is the subject of considerable debate. The recurrence of child abuse and neglect in the families of parents who suffered childhood maltreatment has been the subject of much research, including part of a continuing 30-year longitudinal research project - *The Mother-Child Project*, (Egeland, Jacobvitz and Papatola, 1987) later called *The Parent-Child Interaction Project*, (Egeland and Erickson, 1999). The phenomenon is variously referred to as the theory of 'intergenerational transmission of maltreatment' or 'the cycle of abuse' (Egeland, Jacobvitz and Stroufe 1988; Widom 1989,1992). However, the concept of intergenerational transmission of maltreatment is controversial. While there is evidence that some parents who were abused or neglected as children go on to maltreat

their own children, (e.g. Egeland, Jacobvitz and Stroufe (1988) report a 40% rate of maltreatment across the generations in their study), most parents who were maltreated children do not abuse their children (Egeland and Erickson, 1999; Kaufman and Zigler, 1993).

Egeland and Erickson (1999) use attachment theory to explain both how maltreatment is transferred across the generations and also how the cycle can be broken. Some of the mediating variables include the availability of persons who are emotionally supportive for the parent, stable and positive relationships with a partner, and therapy to assist the parent to deal with the childhood abuse. (Egeland and Erickson 1999, p.6)

In reviewing the literature, Tomison (1996b) notes that studies involving intergenerational transmission of maltreatment are both prospective and retrospective and estimates of the rate of intergenerational transmission vary widely, between 7% and 70%. Studies also vary according to the types of maltreatment being measured. Tomison cites three main theories to explain intergenerational transmission of child abuse and neglect. The first of these is *social learning theory*, which suggests that the child learns to use aggression and violence by witnessing or experiencing this from parents, who are powerful models of social behaviour. Secondly, *biological theory* suggests that the temperament associated with aggression may be an inherited characteristic. The third theoretical model is a *combination of the first two* - i.e. that an individual with a genetic predisposition towards aggression, who also is exposed to parental modelling of violence, is at greater risk for demonstrating violent behaviour towards his/her children.

The ecological model assists in providing an explanation of child maltreatment that appears in successive generations. It emphasises that no single factor can explain intergenerational transmission of maltreatment, but that it is likely to be the result of an interaction between *risk factors*, (including genetics, temperament, social learning, and environmental or interpersonal stress) and *mediating protective factors* (including exposure to alternative

parenting practices, positive parent-parent and parent-child relationship, education, and formal or informal social support systems that assist the parent to deal with stressful situations.)

3.3.2 b. Parental Substance Abuse.

The association between parental substance abuse and child abuse and neglect is well documented (Sheridan 1995; Chaffin et al 1996; Ammerman et al 1999; Walsh et al 2003; US Dept of Health and Human Services 2003a, 2005). U.S. estimates suggest that 50%-80% of all substantiated child abuse and neglect cases involve some degree of parental substance abuse (US Department of Health and Human Services 1994), and in one Australian state, it is also associated with over 50% of care and protection applications (Leek et al 2004, p.iv). U.S. research has indicated that children whose parents abuse alcohol and/or drugs are nearly three times as likely to be abused and more than four times as likely to be neglected as children of parents who do not abuse alcohol or drugs (Milliken and Rippel 2004, p.95).

Children of substance abusing parents are more likely to have compromised physical, intellectual, social and emotional development, are more likely to be placed in foster care and to remain in care for longer periods of time and are more likely to develop substance abuse problems than children whose parents are not substance abusers (Grayson 1998 p.4; US Dept of Health and Human Services 1999; National Clearinghouse on Child Abuse and Neglect Information 2003 p.1). The situation is more serious for the children of parents who commence using drugs and/or alcohol and have children at a younger age (Milliken and Rippel 2004, p.103). These parents are likely to be developmentally impaired by substance abuse during adolescence, affecting their social and emotional development, and often educational achievement, leaving them with fewer skills to gain employment or maintain positive social connections. The effects of substance abuse on parenting include lowered frustration tolerance, disinhibited aggressive response, impaired judgement and distraction from parenting while searching for,

consuming and experiencing the after effects of the substance (Ammerman et al 1999).

Clinical levels of alcohol intake may be associated with depression, poor health and economic disadvantage, which impact upon parenting ability. Research indicates that where *both* parents abuse alcohol or drugs, the child protection risk is significantly elevated (Walsh et al 2003, p.1409). Keller et al (2004) cite studies that found substance abuse disorders to be associated with harsh discipline, authoritarian or permissive parenting styles and unrealistic expectations of children's abilities. However, the findings of their own study were that parental drinking may be indirectly related to poor parenting practice through its effect on the marital relationship. Maternal and paternal drinking were found to be related to marital conflict, which in turn was associated with inconsistent discipline, more marital hostility and greater parental psychological control and/or emotional unavailability, all these factors being associated with child adjustment problems.

3.3.2 c. Parents' Physical and Mental Health.

Chronic physical illness in the parent was found to affect the development of male children more than females (Blackford 1988). However, the effect on children was found to be mitigated by compensatory factors such as support of family members, availability of the other parent, and the absence of conflict and discord in the child’s presence (Hetherington and Martin 1986).

Parent psychiatric disorder and its effect on children’s development has been the subject of much research, which while it has indicated that such children are at greater risk of developmental difficulties, has failed to produce any conclusive causative link. The link between mental illness and child maltreatment often appears to be indirect, i.e. mediated by other factors such as stress, substance abuse, antisocial behaviour or disrupted social relationships.

It has been demonstrated that children who have two parents with psychiatric illness are more at risk of suffering developmental problems than children with one or no parent with psychiatric illness (Cantwell and Baker 1984). More behavioural problems were found in children with two psychiatrically ill parents if one of the parents was diagnosed as having an antisocial disorder (compared with any other diagnosis). A similar result was reported in a separate study of children of parents with criminal behaviour. (Kandel et al 1988).

Factor and Wolfe (1990) propose a concept of reciprocal influence between parents and children, and have studied the effects of a specific parental psychiatric disturbance or identifiable adjustment problem on children's development. They examined a number of types of parental disorders (including depression, criminality, immaturity and chronic illness) and found that two common features of many of these disorders are an impairment of the parent's age-appropriate demands on the child and the parent's sensitivity and responsiveness to the child's capabilities, in contrast with healthy, appropriate parenting. The factors perceived to affect children relate to the parents' modelling of inappropriate behaviour, the effect of the psychopathology on marital and family relationships, inconsistency or inappropriate child-rearing methods and unpredictable moods or behaviour (p.172). Chaffin, Kelleher and Hollenberg (1996) found a link between parental depression and physical abuse, and report that substance abuse combined with some types of psychiatric disorder has a significant impact on the likelihood of physical abuse and neglect.

Depression in parents not only has an effect on self esteem, behaviour and mood, but also on family relationships and child rearing. Because of these areas of influence, parental depressive illness and its relationship to children's development has been the subject of a great deal of research. Orvaschel (1983) cites studies that strongly suggest a causal relationship between parents with depressive illness and behaviour and relationship problems in their children.

Factor and Wolfe (1990) note that there is some conjecture as to the degree to which the depressive illness in the parent plays a role in affecting the child through disturbance of childrearing practice and parental relationships, rather than the presence of a unilateral causal relationship between parental depression and child dysfunction. In particular, maternal affective disorder may interfere with the responsibilities of child care, quality of attachment and the day to day interactions between parent and child, particularly in the areas of involvement and disinterest, communication, affection and hostility (pp. 186-8).

Coyne, Khan and Gotlib (1987) note that most studies concentrate on mothers with depression, not fathers, and there are very few studies which employ observation of the daily interactions between depressed mothers and their children, so that the actual impact may be measured. "Similar to other situational and familial factors (such as child maltreatment) associated with developmental risk...the presence of parental depression appears to disrupt the child’s normal, ongoing development in a pervasive manner that cannot be predicted or described in a unidimensional fashion. Rather, parental depression, and perhaps other forms of psychiatric disturbance as well, interferes with the child’s normal development of behavioural, cognitive, and affective abilities and such interference carries with it an unpredictable developmental course."

Turner, Beidel and Costello (1987) report that children of parents with anxiety disorders are twice as likely to have a DSM-III disorder as children of dysthymic parents, and were twice as likely to themselves have an anxiety disorder. Similar findings confirming a link between anxiety disorders in parents and psychiatric disturbance in children have been recorded by a number of other researchers (Sylvester Hyde and Reichler 1987; Silverman, et al 1988).

In discussing the impact of parent's own attachment issues on their ability to bond with and parent their children, Vondra (1990) cites a body of research

into the interpersonal relationships of maltreating parents. She suggests that abusive and neglectful parents often report or display difficulty in forming secure attachments with their families of origin, and have often experienced unstable, insecure or pathological relationships. They also have difficulties forming intimate relationships with their partners, many of whom also experienced impoverished child-parent attachments. While cautioning that all children who had serious attachment difficulties will not necessarily mistreat their children, she concludes that: "Taken together, these and other findings strongly suggest that attachment issues form the crux of the maltreating family's interpersonal problems." (p.27)

Vondra (1990) believes that attachment issues may render the parent less capable of dealing with everyday problems, and their inability to sustain intimate relationships and supportive friendships also denies them access to physical and emotional assistance in dealing with stressful situations in their lives. In the absence of supportive family and friendship networks, the socially isolated parent may turn to substance abuse to deal with stress, further compounding the problems of family functioning and adequate child care. In the context of other co-existing social stressors such as poverty or unemployment, if deviant or difficult child behaviour is added to the equation, the potential for developmental problems and/or child abuse is greatly intensified. The situation is further magnified if the parent/s also suffer from personality characteristics associated with anxiety or depression.

Killen (1994; 1995) cites the findings of Polansky et al (1981;1991) regarding child neglect and parental inability to adequately meet children's needs. Polansky et al classify *parental immaturity* according to two types, each defined by specific characteristics as follows:

- *The 'Impulse driven Parent'* - has behaviour similar to a young child; cannot plan ahead or consider the consequences of their actions. They are characterised by behaviours such as restlessness, aggressive defiance, wishful thinking, manipulating to achieve their own ends, strong

emotions, superficial relationships, seeking excitement and change, and lack of impulse control. (Killen 1994, pp.11-12)

- *The 'Futile / Apathetic Parent'* has experienced early childhood rejection and deprivation, and in a self-protective response, has withdrawn from relationships. Such parents are passive, unresponsive, emotionally numb, lack self confidence, have poor verbal ability, lack close relationships, and have little engagement with, and poor perception of, their child. (Killen 1994 pp.13-14)

In examining the links between parental immaturity and child neglect, Killen (1994;1995) further describes two types of immature parents, placed on a continuum. The first group she describes as parents with *Primary immaturity*, lacking early secure attachment and never having functioned at a higher level. They may have had immature parents as role models, or have experienced early trauma that has never been addressed. Killen (1994) regards this group as inaccessible to intervention in adult life, and is pessimistic about their ability to parent satisfactorily.

Killen (1994) regards parents with *Secondary immaturity* as different from those with primary immaturity because, although they also suffered early deprivation or trauma, they have benefited from a significant attachment and more structure for at least part of their lives. They have been functional at some level at some time, and this provides some cause for optimism about change following intervention. However, future functioning as a parent is vulnerable to the effects of risk factors such as social isolation, substance abuse and/or domestic violence. Killen rates parental immaturity as a bigger risk to parenting functioning than emotional problems, which may be more transient and have a better prognosis. However, the presence of both emotional problems (especially depression) and parental immaturity is linked to a poorer prognosis and higher risk of neglect for the children of these parents.

Wolfe (1987) found a significant link between child abuse and the age at which mothers first give birth. The developmental risk to the child significantly increases when parental immaturity is combined with societal factors, such as instability of housing or income, lack of access to education and social and economic resources, and violence in the parental relationship. Killen (1995) is less pessimistic about the outcome for young parents, unless their youth was accompanied with primary immaturity or other risk factors. Scott, Field and Robertson (1981) found that immaturity in adolescent fathers/partners may commonly be expressed in poor employment history, violence (including domestic violence), substance abuse, financial irresponsibility and minimal contact or involvement with the infant or toddler.

While acknowledging the interactional effects between child, parent and the family's wider social system, some other research has indicated parental factors associated with specific types of child maltreatment. Garbarino, Guttman and Seeley (1986) view the concept of psychological maltreatment (emotional abuse and emotional neglect) in terms of a pattern of psychologically destructive parental behaviour which may include any or all of the following behaviours: rejecting, isolating, terrorising, ignoring, corrupting, i.e. ‘mis-socialising’ the child and reinforcing destructive or antisocial behaviour. (p.8)

Child sexual abuse within a family context has been the subject of an extensive body of research. Theories as to the causes and degree of impact of adult-child sexual contact vary widely, but it is a generally held view across many cultures that an adult family member engaging in sexual behaviour involving a child is seen as having a detrimental effect on the child, whether or not the child is said to be consenting to the activity. This is because the adult is in a position of power and trust, and the child does not have sufficient information or the authority to give informed consent to sexual activity (Finkelhor 1984).

Families in which adult to child sexual contact occurs are seen to have insufficient psychological boundaries between the adult and child. The causes for the lack appropriate role delineation between parent and child can also be examined in terms of social or personality/psychopathology theories. Incestuous fathers are reported to have had various degrees of childhood deprivation, chaotic family backgrounds and have often themselves been victims of abuse (Tower 1996, p.144). The personality characteristics of the sexually abusive father range from "overbearing and tyrannical" (Herman and Hirschman 1981) to "passive, immature and dependent" (Ballard et al 1990) and possibly displaying "poor impulse control, low frustration tolerance, social and emotional immaturity, faulty ego operation, and frustrated dependency needs." (Tower 1996, p.145).

Finkelhor (1984) cites four preconditions for sexual abuse to take place - *motivation* on the part of the perpetrator, a *lack of internal inhibitors*, an *absence of the usual external inhibitors*, and the *need to overcome the child's resistance*. He therefore sees interplay between the personality characteristics of the adult and child, and the social environment in which the abuse takes place. He notes that children from families who are socially isolated are much more vulnerable to abuse and that abuse may also occur more frequently when the absence of the mother provides less supervision of the child and more opportunity for the perpetrator to have access to the child alone.

In summarising the evidence for the role of parental psychopathology in child maltreatment, Factor and Wolfe (1990) note that extensive research has failed to produce any conclusive psychological profile to support the view that parental psychopathology is "at the root" of child maltreatment. (p.191) They caution that the role of parental adjustment in abusive and neglectful behaviour must be viewed in the light of the nature and context of the behaviour, including the interaction between parental functioning and situational demands. Rather than reinforcing the notion of a distinctive personality profile of an abusive parent, they emphasise the interactive

nature of child abuse, i.e. there may be a set of 'predispositional characteristics' in some parents that increase the risk of abusive behaviour when coupled with certain situations (p.193).

3.3.3. Child-related factors.

Ambert (1992) argues that each child is born with a particular set of personality traits and characteristics, and it is the interaction between these and parent (and later other socialising agents) that moulds the final personality of the child. These same intrinsic child-related personality features determine the extent to which the child is shaped by the positive and negative aspects of his/her wider environment.

In a provocative contribution to the debate on etiology of child maltreatment, and while acknowledging that young children are in need of physical protection, Ambert (1992) proposes that the role of the child in his/her own development and in influencing his/her parents has been overlooked or disregarded in much of the literature. She cites research on child abuse that "…acknowledges that child characteristics can contribute to this unfortunate syndrome." (p18). She gives the example that children with physical or health problems or behavioural difficulties negatively affect their parents' wellbeing, and the parents' potential to affect the child may be influenced by negative parent characteristics, incompatible with good parenting. Societal factors such as parent education, social support and adequate welfare assistance may militate against the effects of negative parent factors. In addition, the child's positive effect on the parent will be determined by the level of compatibility between them.

In reviewing the role of child factors in the etiology of child abuse and neglect, (Ammerman 1990) examines early childhood factors that may disrupt the relationship between mother and child. He cites the work of Ainsworth (1980) on attachment formation and notes that while there is no definitive data to demonstrate that disrupted attachment leads to maltreatment, insecurely attached children and mothers are overrepresented

in cases of maltreatment. The issue to be determined is whether the attachment difficulties are a cause or consequence of the maltreatment. The same question arises with children who have difficult behaviour and less positive affect (Crittenden 1985). Ammerman (1990) concludes that while they are not responsible for abuse, child-related factors (e.g. non compliance) can interact with parent related factors (e.g. coercive discipline styles) and contribute to escalation of conflict which precipitates abuse. (p.210)

Many of the child-related characteristics in the literature on physical and emotional abuse and neglect tend to relate to babies, infants and children, as this age group is the most at risk and vulnerable to the effects of these types of maltreatment (Kempe and Kempe 1980). In discussing the child-related characteristics that may be associated with child maltreatment, it is important to be very clear that in the context of this study, child attributes or behaviour are regarded as vulnerability factors and are not presented for the purposes of laying responsibility for the maltreatment with the child victim, even if the child's provocative or stress-inducing behaviour is one of the factors that interacts with parental characteristics and results in abuse. An additional consideration is whether the child's behaviour is an individual characteristic or a response to previous maltreatment.

The impact of adolescent characteristics and behaviour on physical and emotional abuse is a somewhat different issue and their impact should be seen in the context of the age and developmental level of the adolescent and the functional level of the parent. This is not the case for sexual abuse, however, where full responsibility is always ascribed to the adult, regardless of the behaviour, or perceived behaviour, of the child or adolescent (Finkelhor 1984).

As listed previously, in Fig.3.4, there are a number of child-related factors that are most commonly cited across the research as being associated with child maltreatment, although, depending on the focus of the research, some

characteristics are related to only one type of abuse or to neglect, while others are common to more than one form of maltreatment. Child related factors may be demographic, or related to the personal characteristics of the individual child.

3.3.3. a. Child-related demographic characteristics.

The child-related demographic characteristics commonly nominated as associated with maltreatment are: age, sex, birth order, whether a single child or part of a multiple birth, whether from the current relationship or a previous relationship, and quality and composition of the sibling group.

Age is a critical factor to be considered in child maltreatment, although there is some variation in incidence studies. There is general agreement in the research that very young children are at most risk for abuse. Babies, infants and young children are at risk of physical abuse and neglect, because of their vulnerability, and their close proximity to and dependence on their parents (Belsky 1993; Saville-Smith 2000, pp.18-19). At the most extreme end of the spectrum, children under four years of age are significantly over-represented in fatal child assaults (Reder, Duncan and Gray 1995; Lawrence and Fattore 2002) and fatal neglect (Lawrence and Irvine 2004).

The Third U.S. National Incidence Study (Sedlak and Broadhurst 1996) found a higher rate of reported abuse in the 6-11 year old children, relative to the under 5's. However, this was seen as an under-representation, related to pre-school age children being less observable to professionals. From the age of 11, the incidence of maltreatment was seen to diminish with increasing age of the children. (p.13)

Older children and teenagers are also at risk of abuse (Saville-Smith 2000 pp.18-19), however, gender is a mediating factor. The Canadian Incidence Study (Trocme et al 2005) found that risk for physical abuse was higher for pre-teenage boys than girls, while the reverse applied in the teenage years. The incidence rate for sexual abuse was roughly the same for boys and girls

under 8 years, but heavily skewed towards females in the pre-teen and teenage years.

Gender related abuse. The Third U.S. National Incidence Study (Sedlak and Broadhurst 1996, p.8) found that while all children over the age of three years are vulnerable for sexual abuse, girls are three times more at risk for sexual abuse. This incidence rate for sexual abuse in girls skewed the general rates for all maltreatment towards females, although boys were at greater risk for serious physical abuse and emotional neglect.

In the Canadian Incidence Study (Trocme et al 2005) overall rates of substantiated maltreatment were similar for boys and girls, but varied by age group. Up to the age of 7 years, the rates were similar, after which boys were over-represented in the pre-teenage years and girls in the teenage years. As noted earlier, the incidence of sexual abuse is heavily skewed towards girls in the 12-15 age group.

Birth order can affect the impact of abuse and neglect, with risk skewed towards the youngest child. There is risk of physical abuse and neglect associated with being the last child born to a mother who is already feeling overwhelmed (Tower 1996, p.73). However, the age of the child (and therefore vulnerability) is a pertinent confounding factor in the most serious cases of physical abuse and neglect.

Reder et al 1995 p.37 report that 66% of the children in their study of child deaths were the youngest or only child in the family, while 88% of the children in a similar Ontario study (Greenland, 1987) were the youngest child. These results are supported in the NSW Child Deaths Review 2001-2002 (NSW Child Death Review Team 2002) where 80% of the children were the youngest or only child.

Crouter and Seery (1994) emphasise the need to continually reassess notions of 'causal directionality' and to be mindful of the role played by the

individual's own *understanding* of his/her experience. They argue that the outcomes of different parenting styles may in fact be quite different for siblings because of 'child effects', in which children elicit different responses from their parents, and also because of each child's different subjective experience of being parented. Crouter and Seery cite the findings of Dunn and Plomin (1990) on birth order and possible causes for different experiences between siblings. These include differential treatment of siblings by parents, or the child's perception of differential treatment, the effect of siblings on one another, timing differences due to the fact that siblings are at different developmental levels when they experience the same events, and the influence of different experiences and contacts siblings have outside the family environment. (p.427).

Children from multiple births have been associated with increased risk for physical abuse because of the additional stress on the mother (and her marriage/relationship) related to their birth and care (Tower 1996). Quality and composition of the sibling group is not a well documented factor, but there is some evidence of an association between neglect and families where there are greater numbers of children or short spaces between births.

Relationship to caregiver. The association between whether a child is from the current relationship or a previous relationship is not easily accessible in general incidence studies. While there is some anecdotal and reported association between child maltreatment and blended families or stepparents, the link is not clear. In fact, sexual abuse is more likely to be perpetrated by a non-parental relative rather than a stepfather or parent's boyfriend or girlfriend (Trocme et al 2005) and physical and emotional abuse and neglect are most likely to be perpetrated by a biological parent, regardless of family structure (Sedlak and Broadhurst 1996, p.13; Saville-Smith 2000, p.20). However, the association between abuse and parentage may lie in fact that the child is not the biological child of one of the parents, which may place additional stress on either the parent-child or the parent-partner relationship, or both, precipitating physical abuse or emotional abuse (rejection).

In addition, families where there are a number of children by different fathers have been associated with increased risk for abuse or neglect, although the association may be mediated by situational and environmental variables (Saville-Smith 2000, p.20).

3.3.3 b. Child-Related Personal Characteristics.

A number of child-related personal characteristics are reported to be associated with child maltreatment (Horowitz and Wolock 1981; Belsky 1988; Ammerman and Hersen 1990; Tower 1996; Tomison 1996c). These include prematurity; low birth weight; physical ill-health or chronic illness; physical appearance / physical disability; I.Q./ intellectual disability or mental health issues; temperament personality traits, attitudes, affect; quality of attachment to parents; behaviour (home, school, peers, neighbourhood); school performance and achievement; performance & achievement in activities; relationship with other significant persons (peers, teachers, siblings); and quality and composition of peer group.

Given that many children with one or more of these characteristics are not subjected to child abuse and neglect, the importance of these factors must be evaluated in the context of the parent-child and child-family relationship, and in terms of placing additional stress on the parent/s rather than as intrinsically contributing to child abuse or neglect. As with the demographic child-related factors, these factors (apart from behaviour in older children) are outside the control of the child, who cannot be held responsible for intentionally precipitating abuse or neglect.

Prematurity and low birth weight are frequently cited as risk factors for maltreatment (Kempe and Kempe, 1980, p.40; Browne and Saqi 1988; Saville-Smith 2000, p.19; Prilleltensky et al 2001, p.94). Associated problems of physical appearance, illness or physical disability can increase the risk potential. The associations are complex and multi-level, but can have significant effect on the stress of the mother (e.g. fractious child's crying,

child difficult to settle, difficulty feeding the child, a child who appears unresponsive can be perceived as rejecting by a mother with low self esteem). These factors, perhaps accompanied by the fear of losing a very low birth weight or sickly child, have a major impact on the process of mother-child bonding and attachment, which in itself is a significant risk factor for physical and emotional abuse and/or physical and emotional neglect.

Children with lower intellectual ability, developmental disability or mental health issues have been associated with maltreatment in some studies (Roberts 1988; Oates 1996, p.47), but other research has not substantiated a direct link (Ammerman and Patz 1996; Oates 1996, p.47). Physical or intellectual difference in itself may be a risk factor for child abuse and neglect, but a strong mediating factor is the complex interaction of the child's disability or mental health status with parental factors, particularly the primary caregiver. Children with intellectual disability are at increased risk for sexual abuse because of their dependence on adults, and limited communication and understanding. Ammerman (1990) suggests that the increased risk associated with children with disabilities are related to three factors - disruption to the mother-child attachment, greater stress on caretakers because of behaviour problems associated with disability, and heightened vulnerability of the children to maltreatment (p.211).

School performance, especially in tasks associated with communication (i.e. reading and writing) may also be associated with abuse, but achievement is even more likely to be negatively affected by a history of neglect (Kempe and Kempe 1980, p.56). Households affected by abuse or neglect do not usually provide an environment conducive to acquiring the study skills or the interpersonal skills required at school.

Children with **Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder** (ADD/HD) are at risk for physical and emotional abuse because of the behaviour associated with the disorder. If the behaviour is introverted, it can be mistaken for inattention, day-dreaming or deliberately ignoring the

parent. If the disorder is expressed in hyperactive behaviour, the child often also demonstrates impulsivity, volatile moods, verbal or physical aggression. ADD/HD has been linked with poor school performance, peer rejection, and risk-taking.

ADD/HD has been found to be one type of childhood psychopathology associated with depression in mothers, along with major depression and anxiety (Factor and Wolfe 1990). The associated behaviour can have an impact on parental stress and frustration. The child's behaviour may isolate the family from other families who may otherwise be social supports (Salmelainen 2002). The combination of these and other stress factors may induce abuse, especially physical abuse and emotional abuse in the form of rejection or scapegoating, or neglect, because of parental withdrawal.

Perry (1994) suggests that children who have been subjected to early childhood trauma (through abuse, neglect, witnessing violence or other serious event not associated with maltreatment) may develop post traumatic stress disorder (PTSD). In some cases, the incident or situation causing the PTSD may have occurred early in the child's life and the child may not be consciously aware of it. Hyperarousal is common feature of PTSD, and many of the behaviours associated with this disorder may present as similar to those of ADD/HD, conduct disorders, mood disorders or anxiety disorders leading to similar associations with child abuse and neglect.

Children's behaviour has been associated with increased risk for child maltreatment (Kempe and Kempe 1980, p.50; Oates 1996, p.45), however, this is a complex and complicated issue. Parents who have abused their children often identify the child's behaviour as different, more difficult to rear and/or more aggressive than their siblings (Oates 1996, p.45). However, the child's reported 'difficult' behaviour may be coloured by the perception of the abusing parent, unless it is corroborated in other settings, e.g. in school, with peers and in the neighbourhood. If the child's behaviour is confirmed, it may be subject to confounding factors such as mother-child interactional patterns,

response to previous abuse, or attempts to cope with a threatening or hostile environment.

Factor and Wolfe (1990) report that children of depressed mothers demonstrate a number of affective, behavioural and adjustment problems (p.184). If negative, children's temperament, personality traits, attitudes and affect may interact with the perceptions, expectations and emotional functioning of the parent to produce increased risk for child maltreatment. On the other hand, if some or all of the same child factors are present in a positive sense for the child, they are associated with resilience, a compensatory factor in child maltreatment.

Similar to the temperament and personality traits above, the last group of potential risk factors for child maltreatment - quality of attachment to parents; relationship with other significant persons (peers, teachers, siblings); and quality and composition of peer group - may be resilience factors if they are positive, rather than risk factors if they are negative or absent.

3.3.4 Resilience.

The concept of resilience in children has been the subject of increasing interest and investigation over the past two decades. Children whose positive characteristics withstand negative parental and societal impacts are seen as *'resilient'*. Resilience is promoted by the development of *'protective factors'* - i.e. qualities or interventions that help to alter or reverse expected negative outcomes. Protective factors can be internal (personality, temperament, attitudes) or external (involving positive relationships and opportunities within the family, school, and community), and resilience can be increased by providing and promoting protective factors in a child's life.

- **Internal Protective Factors.**

Benard (2004) classifies the range of internal protective skills in four categories: *Social competence, Problem solving, Autonomy, and Purpose / future* (p.14). Using these categories, Benard (2004) cites the work of other

authors, including Maslow (1954) and Erikson (1963), listing the needs and personal qualities associated with fostering and developing internal protective factors:

- *Social Competence*: need for love/belonging, relationships, positive values, empathy, connectedness, trust, generosity, sociability
- *Problem Solving*: need for challenge and mastery, insight, intellectual/cognitive functioning, industry, planning, common sense, frustration tolerance
- *Autonomy*: need for power/ respect, independence, initiative, self control, positive identity, self-awareness, self esteem, confidence.
- *Purpose/Future*: need for meaning, commitment to learning, self-motivation, integrity, responsibility, perseverance, optimism, future orientation. (Benard 2004, p.119)

- **External Protective Factors.**

Christle et al (2001) list some external protective factors that the child or young person may derive from a supportive family and functional community:

- Caring relationships, especially a positive, affirming attachment to at least one family member who gives the child a sense of belonging within the family unit.
- Someone who values and reinforces the child's abilities and has high expectations of, and seeks positive outcomes for, the child.
- Opportunities for the child or young person to meaningfully participate in social /community activities in an age appropriate way.

Protective factors that families can provide for their children include:

" • Caring relationship of a family member
• Warm, structured, and positive discipline practices
• Parental monitoring and supervision
• Support from extended family
• Good health and good prenatal care
• Opportunity for children to contribute to the family goals
• Listening and talking to children

- Stable environment and home
- Responding to and accepting children's behavior
- Providing toys and materials
- Providing safe places for exploration and privacy
- Providing positive experiences for children in the community
- Teaching children effective and appropriate problem-solving skills
- Family members who show respect for other relatives and adults
- Family quality time with each other. " (Christle, et al 2001, p.2)

Taking a broader ecological perspective, The Search Institute (2003, 2006) surveyed two million young people in the USA and Canada, to determine personal and community factors that increase resilience in children and young people. The Institute identified *40 'Developmental Assets'* - concrete, positive experiences and qualities applicable to children at different developmental stages, which it believes are associated with young people who have successfully grown to maturity. The greater the number of Developmental Assets a child or young person has or is exposed to, the more positive and successful will be his/her development. The fewer Developmental Assets present, the greater the possibility that the young person will engage in risky behaviours, e.g. substance abuse, unsafe sex or violence.

The Search Institute's *40 Developmental Assets* are divided into two groups. The 20 **Internal Assets** are personal characteristics and behaviours that reflect positive internal growth and development. They are grouped under the categories *Positive Identity, Positive Values, Social Competencies and Commitment To Learning*. The 20 **External Assets** relate to important roles that families, schools, congregations, neighbourhoods, and youth organizations can play in promoting healthy development. They are organised under four major headings *Support, Empowerment, Boundaries and Expectations, and Constructive Use of Time*.

Clearly, community factors are highly relevant to the development of resilience in children and young people. The number and quality of External Assets is likely to be greatly diminished in socially disadvantaged communities where adults are already struggling and formal and informal community supports are overburdened. In addition, any Internal Assets that the child or young person has are much less likely to be supported and fostered in socially impoverished neighbourhoods.

In summary, this chapter has reviewed local and international literature related to factors that may impact on child development, welfare and wellbeing, as well as factors that may be associated directly with child abuse and neglect. It has also looked at protective factors associated with assisting children and young people to overcome the effects of disadvantage, trauma and child maltreatment.

Chapter 4 describes the Montrose Home-Based Family Assessment Program, its history, processes and its relationship to current theory on child development and child maltreatment.

CHAPTER 4: THE MONTROSE HOME-BASED FAMILY ASSESSMENT PROGRAM.

4.1 A Brief History of the Development of the Montrose Home-Based Family Assessment Program.

Introduction.

This chapter describes the Montrose Home-Based Family Assessment Program and the child protection legislation and statutory response processes in place in NSW at the time that the program was being developed. The home based version of the Montrose Program replaced a previous residential model, with the aim of providing a statewide family assessment consultancy service, rather than one for only metropolitan Sydney. A growing acceptance of the usefulness of the ecological perspective in child protection meant that assessment of families in their homes and local communities was seen as having advantages over a residential assessment service where the families were removed from their local environment, its stresses and supports.

Under the child protection legislation applicable in NSW at the time of this study,* a child protection report (notification) was made to a local Community Services Centre (CSC) of the NSW Department of Community Services (DoCS)* when a person "formed the belief, on reasonable grounds," that a child had been, or was at risk of being abused, or was in need of care (s.22).

At intake, a decision would be made as to whether the information given was sufficient to constitute a formal notification. Following the acceptance of a notification, there was an investigation or assessment, which could involve a range of interventions, including phone calls, home visits, interviews with the

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* *NSW Children (Care and Protection) Act 1987:* (Notifications - s.22)

* Known variously over the life of the Montrose Residential Program and then Home-based Program as the *Department of Youth and Community Services (YACS)*, then the *Department of Family and Community Services* (FACS) and finally the *Department of Community Services* (DoCS) during the life of the legislation. .

parents and/or child, and in some cases arrangement for a specific medical examination of the child.

The investigation process established the degree of risk to the child, the child's level of wellbeing and possible supports required for the parent/carer or child. From 1996, notifications were classified according to 'harm' or 'risk' reports, and requests for support from parents or by other persons on their behalf.

Following the investigation by DoCS officers, one of the following decisions could be made:

- to confirm the notification and register the child as a child at risk, and to offer an ongoing service to the family and child, which may or may not involve Court action or referral to other services, or
- to confirm the notification and to refer the child and/or family to a more appropriate service and continue to monitor or close the case, or
- to confirm the notification but close the case on the grounds that the child was no longer at risk, or
- not to confirm the notification and close the case.

The Department's stated objectives with regard to Child Protection were:

" *- to assist in the protection of children from abuse and neglect; and*
- to reconcile and strengthen family relationships wherever possible, except where this would jeopardise the child's safety."
(NSW DoCS *1995/6 Annual Report,* p.4*)*

As discussed in Chapter 2, the child protection notification rates across western urban society increased enormously over the late 1980s and early 1990s, and continued to do so over the next decade. In the five years up to 1993-4, levels of notifications in NSW increased by 85%, confirmations of abuse by 53% and registrations by 28% (NSW DoCS August 1995). In 1995/6, DoCS completed investigations on 23,319 notifications where the notifier considered the child to be at risk of harm or neglect (NSW DoCS

1995/6, p.13). This exponential rise in the number of notifications and the subsequent need for interventions, including referrals for support, court action or for some children, out of home care, was having a significant economic impact. By the same token, high profile media coverage of failed cases put increased pressure on child protection services Australia wide to respond in a different way (Goddard and Saunders 2001).

It was in this social, political and economic climate that the Montrose Program evolved, from a residential crisis intervention and assessment unit in 1977 to its current model as a home-based family assessment program from 1992 to the current time (2007).

4.1.1 The Development of the Montrose Home-Based Assessment Program.

The first '*Montrose*' program was the *Montrose Child Life Protection Unit*, (CLPU) established on 1 July 1977, in the inner western area of metropolitan Sydney, as part of the then NSW Department of Youth and Community Services (YACS).[*] The CLPU was designed as a specialist child protection unit to support generalist child welfare staff in locally based YACS offices, and was described as a: "multidisciplinary, multi-purpose facility that houses a 24 hour crisis 'hotline', residential care facility and a day program for families." (Brazier et al, 1982, p.390)

Changes to NSW legislation *(The NSW Child Welfare (Amendment) Act*. 1977) required *mandatory* notification by medical practitioners who had reasonable grounds to suspect that a child had been "assaulted, ill-treated or exposed" and permitted *voluntary* notification by other persons who on reasonable grounds believed that a child had been assaulted or neglected under the definition of the Act (Lawrence 1983, p.5). Prior to this time, there was no central register of child abuse reports in NSW.

[*] Known as the *NSW Department of Community Services* (*DoCS*) at the time of this thesis.

The Montrose CLPU was responsible for retaining a central register of initial notifications, which would then be followed up by the relevant local YACS office. In the first 12 months of the program's operation, there were 889 notifications, compared with 645 cases known to YACS from 1968-mid 1977 (Lawrence 1983, p.11). From the first year of recording notifications until 1981, it is reported that there were consistently around one thousand notifications of suspected child abuse per annum in NSW. (Brazier et al 1982, p.389)

The mandatory reporting amendment allowed children to be taken into custody for up to 72 hours for the purposes of a medical examination (Lawrence 1983, p.5). The CLPU was designed to provide crisis or assessment admissions to families with high risk child protection concerns, as well as a crisis nursery (preschool) and a day program. Admissions could be involuntary, for children referred by the Children's Court for neglect, or voluntary. The crisis service was augmented by the 24 hour telephone hotline and on-call service.

The Montrose CLPU used a psychodynamic model, and was parent-focused, based on the belief that "given an accepting and nurturing environment damaged parents, with a potential for change, can grow and develop together with their children." (Brazier et al 1982, p.392). The program employed a multidisciplinary approach to assist change in parental functioning, taking into account parent-child and parent-parent interactions, but without reference to the wider community factors that may be impacting the family. "Parents must recognise that a problem exists and be willing to have some involvement in the programme however marginal their potential for change may be." (Brazier et al 1982, p.392). Day program attendance was for up to three months, prior to referral to community facilities in the family's home location.

After two years, the program was struggling to meet the demand resulting from referrals and devolved its specialist child protection casework services

to several metropolitan Community Services Centres, so as to disseminate the expert knowledge of child protection across more sites, to provide more local response to urgent cases and to address the problem of 'burnout' of specialist staff.

The restructured program was known as the *Montrose Child Protection and Family Crisis Service*, and operated from 1981-1991. The original Montrose program retained the role of a specialist assessment and treatment centre, and was extended to include a crisis nursery, residential facility, a day program for parents and children and an on-site day care program for preschool aged children. In the residential program, up to three families were housed in separate units, for a two week assessment. The 24 hour intake service was re-organised and staffed by specially trained YACS District Officers, while the CLPU retained the after-hours on call service (Brazier et al 1982; Scott 1983; Lawrence 1983).

In a review of the original Montrose program Alexander (1983) describes the context of the residential admission: "It is important that the whole family comes into residence…Ideally children are of preschool age because the school age children go out to school and are not as available for assessment as younger ones…It is possible for fathers to go out to work and arrangements are made for Social Workers to interview them after-hours… Mothers occasionally go out to work but this does interfere with the assessment process. At times a defacto husband or boyfriend may be reluctant to come into residence…Arrangements are made for that person to pay several visits so that his involvement with the family may be assessed."(p.3)

Two Social Workers and a Psychologist assessed parents and children during the admission. The Social Workers' role involved gathering information from the parents about family background, social history and relationships, observing parent/child, husband/wife relationships, and assessing child management issues. The Psychologist assessed the

"developmental, emotional and intellectual status of each child", and sometimes assessed the psychological functioning of the parent if necessary. Residential care staff monitored day-to-day child care issues and assisted parents to learn or improve basic parenting skills with regard to daily physical needs of the children – feeding, bathing etc, and observed family interactions around these routines. Other specialist assessments available included speech and hearing assessment, dental assessment and medical examinations by a local GP or the Sydney Children's Hospital.

The residential assessment period was followed by a Case Conference, attended by the Montrose Program staff, the referring Caseworker, and the family. A review took place three months after the Case Conference, to evaluate uptake of the recommendations and the family's ongoing progress. Because the families referred to the Montrose program were very frequently involved in Children's Court proceedings, the Montrose Report and its recommendations were made available to assist the Court in its deliberations.

In September 1983, Professor R.J Lawrence released his report into the "statutory and moral responsibility" of the Department of Youth and Community Services in conjunction with the highly publicised death of a 10 year old boy known to the Department (and to Montrose). The boy died in a house fire allegedly lit by his mother, who was subsequently charged with his murder (Lawrence 1983). The inquiry report echoed many of the systemic concerns of similar tragedies documented elsewhere (Reder et al 1994), and cited the case of Maria Colwell in particular (Reder et al 1994). Among a number of other systemic issues, the inquiry found in this case an ambiguous system of responsibility in the Department's decision-making, in which the bureaucratic model took precedence over the professional.

Recommendations of the Inquiry included the Department's community welfare staff requiring professional qualifications, and special support and recognition of the stressful work of child abuse workers. With regard to the

Montrose program, it noted that: "it seems hard to justify… the resources currently going into the small number of cases being dealt with by …Montrose… unless it is used far more obviously as a demonstration and research facility." (p.83). It recommended that ..."Consideration should be given to the long-term development of similar, specialised multi-disciplinary facilities in each Region, if further resources become available in the future." (Lawrence 1983 p.83 : Rec.19).

A contracted evaluation of the Montrose assessment service in 1987 (Robinson 1987) noted that the program was basically servicing the needs of metropolitan Sydney and was inaccessible for country regions. It found that families headed by young, single mothers were over-represented, as were children under 5 years of age. The review recommended that reports should be standardised, that recommended caseplans should be achievable and that parental response to the caseplan should be sought.

Significantly, the review recommended that: "Given the current state of research knowledge it may be appropriate to move beyond a predominantly 'psychological' emphasis and place equal weight on relevant sociological factors." (Robinson 1987, p.xv). This was a move away from the previous 'insight oriented' approach to child protection intervention. In keeping with a more 'multi-dimensional model' of child maltreatment, the recommended focus for the assessment was to include education, occupation, financial status, family supports, community network, gender issues and multicultural issues, in addition to the current issues addressed. It also encouraged equal attention to of the role of the mother and the father in family dynamics. The review cites Garbarino (1977; Garbarino and Sherman 1980) for a model that "incorporates the interactions between parental and child characteristics, intra and extra-familial stressors and the social and cultural systems." (Robinson, 1987. p.4) Finally, the review recommended the development of similar facilities throughout the state, to increase accessibility to remote areas.

Hence, the review reflected the cultural and political climate of child protection in the late 1980s, and moved the Montrose program closer to an ecological model, viewing the child and family in the context of their neighbourhood, community and culture, and laying the groundwork for the home-based service that was to come. In 1990, the Department conducted a feasibility study and called for expressions of interest for provision of a new family assessment service.

In 1991, the decision was taken to adopt a statewide, non-residential family assessment model, to be conducted within the family's home and local community by a specialised child protection unit of the Department. It was believed that home-based assessment model was superior from an ecological perspective. Observing and interacting with all family members in the family home provided a more realistic assessment of the level of parenting, and also insight into the family's day-to day routines and relationships. Using this model, which went beyond the 9am-5pm time band, children of all ages could be involved in the assessment without disrupting their schooling, and given sufficient notice, both parents could be asked to be available for the week of the assessment.

Family members could be observed in their social context - engaged in interaction and activities with neighbours and also with extended family members who may be significant in the family's daily life. Seeing the family in its local social setting - urban, regional or rural, advantaged or disadvantaged, functional or 'toxic', would provide invaluable insight into the exosystem issues that impact on the family, as risk or protective factors. The home-based program also had the advantage of access, with the parents' consent, to local services involved with the family. This would provide historical perspective on the family's child protection issues and would be a source of new or continuing services for the family as part of a recommended caseplan. Access to relevant members of local indigenous or ethnic communities would have definite cultural and practical advantages when assessing aboriginal or culturally diverse families.

4.2 The Montrose Home-Based Family Assessment Program During the Years of This Study (1993-1999).

The Montrose Home-based Assessment Program commenced as a ***statewide***, ***home-based*** service in January 1993. The program is a tertiary level child protection service, based in a Community Services Centre (CSC) in metropolitan Sydney. It provides consultation, by way of a comprehensive family assessment, to all New South Wales Department of Community Services (DoCS) offices for families who are:

- already identified as at risk and
- are current clients of the Department and
- where the child/ren's continuing placement in the family is in jeopardy.

The risk of out of home care placement may be because of concerns regarding the parents' capacity to provide a safe and nurturing environment for the children and/or because the parents are unable to manage the children's aggressive, antisocial, or risk-taking behaviour.

Assessment is voluntary and no assessment takes place without the signed consent of the parent/s*.

4.2.1 Staff.

Montrose has a staff allocation of 7.5 full time staff. During the period of this study, the Montrose team comprised a Manager, three Social Workers, three Child Protection Caseworkers and a half-time administrative assistant. The original structure included a position for a Clinical Psychologist, but several recruitment campaigns failed to attract a suitable candidate, so the position was converted to an additional Child Protection Caseworker.

Assessment teams, usually a Social Worker and a Child Protection caseworker, conduct the assessments. Staff are rotated after each

* Although most families described in this study will have at least one biological parent, a significant number of families comprise one parent and a partner who is not biologically related to all (or sometimes any) of the children. The word "parent" is used in this thesis to describe a person with a biological or legal relationship with the child/ren. The word "carer" or "caregiver" will also be used in a generic sense, to describe the partner of a parent, a foster parent, or surrogate parent such as a relative, who is fulfilling a caregiving/parental role with the child.

assessment so that they work with and learn from all team members, and also so that there is less risk of two team members who routinely work together falling into a standard pattern of operating rather than seeing each family as a new experience. Teams do two assessments in a row, i.e. 4 weeks on assessment and report writing, and then have one week in the office taking referrals and working cases up for allocation.

Because referrals can sometimes 'stall,' or scheduled assessments occasionally drop out, all team members have special research or practice improvement projects to work on in the rare quiet periods, and they also take part in promotion of the service to CSCs and other agencies.

Staff must be exceptional time managers, given that their personal and social life is disrupted during the week of the assessment. Interestingly, during the period of this study, a number of staff completed degrees, in social work and law, and two undertook Masters' degrees.

4.2.2 A Brief Overview of the Montrose Assessment Process.

Because the Montrose assessment is voluntary, its success relies on the development of a cooperative relationship between the assessment team and the parents/carers. Information gathering and caseplanning relies on a good two-way relationship between the team and other services involved with the family.

The Montrose assessment process takes two (Monday to Friday) weeks. The first week involves a comprehensive family assessment in the family home and local community. For country and regional area assessments, the teams fly or drive to the family's town and stay locally from Monday morning to Friday afternoon, visiting the family home daily, as well as making visits to local services. For metropolitan assessments, the team drives to the family's home daily and also makes agency visits.

The assessment team spends up to 8 hours each day with the family, in 2-3 hour sessions, with breaks in between. During the period of the study, the Social Worker concentrated primarily on the parents and their history and current life situation while the Caseworker engaged the children in discussions about their perspective of their life situation. This is because at that time not all DoCS child protection Caseworkers had a Social Work / Social Welfare or equivalent degree which would have included training in how to take a comprehensive social history and evaluate the impact of this on current life situation and parenting capacity.

The team members debrief with each other after each session with the family or with agencies or extended family, so that information can be put into context and cross-checked with the parent/s or child/ren if necessary.

In the second week, the assessment team writes its report and finalises its recommendations, which will have been developed in conjunction with the family, the referring DoCS caseworkers and relevant local support services. A copy of the Report is sent to the family and to the referring caseworker at least 24 hours before the Case Conference, held on the last day of week 2. The parents have a formal feedback meeting (or teleconference for country families) with the assessing team in the hour before the Case Conference, and their responses to the Report and its recommendations are noted in writing for the file. These responses also form part of the Case Conference agenda. A formal evaluation process is conducted with the parents and the referring child protection caseworkers following the assessment.

4.2.3 Montrose Program Goals.

- To increase the viability of children remaining in their families.
- To identify the resources necessary to achieve secure, long-term placement for the child.

4.2.4 Montrose Program Philosophy.

- The wellbeing and safety of the child are paramount.
- Whenever possible, children's physical, emotional and intellectual needs are best met within a family environment.
- A comprehensive assessment must incorporate an holistic approach which:
  - builds on strengths
  - promotes positive change, and
  - is aware of and sensitive to cultural issues.

4.2.5 Referral criteria.

The referral criteria for the Montrose Program are:

- families with at least one child who is a registered DoCS child protection case, or under investigation as a child at risk, and there is a DoCS Caseworker currently allocated to the family.
- the ongoing placement of the child/ren within the family home is in jeopardy without some immediate intervention to address identified child protection risks.
- the family is willing to participate in an assessment, and to be available for the required period of time.
- there are some identifiable family strengths on which to build.
- there are no immediate risks which would threaten the children's safety during the referral and assessment period.

4.2.6 Target group.

The client group includes families living in NSW, who meet the referral criteria, with children from birth to 18 years. Most referred families have had multiple previous notifications and interventions. Family structure varies widely. Families who do not speak English, or are not confident in English can be assessed using the services of an interpreter. Indigenous families are assessed in consultation with a DoCS aboriginal Caseworker (not the worker allocated to the case), or member of the relevant local indigenous community

(if the family wishes this). Parents and children with intellectual or physical disabilities are eligible for assessment, in consultation with their advocate or support person if they wish.

4.2.7 Main reasons for Referral to Montrose.

The most common reasons for referral to the Montrose program during the period of this study were:

1. Parent failure to control child's risk-taking/disturbed/violent behaviour.
2. Severe Neglect; inadequate care / supervision; safety issues.
3. Parent psychiatric disorder affects ability to care for child.
4. Serious physical abuse: multiple fractures, head injuries, severe bruising, burns.
5. Severe emotional abuse.
6. Parent drug / alcohol abuse affects ability to care for child.
7. Parent/s' long term relationship problems (including domestic violence) affect child's behaviour.

4.2.8 Referral Procedure

Referrals are initially taken by telephone from the DoCS child protection caseworkers responsible for the family. All referred families must have current caseworkers, so that there is continuity of service from the referral, through the assessment and for the implementation of the recommended caseplan. Families must be informed that the referral to Montrose is being made.

The referral is initially discussed with the referring caseworker and if the family meets referral criteria, an Intake Form (Appendix 4.1) is completed over the telephone detailing the reason for the referral, basic family information and what the caseworker wants from the assessment. If the family does not meet the criteria, the referral is counted as an enquiry, and the paperwork filed in case of a later re-referral, which frequently occurs.

For cases accepted into Intake, a Referral Checklist (Appendix 4.2) is sent to the referring caseworker, asking for more comprehensive family history and current information, together with a request for copies of file information, reports, court orders, medical or psychological assessments and any other relevant documentation. On receipt of this information, first contact is made by Montrose intake staff member with the parents to ensure that they know about, and agree to the referral for a home-based assessment. The Montrose worker gives general details of what an assessment involves, in terms of time and personal commitment from them, and possible outcomes, from parent and family support to child removal if there are deemed to be safety or serious welfare concerns. The Montrose worker answers any questions from the parents.

If the family is willing to proceed, the case is worked up in detail for presentation to the team at a weekly allocation meeting. This process includes a chronological history of every previous notification to DoCS of any child of these parents, whether or not they are currently living in the family (Appendix 4.3). Patterns and trends are highlighted, as well as periods of particular stress or success, and the factors associated with these. Support services (including extended family) are identified and a synopsis of the case is developed.

At the allocations meeting, all available team members discuss the referral, and a decision is made whether to accept the case, or to decline if the cumulative information from the case workup indicates that the safety risks to the child/ren are too chronic or severe and immediate (court) action is necessary to protect them from harm. If the case is declined, the Montrose Manager makes contact with the referring Manager to explain the reasons, and make suggestions for alternative action. This information is confirmed in writing.

When a case is accepted for a Montrose assessment, it is allocated to two Montrose staff and dates are set. The referring caseworker's goals for the

assessment are checked to ensure that they are realistic and achievable. If not, there will be discussion with the caseworker to modify the goals. Typical goals might include one or more of the following:

- assessment of parenting capacity,
- assessment of the dynamics between family members which impact on the child/ren,
- assessment of the individual needs of a specific child or of all the children in a family,
- assessment of parental health or lifestyle issues (e.g. mental health issues, disability, substance abuse, or domestic violence) that may impinge on their ability to adequately meet the child's physical, emotional or developmental needs,
- suggestions for resources to help the family remain together, and
- assessment of the parent's future ability to meet the physical, emotional and safety needs of the child/ren.

When the goals are agreed, they are included on the Parents' Consent Form (Appendix 4.5), which is sent to the parents via the referring caseworker, with a Parent Information Sheet and a Consent Form allowing the Montrose team to seek information and discuss the assessment goals with support agencies. Parents must consent in writing for the assessment team to have discussions with relevant support agencies and services that are involved with them, including family support services, non-government services, mental health and drug and alcohol services, medical practitioners, schools and child care services. The assessment process includes interviews with extended family where they play a significant role, and also any regular respite carers for the children.

On receipt of the signed consent forms, one of the assessment team makes telephone contact with the parents to introduce themselves and confirm the goals of the assessment and the arrangements for the assessment week. The children's primary caregiver is expected to be available for several hours

on each of the 5 days of the assessment, and for the Case Conference the following week. Any working partner is expected to be present for at least part of 2 days, and after hours on one day for observation of the family's evening meal and routines, and also for the Case Conference.

Parents have reported that this initial telephone call is a very important step in 'breaking the ice', and helps them to feel less anxious about the assessment because they have already 'met' one of the assessing team.

Arrangements will be made to interview any non-resident parent with shared custody of the children, in which case, the children may be taken to visit the parent so that the team may observe relationships and interactions. Even if a non-resident parent does not have regular or overnight contact with the children, s/he will be interviewed in person or by phone if s/he plays a significant role in the lives of some or all of the children.

The assessing team allocates their individual roles (i.e. working primarily with the parent/s or the child/ren) and the schedule for the assessment week, including arranging meeting times for school and agency visits. Travel and accommodation arrangements are organised for country assessments and the team chooses from a selection of age-related toys and sports equipment to assist in building rapport with the children.

The Montrose referral and allocation process is summarised in Fig. 4.1.

Fig. 4.1: Montrose Referral and Allocation Process

REFERRAL, CASE ALLOCATION, and PREPARATION FOR ASSSSMENT.

1. PHONE REFERRAL FROM CHILD PROTECTION CASEWORKER.

REFERRAL
Case meets referral criteria.
Intake form completed

ENQUIRY
Case Discussed, does not fit Montrose referral criteria.
Information given re other options.
Enquiry form completed and filed.

2. REFERRAL CHECKLIST FAXED / EMAILED TO CASEWORKER .

3. COMPLETED CHECKLIST and REPORTS RETURNED TO MONTROSE

4. MONTROSE WORKER HAS TELEPHONE CONTACT WITH PARENTS
to ensure that they agree in principle to referral, discuss process & answer any questions .

5. PREPARATION OF CASE FOR WEEKLY ALLOCATIONS MEETING
Montrose worker prints off DoCS computerised child protection database details of all child protection notifications, Children's Court and out of home care history for this family and for any previous children of the parents.
Reads and summarises reports and intake form and caseworker checklist details
Prepares case synopsis for presentation to allocations meeting

6. ALLOCATIONS MEETING
Discussion of referral, according to program referral criteria, requested goals of assessment and motivation of parents for assessment.

REFERRAL ACCEPTED

Assessment dates set.
Montrose assessment team allocated.
Referring Caseworker notified; goals & dates confirmed.
Letter to referring Manager confirming staff, dates, goals.
Introductory Letter, with Parent Information & Consent forms faxed / emailed to referring Caseworker to take to parents for signature.

REFERRAL DECLINED
Montrose Manager phones referring Child Protection Manager with reasons for declining referral and suggested alternatives.
Letter sent to Manager confirming same.

6. PARENT CONSENT FORMS SIGNED AND RETURNED

7. PREPARATION FOR ASSESSMENT.
File information, reports, and child protection database information read and assessment procedures and equipment planned by allocated team members.
Travel +/- accommodation arranged.
Parents phoned in week before assessment by assessing Team members to introduce themselves and work out preliminary schedule.
Agency visits scheduled.

4.2.9 Roles.

- **Montrose Role**: Montrose's role as part of the Department of Community Services is reinforced with the parents from the first telephone contact. However, because of the voluntary nature of the assessment and the way the Montrose process seeks their active participation, parents sometimes still have difficulty seeing the Montrose program as part of DoCS, because DoCS Caseworkers normally fulfil a statutory child protection / investigative role with them.

To reinforce that the Montrose program is part of the Department, the referring child protection Caseworker introduces the assessment team to the parents, and the goals of the assessment are confirmed in the presence of all parties. The parents must understand the statutory nature of the Montrose team members' role, including the need to make a child protection notification if team members observe situations during the assessment week that constitute child abuse and neglect.

- **Parents' Role:** The Montrose philosophy places a high value on respect for parents and seeking their participation in the assessment process. The team members discuss their observations and impressions openly and frequently with the parents. Establishing an honest and collaborative relationship is designed to allow the parents to feel more comfortable about giving sensitive personal information to team members where necessary, and also allows the team to raise concerns and clarify issues with the family as they arise. During the assessment, parents are invited to contribute their ideas of what they and their children need in order to improve the home situation. Parents' input is sought in developing recommendations for change and supports that might enable the children to remain safely within the family.

The Montrose concept is one of participation of the parents, rather than 'partnership' between them and the Montrose team. This is felt to be a more accurate and honest description of the status of the relationship. The UK Department of Health's publication *The Children Act Now: Messages from*

*Research (*Aldgate and Statham 2001, p.67*)* notes that the term 'partnership' is possibly misleading, given that there is clearly a difference in power in the relationship between a statutory agency representative and the parents. If this imbalance is not acknowledged, parents may feel that their input is tokenistic or that they are being patronised. If the reality of the situation is acknowledged, parents can still be included, as far as possible, in the decision making process regarding their children.

*Messages from Research (*Aldgate and Statham 2001*)* lists the following features of successful partnership with parents, all of which are applicable to the Montrose way of conducting assessments:

- "…a shared commitment to negotiation and actions about how best to safeguard and promote children's welfare;
- mutual respect for the other's point of view;
- recognising the unequal nature of power between parents and professionals;
- recognising parents have their own needs which should be addressed;
- good communication skills by professionals;
- the establishment of trust between all parties;
- integrity and accountability on the part of both parents and professionals;
- shared decision-making;
- joint recognition of constraints on services offered; and
- recognition that partnership is not an end in itself." (p.67).

The home-based nature of the Montrose assessment means that issues about parenting are able to be discussed as they arise, to gain the parents' and children's understanding of the situation. Concerns about the family's functioning and situation are discussed with the parents, with a view to getting them to nominate areas of possible change and the resources they feel may help them achieve the desired change. They are also encouraged to respond to and discuss any feedback on parenting practices given to them by

the team, even when it may be confronting for the parents to hear and may raise feelings of anger or frustration.

In this way, the Montrose Report and its recommendations should hold no surprises for the parents, because issues of concern have already been raised in person with them, and their responses noted. In general, most families respond positively to the direct, honest approach taken with them during the week the team spends with them. They generally acknowledge that there are problems in their families (although these are often underestimated), and that they are concerned about them and want assistance.

Parents tend to be more motivated for change when they feel that they have a clear role to play in decision-making about their children's future. Even in the minority of cases where there is a Montrose recommendation to remove the children from their parents' care, in most cases, the recommendation is for short term placement and the focus remains on what the parents can do so that the children can be safely returned to them.

- **The Montrose Assessment Team's Roles:** During the assessment week, one team member (Social Worker) focuses on the parent/s' history and perspective, initially using a genogram[#] to establish rapport and gain a structural view of the immediate and extended family, as well as any other persons who live or have lived in the family home. This leads to an exploration, over the course of the week, of the parents' own childhood and adult histories, the developmental histories of the children, the current stressors for the family and what the parents think would assist them to deal with these stress factors. This worker also focuses on parenting issues from the perspective of the parents.

[#] Sample Genogram: Appendix 4.6

The second Montrose worker (child protection Caseworker) concentrates on gaining each child's view of the family and his/her life, and focuses on parenting issues from the perspective of their impact on the children.

Children (as age appropriate) are told at the beginning of the assessment week that a team member will be speaking to them on their own about their lives and their family. This gives them some time to collect their thoughts, rather than asking them to comment about potentially sensitive issues without warning. Younger children are interviewed as appropriate, often in the course of play, with paper and crayons, family dolls or other toys that may elicit conversation about family life. This is not a formal assessment, but a means of obtaining their perspective on their lives, and how things could be better for them.

For babies, infants and young children who cannot be engaged in formal conversation, observation is an essential part of the assessment process. Over the course of a week, these children will be seen in many interactions with their parents and siblings, in all their various moods, when they are hungry, tired, requiring comfort, anxious, or frustrated. Such observation provides clear indications of the quality of bonding and attachment between the children and their parents, and the relationships with their siblings, all of which can be used in the Report to represent the strengths and needs of the non-verbal children.

This division of Montrose workers' roles is very important to the assessment process, as it ensures that the perspective of the parents (who are usually more verbal and vociferous than the children) does not dominate the process. Having a worker who represents the interests of the children, even the pre-verbal ones, can act as a useful balance in situations where the Montrose worker working with the parents may be presented with a parent's history of extensive childhood and adult abuse, loss and trauma, which may make the parent's current behaviour more understandable. The children's worker can assist to maintain perspective, by focusing on the parent's

behaviour in the current context of how it impacts on the children. In addition, the children's worker can bring information regarding the effect of past trauma on the child's current behaviour.

An analogy for this dual perspective process is looking at a scene through a pair of binoculars. Looking down one lens provides one view of a scene (the parent's view), and looking down the second lens provides an equally valid view (the child's view). However, focusing on the view with both lenses together incorporates both perspectives (i.e. the interactional effect) and gives clarity to the whole image. In this way, the team can remain empathic about the contributing reasons for the parent's and/or child's behaviour, but not lose sight of the need for family change so that the children's needs can be adequately met within the family.

Giving all the children a 'voice' in the assessment process and especially in the Report is a powerful tool for change in families. A family assessment that reports parents' and children's perspectives separately (as well as in the family context) is a potent way of emphasising their similarities or differences. This can be a powerful and confronting experience for parents to read, especially when the children's comments are in their own words.

- **The Montrose Manager's Role:** Because of the very intensive nature of home-based assessment over a five day period, it is very important that the team have consultation with the Montrose Manager. The Manager is aware of the reasons for the assessment, but is not working directly with family member and is able to maintain a detached perspective on the situation as it unfolds during the assessment. For this reason, the assessment process includes a phone link with the Manager on the afternoon of the third day (in addition to other consultation times if there are problems during the assessment week).

In addition to being an opportunity for the assessment team to debrief and to step back from its 'immersion' in the family processes, this consultation is an

essential part of keeping the assessment on track. The goals are reviewed and strategies put in place to ensure that they will be met by the end of the week.

- **The Referring Caseworker's Role:** The referring child protection Caseworker maintains primary case responsibility for the family and the Montrose team has a consultation role. In order to maintain clarity, the assessment team meets with the referring Caseworker and Manager from the local CSC, at the beginning of the assessment week, to confirm the assessment goals. At the half-way point of the assessment, they meet again, to check on the accuracy of the information provided by the family and to give an initial, high level view about what the possible recommendations may be. This is done in the context that at this stage the team has not visited all the support services and may still be working through some resistance with the parents. It is important to ensure that recommendations are achievable and not to over-commit the local CSC (or any other agency) if they are not able to provide the required level of service. Recommendations may need to be re-considered if this is the case. On the last day of the assessment there is a meeting to finalise the recommendations that impact on the CSC staff, before they are discussed with the parents and confirmed in the Report.

- **The Roles of Local Support Services and Agencies:** Community support services for the family have a role in providing a history of the family's contact and also their impressions of the family members' strengths and any concerns they have regarding the children's safety, welfare and wellbeing. They may be asked to provide or continue a service to the family as part of the caseplan. If this is the case, they are invited to attend part of the Case Conference to confirm their roles. If the parents agree, they may also be given part or all of the Montrose Report on the family to assist them to provide the most appropriate service.

4.2.10 The Montrose Assessment: Week 1 – The Home-based Assessment.

The Montrose home-based family assessment provides the family and the Department with a detailed 'snapshot' of exactly how the family is functioning at a single point in time, which is useful for case planning purposes and as a baseline against which change can be measured. It includes all significant people involved with the family, including non-resident parents and significant extended family members. Children who do not live with the referred family, but who are considered significant, may be invited to visit on one day of the assessment week (possibly during the family picnic - discussed later). The assessment may also include the perspectives of regular respite carers, child care providers, school personnel, medical practitioners, family support, counsellors, and specialist agency staff.

The home-based nature of the Program has the distinct advantage of allowing the family members to stay in their familiar surroundings. Family members are more relaxed and comfortable in their own homes and after one or two days, most families fall back into their normal routines and relationship styles, despite the team's presence. This allows the team to make a much more realistic assessment of normal functioning in the family. In addition, the physical and emotional environment of the house and the neighbourhood are immediately observable. The team is mindful of the normal activities that the families need to attend to during the week (children's sport / activities, doctors appointments, shopping etc), and attempts to accommodate these as far as possible.

Being in the home allows the Montrose team to observe very basic aspects of life in the family - safety, suitable accommodation, sufficient food, a basic standard of hygiene, child care routines, financial management, drug and alcohol use, extended family contact, the number and type of visitors to the house, childminding arrangements, etc. The team can talk to the children in their own environment, and observe their relationships and activities. They can also assess the more complex issues of family dynamics, bonding and

attachment, and parents' knowledge of and responsiveness to children's physical, emotional and developmental needs.

Once the introductions have been made on the first day of the assessment, the referring child protection Caseworker departs and the assessment begins. After some initial rapport building conversation and answering any questions the parents may have, the team member working with the parent/s will usually begin the assessment process by developing a family genogram with the parent/s. This process can be commenced on a non-threatening structural level and has proven very useful in assisting to establish a relationship with parents.

The genogram is then used as a means of exploring each parent's own family of origin in an individual session. It can be used in subsequent sessions to explore positive and negative aspects of the parents' family of origin relationships at a deeper level, and as a means for the team to begin to understand each parent's viewpoint in the context of their history and life circumstances. This process is described very well in *Messages from Research (Aldgate and Statham 2001),* which states that "Recognition of each family's individual biography is the foundation of working in partnership with parents." (p.70)

In the Montrose experience, genograms have also proven popular with children, who see the parents' activity and tend to enjoy constructing their own genogram (which may take the form of a family drawing) while discussing current and extended family members, as well as past or transient members of the household, usually including pets. This process is a useful way of understanding more about family relationships, and starting to uncover alliances or stresses between family members.

The assessment involves obtaining a full psychosocial and relationship history for each parent or caregiver who lives in the family home (and for non-resident parents, if appropriate), a developmental history for each child,

a fortnightly family budget and each parent's drug and alcohol history. The process also includes observation of family routines at different times of the day, including one breakfast and one evening meal and the younger children's bedtime. Safety issues (e.g. unfenced yards, busy roads, broken door latches, holes in walls, exposure to danger - sharp objects, medication, drugs or poisons within reach of children, unsafe pets, etc) become instantly apparent. In addition, the team is able to observe any unsafe child care practices such as leaving children unattended in the bath, unsupervised in the yard, with inappropriate carers, or exposed to inappropriate transient visitors.

The assessment involves an informal family outing, usually a picnic, where the parents and children can be observed together outside the home in a more relaxed atmosphere. The Montrose team provides the food, and the family members choose a local venue. This outing usually takes place on the second day of the assessment week, and has proven a very useful tool for observing children's' activities, physical and social development, co-ordination, and fine and gross motor skills while they are playing, eating and interacting with other family members. It also allows observation of parental supervision of the children, safety issues, care and hygiene, discipline styles and family communication patterns. The family picnic is also an important step in the engagement process, allowing the family members and the assessment team to interact in a less formal environment, and usually having the effect of advancing the relationship between the family and the team members, which assists with the later, potentially more confronting, parts of the process.

During the assessment week, the Montrose team liaises with any local agency or service relevant to the family. This may include schools, child care, family support services, other non-government services, mental health or drug and alcohol services, and medical practitioners. Interviews with extended family and/or respite carers or previous foster carers can provide useful information about the family from different perspectives, indicate

whether the current concerns are longstanding or recent, and whether there are trends and patterns in family history and functioning.

In the experience of the Montrose program, rather than a paucity of service providers, it is more common for a variety of agencies to be involved with tertiary level, multi-problem families, but often with little communication between the service providers. The Montrose assessment often helps agencies to clearly define their respective roles, and to avoid service overlapping and gaps. In fact, "DoCS to co-ordinate support services and review progress" is the most frequently made recommendation for the first 100 assessed families, being present in almost 80% of caseplans. The assessment also provides an opportunity for the agencies to re-assess their own roles and progress with the family. Where services will be continuing to work with the family after the assessment, their future roles can be discussed at the assessment interview.

At the end of four days with the family, the assessment team members meet with the parents to discuss the assessment goals and the family strengths they have observed, or that other agencies have reported, and also any child protection concerns that have been noted. The parents are given the opportunity to clarify information or comment on the team's perceptions. As a result of this discussion and the information and observations of the previous days, together with the family history, the team members begin to formulate the recommendations.

On the final day of the assessment, the team visits the referring Caseworker and Manager, to confirm that the recommendations that involve DoCS are achievable. Having done this, the team makes a final visit to the family home, to discuss the proposed recommendations, in principle, with the parents. Although there is usually no major change in the recommendations after this point, they are not finalised until the Report is completed, because at this point in time, the team members are still somewhat immersed in the family culture and require some distance (and debriefing) in order to impassively

weigh up all the information they have gathered. As all the information collected over the week comes together in the Montrose Report, the total picture can have an impact on the team's perception of the family situation, either in a positive or negative direction.

The standard assessment week process is summarised in Fig. 4.2. While the activities may not always occur on the day indicated, to allow for the family's usual commitments, the schedule demonstrates the range of activities that must be achieved by the team during the 5-day assessment.

Fig. 4.2: Montrose Assessment Procedure

WEEK 1: HOME BASED ASSESSMENT	
Procedure	**Timeline**
• Assessment team meets with referring Caseworker & Manager • Referring Caseworker introduces Team to parents • Team sets schedule with parents • Assessment commences; Genogram, family history • Team meets school age children after school hours • Assessment / observation continues	DAY 1
• Family Outing (picnic) with Team • Continue assessment and observation • Agency visit/s	DAY 2
• Observe Breakfast • Assessment/Observation - children and parents • Agency / extended family visits • Liaise with referring C/W and Manager • Phone contact with Montrose Manager • Observe Dinner, evening routines (Day 2 or 3)	DAY 3
• Assessment/Observation; Agency visits • Discussion of strengths, concerns with Parents	DAY 4
• Discuss proposed recommendations with referring C/W & Manager • Discuss recommendations with Parents	DAY 5

4.2.11 The Montrose Assessment: Week 2 - The Report, Recommendations and Case Conference

The second week of the assessment process involves writing and distributing the Report, a feedback session with the parents and a Case Conference, as described in Fig. 4.3.

Fig. 4.3: The Montrose Report and the Case Conference.

WEEK 2: REPORT WRITING AND CASE CONFERENCE	
Procedure	**Timeline**
• Case discussion/debrief with Manager • Report writing	DAY 1
• Report writing	DAY 2
• Report - final draft • Report faxed to A.M. - copies to D.O. and Parents	DAY 3
• Time for Parents and referring DoCS staff to read Report	DAY 4
• Report discussed with Parents • Case Conference/Teleconference	DAY 5

Debriefing: During the assessment week, team members dictaphone parts of the Report each evening, so that impressions are kept accurate and new information does not overshadow earlier impressions. The dictaphoned draft is typed by the administrative assistant on the first morning of the second week, while the assessment team debriefs with the Montrose Manager. The debriefing process is essential in order to move the team members back to a more detached relationship with the family. This is necessary because of the intensive nature of the home-based assessment, where the very close working relationship that team members can establish with the family may affect their perceptions of the total situation if they are not debriefed. This is also the time when the perceptions of the parents' worker can be matched to the perceptions of the children's worker, and discrepancies can be explored.

The Report: The team works for three days on the Report, which is checked by the Manager to ensure consistency of approach. Although the content is always individual to each family, all Montrose reports follow a standard template. Clarity is also essential, as the Report must be accessible to the parents (who may have reading difficulties or not have English as their first

language) and also to professionals (the referring CSC staff, and sometimes, with parental permission, support service staff) or the Children's Court if necessary.

Every Montrose Report is written under a standard set of headings:

- Family name; Address; Date of assessment; CSC*.
- Family members; Family genogram (3 generations).
- Reason for referral, background information; Current court action.
- Goals of assessment. (listed, as per original contract with parents).
- Outline of assessment process. (including any atypical events - e.g. accident / illness in the family, which impacted on the assessment.)
- Housing & financial information. (Type, condition of accommodation, list of fortnightly income and outgoings, including debts.)
- Background information on each parent. (Psychosocial history; childhood; relationships with family and any previous partners; education and work history; current relationship history and quality.)
- Drug and alcohol use. (History of past and current use; effect, amount, frequency, drug of choice, polydrug use; periods of abstinence; includes cigarettes and prescription medication.)
- Children: developmental history, relationships and observations of each child; includes the children's descriptions of their life in their own words (or three wishes for what could make their life better).
- Other agencies, social networks, extended family: family history of contact, perceived strengths, concerns; potential for future support.
- Parenting skills. (including physical care, discipline styles, recognition and responsiveness to children's safety, welfare and wellbeing.)
- Areas of strength (listed).
- Areas of concern (listed).
- Summary of assessment process. (Written against each of the assessment goals.
- Montrose recommendations.

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* Referring Community Services Centre.

Having a section of the Report that lists both strengths and concerns in families has a beneficial effect. Acknowledging some family strengths can make it easier for family members to hear about and acknowledge areas requiring change. Parents' ability to accept any positive information about themselves is often affected by a history of abuse, which leads to an expectation of criticism.

Parents respond more favourably to the Report if they have contributed to the recommendations, nominating some areas for change and services they feel would assist them. A list of the most frequently made recommendations in the first 100 assessments follows. (Fig. 4.4)

Fig.4.4: Most Frequent Recommendations for the First 100 Families Assessed.

MOST FREQUENT RECOMMENDATIONS OF THE MONTROSE REPORT Assessments January 1993 - Dec 1996 N = 100 Families	
RECOMMENDATION	**% of the 100 Families where Recommendation was Made.**
DOCS to Co-ordinate support services and review progress	**78%**
Family Support Services	**57%**
Individual counselling: parent	**51%**
Individual counselling: child	**38%**
Pre-school / Family day care	**37%**
Respite care	**35%**
Paediatric / Child Development Assessment / Review	**33%**
Parenting classes	**31%**
After school and holiday care	**28%**
Psychological / Psychiatric assessment (Child)	**28%**
Supervision Order with Undertakings (3mnth - 5yr)	**27%**
Psychological / Psychiatric assessment (Parent)	**22%**
Informal / written Undertakings	**19%**
Speech Assessment / Therapy	**14%**
Short term Wardship (1-2yrs)	**13%**
Educational assessment / assistance	**11%**
Appropriate social activities (child)	**10%**

As can be seen, recommendation for long term out of home care placement accounted for less than 5% of assessed families. It is a confronting situation for any parent to admit that they can no longer care for their child, and an *external* assessment that the child's needs can be met more adequately outside the family can sometimes make the process more palatable for the parent. The parent can then claim to be relinquishing care of the child,

against the parent's wishes, but in the best interests of the child. In these cases, there can in fact be a sense of relief for the parents, and sometimes for the child, that the need for placement is finally recognised.

In cases where out of home care is recommended, the aim of the process is to minimise the emotional damage to the child during the transition into care. On one hand, having parents openly oppose placement may be of some comfort to the child, who can believe that the parents loved him/her enough to fight to keep him/her. However, having the parents take part in the placement planning, rather than having an adversarial Children's Court process, assists in making the transition less traumatic for the child, and can also make future contact arrangements more positive.

The Montrose team members are aware that the Report will have significant impact on the parents. For many, it is a confronting and sometimes quite overwhelming experience. It is often the first time they have thought about how aspects of family members' individual lives impact on each other and on the family as a unit. When writing the Report, the Montrose team members try to incorporate language and terminology that the family uses. Family members are often quoted verbatim, because the description of their circumstances and relationships is more meaningful to them if they recognise their own words.

Despite the anecdotal belief that parents may try to disguise their situation, in practice, those who believe that the assessment is for their children's benefit are remarkably frank. Parents have described their financial management as "up to shit", or "stuffed", and a surprising number acknowledge that among their regular expenses, they spend $x per fortnight on marijuana, alcohol or gambling. They are quite open in disclosing debts and the fact that many have only incoming phone calls because of outstanding telephone bills. In addition, when the team visits the family home, they are immediately aware if the electricity has been disconnected or the money for food runs out before

the end of the social security fortnight and the parents need to get food vouchers from non-government organisations.

Parents whose lives are chaotic and crisis-driven often do not have any idea of the impact this has on their children. In the Montrose Report, the children's words describing their own situation can be poignantly revealing. Children are often asked during the assessment what they would wish for if they could had three wishes. In contrast to the normal childhood wishes for material commodities, the children in Montrose family assessments tend to have more emotionally charged wishes, i.e. money "so that Mum won't be so worried all the time", or "to live in a home where there is no hitting and yelling" or "to go back to my old school". Not infrequently, depressed children or those whose life seems totally bleak say they "can't think of anything to wish for". This type of statement, in the children's own words, sends a more powerful message to the parents than the Montrose assessing team could ever deliver on behalf of the children.

Experience indicates that the parents need at least two days with the Report in order to fully take on board the major issues it raises. Many parents report a negative response to their first reading of the Report, feeling that they are being judged, or being portrayed in an unfavourable light. It is very useful if they can share the Report with a trusted other person. A more detached person may see the Report in a less negative light, and can moderate the parent's initial negative perception, which is often coloured by their low self esteem. A third party may also see if the Report describes some positive aspects of the parents' personality or role, which parents often miss because they expect only criticism.

Some examples of parents' feedback on the Report are:

- *"It's like looking into a mirror - I don't like what I see, but I can't say it's not true."*
- *"I didn't realise it was this bad. I know things have to change. I just want to learn how to be a good parent. Nobody teaches you how to be a parent."*

- *"After reading the Report, if this was anyone else's family, I'd say 'remove the children'."*

The feedback session with parents. Parents are offered an hour with the assessing Team before the Case Conference, going through the Report page by page if they wish, or discussing particular points or issues. (This session and the Case Conference are done by teleconference for families residing outside the Sydney metropolitan area.) Parents may have a support person with them if they wish. In fact, a support person often has a moderating effect on the parents, helping them to give and hear the feedback in a less emotional and more balanced way. All changes and comments made by the parents in the feedback session are documented and attached as an appendix to the final report. In most cases, this appendix is quite short and does not tend to contradict the main thrust of the Report.

This meeting is often a turning point for parents. While even the most positive assessment experience is by its very nature an intrusive and threatening process, reading and discussing the Report can be the pivotal point for change. The parents are presented with the sum total of viewpoints of all the people most closely associated with their family. They are confronted with their own thoughts, their partner's and their children's, together with the opinions of significant others - possibly their extended family, and agencies and services who have regular and/or significant contact with them. The more consistent the opinions, the greater the impact.

It is of interest that when given the opportunity to challenge or question the Report, the vast majority of parents wish to make only superficial changes (spellings of names, dates, etc.). The majority of parents tend to respond with statements such as "You got it right". In many cases, parents' objections arise from misunderstandings about what the Report may be saying, and they are able to be easily resolved in discussion. There are obviously some variations to the positive parental response, but these tend to be a small minority.

In some cases, given that not all notifications are investigated, nor contact necessarily made with the family, parents are unaware of the number of notifications that have been made on their family. When they see these listed, by number and reason for notification, the fact that their family has been under some scrutiny comes as a shock to some parents. Interestingly, those parents who dispute the recommendations of the Report are not necessarily those for whom Children's Court action has been recommended. They are often those who have been passively resistant to the process or guarded in discussion throughout the assessment, and their underlying fear that the children will be removed prevents them from engaging with the team members in finding solutions.

The fact that the Report does not simply criticise, but balances strengths and concerns and presents a list of possible solutions, (which in most cases have already been discussed with the parents), tends to allow parents to join with the process of putting the caseplan together in the Case Conference. If the parents feel they are part of the planning, rather than victims of an external process, they are more likely to follow through with the recommendations. To some extent, the outcome is built into the process.

The Case Conference. The Case Conference follows immediately after the feedback session with the parents. Care is taken not to use this meeting as a forum for discussion of sensitive personal information about the parents or children. It is an administrative meeting to develop a caseplan, largely based on the Montrose recommendations, and to ensure that all parties involved with the caseplan are clear about roles and expectations. The meeting is chaired by the Manager of the referring office and attended by the parents (with a support person if they wish), the Montrose assessing team members, and Montrose Manager.

Although this is not a common occurrence, older children may attend part or all of the Case Conference if they wish to and it is in their best interests to be

there. Staff from support agencies and services usually attend for the discussion of the recommendations that involve them directly, or where they are required to co-ordinate with other services.

The standard agenda for the Case Conference begins with general reactions from the parents about the Report. The fact that the parents have been encouraged to share their reactions to the Report in the preceding session usually means that they have little to add at this point. Most appear to be satisfied that their comments were heard and documented in the previous session. As noted earlier, however, there will always be some exceptions. All parent comments are documented in the Case Conference minutes.

The Caseplan. Realistic goals and prompt implementation of the recommendations are the key to a successful outcome for the assessment. Change is most possible while the family is still in the flexible state which the assessment often produces, and before the family members settle back into their characteristic ways of behaving, which can happen quite quickly without intervention. It has been noted through program evaluation feedback from parents that a delay between the Case Conference and the implementation of the caseplan has a significant effect on their motivation. They feel that they have voluntarily exposed themselves and their family life to intrusion and scrutiny into very sensitive areas of their lives, and this risk is not seen as justified unless it is quickly followed by action which improves their situation. They are wary of a process which, like many others they have experienced is, in their view, "all talk and no action".

Following the Case Conference, co-operation between services and regular formal reviews are essential to sustaining the progress of the family. Regular, documented reviews allow parents to monitor their progress, can give encouragement for their efforts and can re-focus family members whose progress has faltered.

4.3 Montrose Routine Program Evaluation.

4.3.1 Desired Outcomes Of The Montrose Program.

The stated goals of the Montrose program are to increase the likelihood of children remaining in their families, and to identify the resources necessary to achieve secure, long-term placement. The *immediate goal* is to keep children within their family, unless there are serious safety issues, or their physical, emotional or developmental needs are not being met and are unlikely to be met in this family, even with extended family or agency support. The overarching principle is that the goal of family preservation must be moderated at all times by the best interests of the child.

Improved general family functioning is a *longer term goal* of the Montrose program. This goal is dependent on accurate assessment by the Montrose team of family patterns and trends, and past and present factors related to the parents, the children, the economic or social situation that are preventing adequate family functioning. In addition, the outcome is dependent on family members' motivation for change, the availability of appropriate support services, funding for specialist services, and in our experience, on implementing the caseplan from immediately after the Case Conference.

The goals of each assessment, and therefore the desired outcomes, are specific for each family. Factors which impinged on the team's ability to meet each of the assessment gaols are noted in the Report. These may include: the motivation of the parent/s or child/ren; physical or mental ill-health of a family member; family member/s being unwilling to participate in the assessment or share information; parent/s using drugs or alcohol which affect their participation in the assessment; or the goal becoming secondary to other more pressing issues in the family situation, i.e. safety issues for the children.

In the normal course of events, most or all of the desired goals are able to be met. These include:

- that the children remain in the family.
- that each parent's needs are assessed.
- that each child's needs are assessed.
- that the combined family's needs are assessed.
- that factors affecting the current level of functioning of the family are identified.
- that recommendations are made as to appropriate services to meet these needs, and their availability.
- that all available support is offered to the parent/s to enable them to continue to care for their child on the family home.

In some cases where the initial goals cannot be met, the desired outcome may be to use the information gathered during the assessment to recommend an appropriate plan of action to ensure the immediate safety and wellbeing of the child, and if it is assessed that this cannot be met within the family at this time, an appropriate placement plan. In most cases, short-term placement will be the recommended caseplan, to enable parents to begin interventions to address the issues preventing the children from being in the home (e.g. drug and alcohol counselling, anger management, mental health treatment.) In rare cases, the assessment determines that the long-term child protection history of the family or the current parent attitudes and behaviour towards one child or more are unlikely to change and that the child's need for a safe, stable and nurturing environment can only be met outside the family, long term.

4.3.2 Montrose Routine Program Evaluation Procedure.

Ongoing outcome measurement for Montrose assessments takes place using a formal evaluation process has been in place since the beginning of the home-based assessment program in 1993. This procedure involves two stages:

Stage 1: The assessment *process* is formally evaluated with the referring Department of Community Services staff and the parents. One week after the Case Conference, a questionnaire is sent to the referring DCS officers and to the parents to determine their satisfaction with the assessment process.

Stage 2: Three months after assessment, questionnaires are sent to the District Officer, and to the parents, to determine progress with the implementation of the recommendations and the *outcome* of the assessment to date. Both parties are also asked again to comment on their general satisfaction with the service offered by the Montrose Program.

Information about implementation of the recommendations is a critical issue, because, as noted previously, prompt implementation can have a positive effect on outcome. Many parents describe the assessment as a positive experience for themselves and their children, because they feel it is their opportunity to show the Department, and tell in their own words, exactly what it is like to live in their family, including the strengths and the difficulties.

It is interesting that in a large proportion of the cases where the Montrose recommendation was for Children's Court action for a Supervision Order or short-term Wardship or Custody Order, the parent did not contest the matter, and the Order was made by Consent. In these cases, parents often recognised the need for change, and agreed that they needed some external control (Supervision Order), or they could not make the necessary changes <u>and</u> care for the children at the same time (short-term Wardship or Custody Order).

Parent satisfaction survey results from 86 assessed families who completed evaluation questionnaires in 1993-1996 were analysed by a Montrose staff member as her Social Work degree, research placement project, in 1996 (Crawford 1996). For the 86 families, the Montrose recommendations included 21 recommendations for Supervision Orders, 10 recommendations

for short-term out of home care placement, and four for long-term/permanent placement.

Although the numbers of parent responses are not large, they may shed light on some parents' feelings about the assessment process. A summary of the results of Parent Questionnaire Part A, distributed immediately after the assessment, and returned by 30 of the 86 families (26%), indicates that a majority of families *who responded* were satisfied with the Montrose process and in general felt positively about the assessment process, the Report and the recommendations. (Crawford 1996). (Fig. 4.5) More than three quarters of respondents felt that the recommendations had been adequately discussed with them and that the Report adequately refected their views as well as those of the assessing team.

Fig. 4.5: Responses to Parent Questionnaire Part A: The Assessment Process. n=30 (Crawford 1996).

Question	Parent Response n=30 (86 sent)			
	Positive	Partly	Negative	N/c /other
How Montrose team conducted the assessment	62%	-	15%	17% other; 6%n/c
Concerns & recommendations adequately discussed with parents	77%	7%	7%	3% other; 7% n/c
Report described family situation as parents saw it	60%	4%	33%	3% n/c
Report included parents' thoughts and feelings as well as team's	77%	3%	17%	3% other
Report gave parents new / different ways of thinking about family	60%	7%	23%	10% n/c
Recommendations agree with how parents saw family needs	60%	20%	17%	3% n/c
Recommendations helpful in suggesting ways to deal with family problems	63%	23%	13%	-

Parents are invited in the questionnaire to give qualitative comments about the *process* of the assessment. Some negative responses included:

- *"I feel that because of the assessment my children were removed …to help relieve stress and depression but instead I am more lonely and depressed than I was before the assessment.."*
- *"They were friendly but the whole time I felt that they were waiting to pounce if I made any mistakes. I felt very uncomfortable throughout."*

- *"They were far too critical and negative… I was devastated by the Report and in retrospect I would not have become involved so far it has made things worse not better."*
- *"I found the Montrose assessment great but I do not like how they come into your home for a week and then drop everything after that if Montrose are the people coming in to give the assessment and recommendations, then they "Montrose" should be the people who follow through with the recommendations, not leave the people in mid stream and pass it on to some other department - and also recommendations on paper always sound and look good but are not very practical in real life."*

Some *positive* qualitative responses included:

- *"The workers conducted the assessment non-judgemental, with a caring approach. They were thorough and honest and I was honest back to them."*
- *"They did a good job of the assessment. I knew I had problems but I didn't know how to find solutions or how to go about it."*
- *"They were very polite, filled us in on what they were there for, very understanding about what it is like for me alone with the children."*
- *"Everything went aright we like when you's gave us warning when you's were coming to see us. We like the freedom of speech, if we didn't like to talk about something."*
- *"The report was a job well done Montrose workers, it was worth your visit to see us. …The assessment went well. There were a lot of good things come out of it. …It wasn't long enough. We all enjoy the picnic it was nice. We have no fault with either the Report or the assessment. It was good to share our lives with you."*
- *" Keep up the good work as a lot of people would benefit by having Montrose as a support in trying to make things better, but I feel the time was too short maybe it should be a 24 hour, 5 day assessment as it would give the team a better advantage in helping people…. In our situation I was very happy about the outcome as it gave me positives about myself I never knew existed. Thank you guys."*

The second parent evaluation survey, sent three months after the assessment, seeks parents' comments on the process of the recommendations being implemented and the short-term outcome of the assessment. Again, the response rate is not high (20%), but results are summarised in Fig. 4.6 (Crawford, 1996). In terms of delay in putting the recommendations into action, changes in DoCS CSC staff were mentioned specifically by a number of respondents, reinforcing the need to ensure that families are properly transferred when staff leave.

Fig. 4.6: Responses to Parent Questionnaire Part B: Outcome 3 months after Assessment. n=23 (of 86 sent)

Question	Parent Response n=23 (86 sent)			
Recommendations put into action quickly enough after assessment	Yes: 61%	-	No: 30%	5% other; 4%n/c
How did Montrose assessment and recommendations affect the family's situation?	Improved: 77%	No Diff: 9%	Worse: 5%	5% other / 4%n/c

Respondents are invited to give comments on the short term outcomes for their family.

Some *negative* responses are:

- "*Montrose team should liaise with DoCS to ensure recommendations are put into place."*
- *"Recommendations were greatly appreciated by the family. Frustration experienced when implementation delayed. Misunderstanding by staff in charge at local office."*

Some *positive* responses include:

- *"I am grateful our family was able to participate in this program. Although a rocky start I am now starting to attend counselling I am happy with and I will do parenting course- even though I postponed it for a while."*
- *I wish they'd come back just to see for themselves how they have helped me make things a lot easier."*

The second parent evaluation questionnaire also requests information about family changes, such as moving house, relationship break ups or new partnerships, children leaving home and children returning to the family. It is not uncommon for these or other significant changes to have occurred even in this short period of time. e.g. one mother's response:

"(Partner) and I are separating after a major argument in which (Son #1) called the cops. (Son#2) to find a home as well as (Daughter #1). (Son #3) is back in trouble with the law, he has been charged. (Daughter #2) and (her partner, also living in family home) relationship still stormy, (Daughter #1) back in court. (Son #3) is home for good more trouble. No peace for '95."

One final example is included, from a parent whose five younger children were placed in care for six months while she attended a rehabilitation program for a serious alcohol problem that had led to long term wardship for her three older children. Her response to the first questionnaire, sent immediately after the assessment was not at all positive. Her response to the second questionnaire, received 6 months after the assessment, included the following:

- *"Since we have all been re-united it's been up and down but nowhere what it was 12 months ago. (A) and (B) are great Montrose workers. They have respect and only intervened when things got out of control. We have another family conference in June… (The Departmental psychologist) comes every Monday and looks at the week and how everyone is interacting and what has happened. I have a lot of respect for DoCS.*

  The children go into respite care one weekend a month…. I still have weekly counselling. I can say I am going slowly but I am. (My son) has fortnightly counselling. The little ones are starting to settle maybe because I have changed (maybe that I am changing). I just want to be happy and have a well adjusted family but it will take time. At first I was negative, but now I can see the positive of it, thanks." (Family #11065)

4.4 The Montrose Model Compared with Other Australian Child Protection Family Assessment and Intervention Models.

An extensive review of Australian and international child protection literature failed to produce evidence of any program that operates in the same way as the Montrose Home-Based Family Assessment Program, i.e. solely as a statutory family assessment consultation service, which has no ongoing intervention with the family.

Australia has a long-established family support service system, delivered by a variety of non-government services. The services work in different ways with a wide range of families, many of whom are child protection services clients. Family support services can be long or short term, practical or educational, and focussed on many aspects of family difficulties. Family support services provide an invaluable secondary prevention service for many 'at risk' families and some tertiary level, high risk families.

There are also numerous intensive family preservation service models, where family support workers provide a one to one in-home service for varying hours a week, usually with an on-call service, 24 hours per day. These 'Homebuilders' or Family Preservation type programs (Fraser, Pecora, and Haapala 1990; Kinney, Haapala, and Booth 1991; Kaplan and Girard 1994) are based on time-limited assessment and intensive intervention with the family. They are generally delivered over a brief period (4-12 weeks), with trained staff actively 'coaching' referred parents to improve basic child care skills, and reduce child protection risks in order to keep the family intact. The intervention is usually a combination of practical support and cognitive-behaviour strategies. While widely promoted, the reports of results of these IFBS programs are equivocal (Rossi, Schuerman and Budde 1996; Honner, Hickey and McManus 2003; Richardson, Higgins and Bromfield 2005). In addition, while acknowledging the potential of the original models, their application to Australian conditions requires due consideration of local

conditions (Bath 1994; Campbell 1998). All of these programs differ from Montrose because their assessment process is primarily focused on the "here and now" family issues, with only passing reference to family history, and also because these services include an intensive home based practical intervention with the family.

The '*Triple P* Positive Parenting Program' (Sanders 2003), developed and widely used in Australia and now in some international settings, is a more universally targeted program, with elements of family assessment and individualised intervention for a sub-group of identified 'at risk' families. However, this service is not specifically targeted at statutory child protection interventions.

One non-government agency in Australia has a model that uses comprehensive assessment and planning tools to guide professional judgement when working with vulnerable families. This is the Barnardo's "SCARF" Program (Barnardo’s Australia 2005). The program's model, philosophy, values and principles are adapted directly from the UK "Children in Need and their Families Assessment and Planning Framework" (UK Department of Health 2000). Based on the Framework, the SCARF program's philosophical basis is: "child centred, rooted in child development, ecological in approach, ensures equality of opportunity, involves working with children and families, builds on strengths as well as identifying difficulties, has an interagency approach." (Barnardo’s Australia 2005). These principles are almost identical to the Montrose values and philosophy developed in 1992, in an Australian child protection environment similar to that in the UK, with escalating referrals to child protection services and increasing complexity of family structure and needs.

While similar to the Montrose program in utilising a home-based focus, the SCARF program differs from Montrose in that it utilises two standardised assessment tools and the process involves assessment and interventions carried out in parallel. Also, unlike Montrose, the SCARF assessment does

not specifically target families with active child protection risks, but has a more universal application, with ‘vulnerable’ families as its stated target group.

4.5 The Ecological Model Applied to Families Referred to the Montrose Home-Based Family Assessment Program.

4.5.1 The Ecological Model and Family Assessment.

Assessment is a continuous process, used to make initial judgments based on available information, and also to evaluate the results of interventions to ensure that they are achieving their intended results, with no unforseen effects. Given the wide range of factors that may be associated with child abuse and neglect, comprehensive individual and family assessment must be the precursor to interventions with vulnerable families.

The ecological model views the family as a system where changes to one part of the system may have repercussions for other individual parts, or to the family unit's interaction with its wider social system. It emphasises the importance of understanding the child and family in their individual and social context

The *Framework for the Assessment of Children in Need and their Families (*Department of Health 2000*)* was developed in Britain in the 1990s, as an improvement on the previous family assessment tool for social workers in child protection and child welfare - "Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment". *The Framework* was developed at a time that coincided with the impact of the UN Convention on the Rights of the Child and it reflects the basic principles underpinning the UK *Children Act 1989.* This perspective is indicative of the child protection climate during that era in western countries, including Australia.

The principles for an ecological approach to family assessment (outlined in Section 1.33 of *The Framework* 2000) also underpin the assessment process developed for the Montrose Home-Based Family Assessment Program at its inception in 1993, and are still in place over a decade later.

The Framework's principles for an ecological approach to family assessment are: "Assessments:

1. are child centred;
2. are rooted in child development;
3. are ecological in approach;
4. ensure quality of opportunity;
5. involve working with children and families;
6. build on strengths as well as identify difficulties;
7. are interagency in their approach to assessment and the provision of services;
8. are a continuing process, not a single event;
9. are carried out in parallel with other action and providing services;
10. are grounded in evidence based knowledge. "

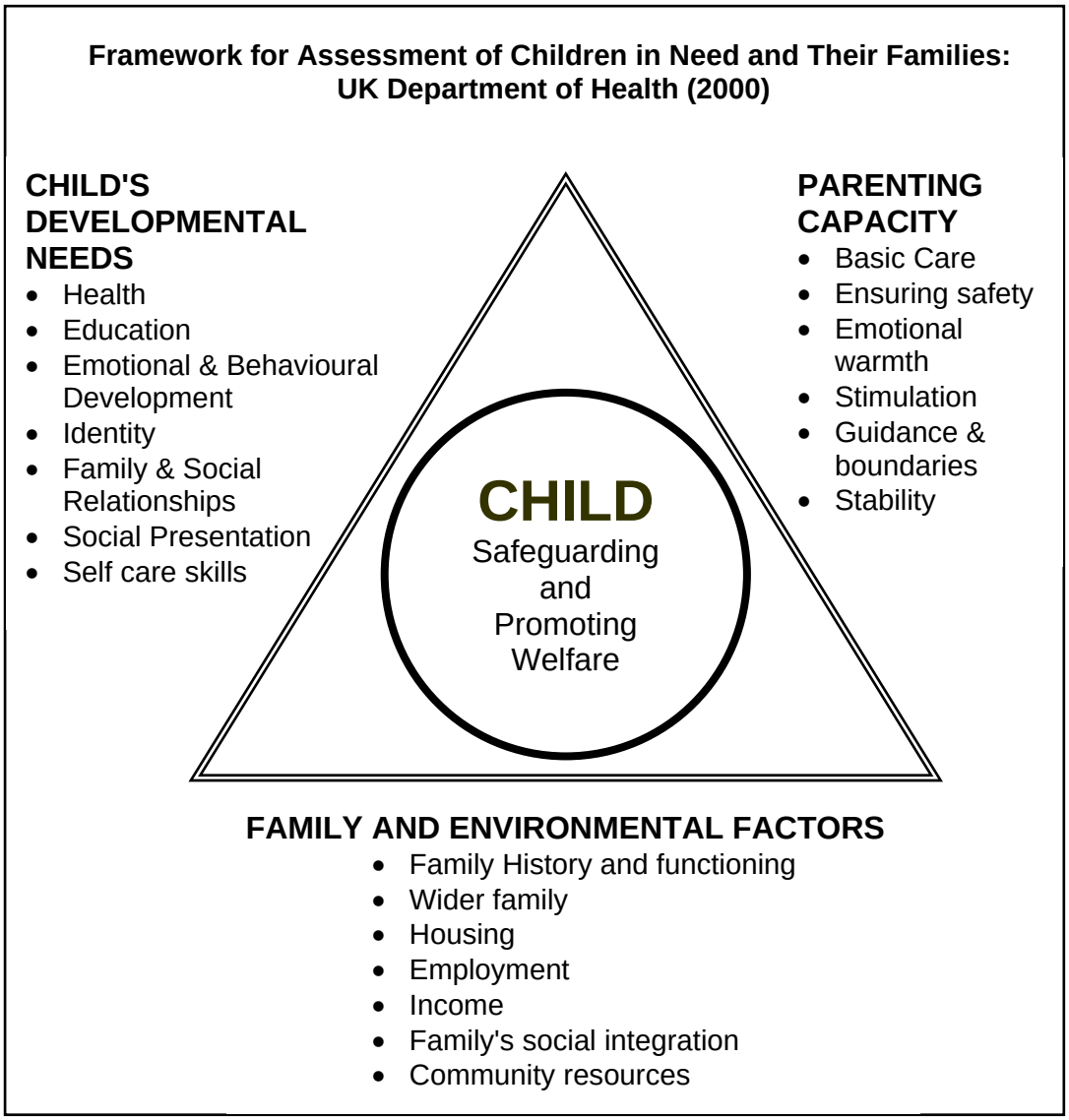
(*Framework for the Assessment of Children in Need and their Families (*Department of Health 2000*)* p.10)

In keeping with an ecological perspective, *The Framework* guidelines state that assessment should take account of three domains:

1. The child's developmental needs,
2. The parents' or caregivers' capacities to respond appropriately, and
3. The wider family and environmental factors. (p.12)

Each of these domains has a number of critical dimensions and the interaction or influence of these dimensions is the focus of assessment, aiming to increase understanding of how they affect the child or children in the family. (Fig. 4.7)

Fig. 4.7: **Framework for the Assessment of Children in Need and Their Families (2000): The UK Department of Health 2000, p.17.**



4.5.2 The Ecological Model and Montrose Assessment.

The Montrose assessment process combines theory on the ecological approach and on factors that may impact on child development, welfare and wellbeing, as well as child abuse and neglect.

The Montrose model encompasses all of the essential features of the Framework for the Assessment of Children in Need and Their Families (UK Dept of Health 2000). The comprehensive assessment process evaluates

the child, parent and family factors, plus extended family and community factors Because the assessment takes place within the family home and community, family members are seen in their usual environment, in interaction with other family members, their neighbours, informal support networks and local services.

As well as examining the family's daily activities and relationships, the assessment process also places this information in the context of the history of individual family members and of the family as a unit. and the impact of the interaction between all of these on the subject family. This requires collection of detailed historical information, parent and child descriptions of the past and current situation, and skilled observation of parent-child interactions during normal daily activities, and at times of stress (including the stress induced by the assessment process.) In addition, there is consultation with significant extended family and community agencies, including the local child protection service involved with the family.

As well as the demographic and personal characteristics of the family and its members, Browne and Herbert (1997) identify six important *interactional* aspects to be considered in assessing parent-child relationships and the child's need for protection in high risk families:

1. The parental/caretaker's knowledge and attitudes to parenting the child.
2. Parental perceptions of the child's behaviour and the child's perceptions of him/her self.
3. Parental emotions and responses to stress.
4. The style of parent - child interaction and behaviour.
5. The quality of child to parent attachment.
6. The quality of parenting. (Browne and Herbert 1997, p.124)

This perspective also underpins the Montrose approach to understanding the complex inter-relationships between individual family members and between the family and its immediate, social and cultural environments. In addition. it promotes an inclusive family-centred approach, which encourages family

participation in the assessment and its recommendations, while at the same time keeping the safety, welfare and wellbeing of the children as its primary focus.

The Montrose model, and this evaluation of its results, take into account all the above ecological and inter-relational principles with regard to children, families and their communities, within the context of child protection policy and practice in New South Wales and social, cultural and economic determinants of child protection in Australia. Given that child protection service delivery in Australia operates from a state platform, the broadest macrosystem factors regarding child protection are outside of the scope of this study. However, a number of exosystem factors relating to child protection practice in NSW are of particular interest, as well as family (microsystem) variables and parent and child variables for the families referred to the Montrose Program. Examples of variables that were analysed in this study are:

Family Variables:

- Urban vs regional /rural residence.
- Parent ethnic origin / cultural affiliation (More diverse cultural backgrounds expected in families in urban settings, particularly in Sydney).
- Family size; number of male / female children.
- Family structure (parent/partner relationship, and carer's and partner's biological relationship to the children).
- Family's primary income source.
- Presenting problem - i.e. reason for referral to Montrose.
- Domestic violence.

Parent Variables:

- Age.
- Sex of children's primary caregiver.
- History of childhood maltreatment and/or placement.
- Highest educational level.
- Mental health issues, especially depression, personality disorder.

- Physical or intellectual disability or chronic illness
- Parental emotional issues, e.g. low self esteem, immaturity.
- Parental substance abuse.

Child variables:

- Age at referral to Montrose.
- Sex.
- Ordinal position.
- Quality of attachment.
- Physical or intellectual disability.
- Mental health issues, depression, behavioural problems, ADD/ADHD etc.
- Educational issues.
- History of child protection notifications.
- Type of abuse.
- Legal status.
- Previous out of home care placements, respite or temporary foster care.

Child Protection Service related variables:

- The Montrose Assessment process.
- Recommendations of the Montrose assessment and whether these were put into action.
- The number of child protection reports (notifications) per family before referral to Montrose.
- The number of child protection reports per family in the three years before and after referral to Montrose.
- The number of these notifications that were substantiated (confirmed), in the three years before and after referral.
- The type/s of abuse or neglect that children were notified for, before and after referral to Montrose.
- Legal interventions by the NSW Children's Court before and after referral.
- Out Of Home Care placements of any child in the family before and after referral.

Some of the family, parent and child related risk factors that were typically observed in families referred for Montrose assessment in the years covered by this study (1990-1999) are:

Family factors:

- Diverse cultural backgrounds, particularly families living in metropolitan Sydney.
- Over-representation of indigenous* families.
- Family structures that include single parents, blended families, step-parents and sequential multi-partnering by mothers, resulting in children from multiple fathers.
- Socioeconomic disadvantage - as measured by Social Security as the main source of family income.
- Multigenerational welfare contact.
- Socially isolated families.
- Transience.
- A high level of reported domestic violence, past and /or present.
- Family functioning is disorganised and crisis driven.

Parent related factors:

- Parent histories of attachment issues, abuse and/or neglect.
- State wardship or other out of home placement, and/or transient lifestyle homeless or living on the streets as young person.
- Limited education.
- Unemployment.
- Revictimisation.
- Substance abuse.
- Juvenile justice interventions and/or jail (especially male carer).
- Parents partnering early (often to escape abusive families) and having first child at a young age.
- Immaturity; inadequate social skills; social isolation.

* In Australia, "indigenous" refers to persons of Aboriginal or Torres Strait Island heritage.

- Psychiatric illness or personality problems, especially depression and aggressive or antisocial personality.
- Intellectual disability (mainly mild or borderline).
- Unrealistic expectations of the child, inability to understand the child's developmental level and needs and put the child's needs before their own.

Child related factors:

- Age range from newborn to late teens.
- Histories of multiple child protection notifications, commonly multiple type abuse per child and per family.
- High rate of serious physical neglect (lack of food, serious hygiene problems), usually associated with inadequate supervision.
- Physical abuse, sexual abuse, emotional abuse, including a very high rate of exposure to domestic violence.
- Multiple respite or temporary foster care placements quite common.
- Numerous children having had longer term care - extended family or substitute care placements.
- Anxious or disorganised attachments.
- Behavioural problems, aggression, conduct disorder; high rate of diagnosis and medication for ADD or ADHD.
- Children with learning difficulties.
- Children with speech difficulties.
- Parentification of the child where parents have substance abuse, mental health issues or intellectual disability.
- Many children able to describe parents' substance abuse or domestic violence in detail with detached affect.

The variables related to the specific families in this study will be discussed in more detail in Chapter 6: The Study Group.

This study was undertaken to gain some insight into the longer term outcomes (three years after referral) for families who participated in a Montrose assessment. Because of the many factors that can intervene in the time between the assessment and the follow-up date, the study uses a database that allows the researcher to look separately at child factors, parent factors, family factors and child protection service factors that may have an impact on outcome. It also allows investigation of the interactions between these factors that may form models of variables associated with family outcome, children's outcome, legal status, out of home care placement, re-notification rate and type of abuse.

Chapter 5 describes the research design, research questions and methodology for the study.

CHAPTER 5: RESEARCH METHODOLOGY AND DESIGN OF THE STUDY.

5.1 Theoretical Background to Program Evaluation and Outcome Research.

The primary research question in this study is whether a greater number of families who participate in a Montrose Home-Based Family Assessment have positive child protection outcomes three years after referral than a similar group of families who met referral criteria for Montrose but did not proceed with the assessment. Program evaluation as a research model is therefore an integral part of the study. This section of the thesis deals with the theoretical basis and concepts related to program evaluation and the practical and ethical choices necessary when programs to be evaluated are dealing with vulnerable human populations. It also deals with the issue of criteria for inferring causality, tests of research design validity and reliability, and addresses issues of vested interest and possible bias when the researcher / program evaluator has been connected with the program being evaluated. Program design and research methods are discussed and the research model and data analysis methods used in this study are described.

5.1.1 Program Evaluation - Background and methodological requirements.

Rubin and Babbie (2001) cite three broad purposes of program evaluation - "to assess:

1. The ultimate success of programs,
2. problems in how programs are being implemented, or
3. information needed in program planning and development." (p.573)

Program evaluation uses research methodology to infer causal relationships between program interventions and outcomes for participants.

It may be used to assess if a program is effectively achieving what it was designed to achieve (goal attainment). (Rubin and Babbie 2001, p.574). Evaluation may have an added dimension of attempting to determine if the program is meeting its goals at a reasonable cost (cost-effectiveness), or if the benefits of the program outweigh the cost of providing the program (cost-benefit analysis) (Rubin and Babbie 2001, p.562) However, quantifying the benefits of a program in purely monetary terms poses the challenge of placing a monetary value on factors such as increased quality of life, or amount saved if a career of juvenile crime is averted by a program intervention.

Before describing the type of evaluation design utilised in this study, it is useful to discuss some theoretical and methodological requirements of evaluation research design. The two major types of program evaluation are *summative evaluation* and *formative evaluation* (Rubin and Babbie 2001, p.573; Fitz-Gibbon and Morris 1987, p.11; Hall and Hall 1996, p.47).

Summative evaluation is conducted at the conclusion of a program to describe the program and its goals, to demonstrate to what degree the program has successfully met its goals and document any unforeseen outcomes. In practical application, future funding of programs may depend on the results of summative evaluations. *Formative evaluation* takes place before and/or during the life of the program, and aims to use information gained through the evaluation to advise about improving existing program processes and possible directions for program development. Formative evaluation may also have a role in measuring progress, and identifying potential problems. There is a time scale difference between summative evaluation, which provides results at the end of the research process, and formative evaluation results which may be fed back as the research progresses. However, the two types of evaluation are not mutually exclusive and complement one another, so it is possible to combine aspects of both summative and formative evaluation (Rubin and Babbie 2001 p.574; Hall and Hall 1996, p.46).

Fitz-Gibbon and Morris (1987) describe tension between researchers and evaluators on research designs for evaluation. Evaluators must comply with the highest level of experimental design possible in the context of their research project: "The very best summative evaluation has all the characteristics of the best research study. It uses highly valid and reliable instruments, and it faithfully applies a powerful evaluation design." (p.13.) However, they acknowledge that realistically: "Few evaluations of course will live up to such rigid standards, or need to. The critical characteristic of any one evaluation study is that it provide the best possible information that could have been collected under the circumstances, and that this information meet the credibility requirements of its evaluation audience." (p.14)

This study combines aspects of both the summative and formative types of evaluation, looking at the outcomes for program participants after the first 100 family assessments, but also making available the information gained from this evaluation to provide feedback to program Managers which could be used to inform future directions for the program.

5.1.2 Program Evaluation in Human Services Organisations.

Program evaluation in human services involves some tension between pure scientific research and action-based social research. In human services research, not applying the scientific technique of randomising control groups may lessen the level of confidence in the findings, compared to a more rigorous scientific, experimental design. While the researcher wants to achieve the highest level of technical integrity, there are ethical considerations in terms of privacy, and because of the vulnerability inherent in some client groups (Pecora et al 1995).

Rubin and Babbie (1993) cite Rossi and Freeman's (1982) description of the purpose of human services program evaluation as: "…to assess and improve the conceptualization, design, planning, administration,

implementation, effectiveness, efficiency and utility of social interventions and human service programs." (Rubin and Babbie 1993, p.537). They add that program evaluation is mainly aimed at increasing knowledge about practical problem solving and developing programs to promote the welfare of the target client group

Fitz-Gibbon and Morris (1987) allude to the problem of applying scientific experimental techniques to populations in social settings, where there are ethical considerations regarding withholding of treatment to the 'control' group (p.12). Hessler (1992) asserts that evaluation research: "...fits on a continuum between at one end, pure basic research and at the other, social action. … Evaluators strive for the best of basic research, that is, carefully designed valid and reliable research, and the best of applied research, where research findings ought to really make some impact or difference in the society. " (p.302)

Hall and Hall (1996) also describe the potential for "conflict between the scientific desirability of controlling variables through experimental method and the practical, political and ethical issues of working in the fluid and challenging setting of program delivery." (p.47). They explore other models of research that may not be subject to the same limitations as scientific models, and suggest that although the experimental model with randomised groups, one using the program and a control group not doing so, is advocated by some as the best way of doing evaluation research, many other methods have been applied in evaluation. They cite Rossi and Freeman (1993, p.30), who use the term 'pragmatic evaluation' to describe evaluation procedures that use non-randomised comparison groups, case studies, existing data and forms of qualitative research in the belief that every evaluation represents a unique attempt to meet the needs of clients and stakeholders.

This study complies with the criteria as outlined by Hessler (1992) above, by seeking to develop and utilise a research design that complies as far as

possible with the major requirements of scientific research methods, while at the same time aiming to improved knowledge to enhance positive outcomes for children and families, while not deliberately withholding a service. The specific research design chosen for this study uses a non-randomised Comparison Group of families who fulfilled all the referral criteria for the intervention, but did not proceed with it. The research design will be discussed in detail later in this chapter.

5.1.3 Controlling for threats to research design.

- **Validity**

Critical theoretical issues to be addressed in research design include discussion of criteria for inferring causality and consideration of methods to reduce potential measurement error, including tests for validity and reliability (Neuman 1994)**.**

Rubin and Babbie (2001) define *validity* as "the extent to which an empirical measure adequately reflects the real *meaning* of the concept under consideration." (p.193). Sarantakos (1993) puts it simply: "A valid measure produces true results that reflect the true situation and conditions of the environment it is supposed to study." (p.75.)

In the absence of pre-existing empirical evidence against which a research tool can be measured, theoretical validation is used to test that a measure does not contradict previously established rules of the discipline (Sarantakos 1993, p.75.) Two relevant measures of theoretical validity are *Face Validity*, which describes the extent to which a measurement instrument, e.g. a test or questionnaire, is measuring what the researcher intends to measure, (Cozby 1981, p.320; Hall and Hall 1996, p.43; Rubin and Babbie 2001, p.193), and *Construct Validity*, the degree to which a measurement instrument accurately measures the theoretical construct it is designed to measure, based on way the measure relates to other variables in a system of theoretical relationships (Cozby 1981, p.311; Rubin and

Babbie 2001, p.196). Two other forms of validity against which a research study can be tested are internal and external validity.

Internal validity describes the relationship between variables in the model, and the level of confidence with which the results of a study demonstrate whether one variable (the independent variable) is the cause of another (the dependent variable) (Rubin and Babbie 2001, p.296) A good experimental design is measured by the extent to which there are no competing explanations, and the results can be attributed only to the influence of the independent variable, and not to some other confounding variable (Cozby 1981, pp. 107, 314).

(Rubin and Babbie 1993; 2001) state that there is no formula for calculating internal validity, and that it is a subjective judgement, but that the strength of the internal validity can be increased by the degree to which the study controls for a number of specific *threats* to internal validity (p.296-7). In order to do this, scientific experimental designs use specific techniques, including randomly assigning individuals to experimental or control groups, then implementing an independent variable (e.g. a treatment modality) with the experimental group and withholding it from control group and finally comparing the amount of change in the experimental and control groups on the dependent variable (e.g. outcome). While random assignment is the most important principle in assuring internal validity in experimental design (Miller 1986, p.38), it must be noted that strictly scientific techniques are difficult to implement in human services settings, because of the ethics involved with deliberately withholding a potentially helpful service from a vulnerable client group.

Rubin and Babbie 1993; 2001; cite Lazarsfeld (1959), who proposed three specific criteria for inferring causality and held that a study has internal validity if these three criteria are met:

" 1. The cause precedes the effect in time.
2. The two variables are empirically correlated with one other.

3. The observed empirical correlation between two variables cannot be explained away as being due to the influence of some third variable that causes both of them." (Rubin and Babbie 1993, pp. 262; 2001 p.294)

Rubin and Babbie 1993; and 2001, p.297 cite Campbell and Stanley (1963, pp.5-6) and Cook and Campbell (1979, pp.51-55), who list nine threats to internal validity in research. The process of controlling for these threats in this study, and the study's level of compliance with Lazarsfeld's (1959) criteria for inferring causality is discussed in detail later in this chapter.

External Validity relates to the extent to which the results and the causal relationship depicted in the study can be generalised to settings or populations beyond the study conditions (Cozby 1981, p.313; Rubin and Babbie 2001, p.296). Before a causal inference can be generalised, there must be adequate grounds for making the causal inference in the first place, under conditions of the original study. Therefore the research method must first satisfy the conditions for internal validity mentioned above before being tested for external validity (Rubin and Babbie 1993, p.268).

A major factor influencing the external validity of a study is the fact that the study group, procedures, settings, and conditions could reasonably be expected to be replicated in at least some 'real world' settings Some problems related to external validity in evaluation studies include lack of sufficient detail regarding the participants (representativeness of the study sample), the intervention (procedures) or the setting. In addition, there may be an effect caused by reactivity to the research procedure whereby clients become more aware of problem behaviours and are more motivated to resolve them. Finally, the 'placebo effect' may come into play, where changes are due not to the intervention, but to the effect of being part of the evaluation. (Rubin and Babbie 2001, p.321-2).

Research may have different degrees of the different types of validity - e.g. a scientific design may have high internal validity because of the amount of

control over the process in a controlled environment, but low external validity, because the controlled scientific conditions cannot be generalised to the 'real world' to measure more practical issues. Alternatively, some small scale studies may claim high generisability (external validity) but be low on internal validity.

- **Reliability.**

In research design *reliability* relates to the ability of an instrument or technique to produce consistent results when applied repeatedly to the same object, i.e. can the results be replicated by the same, or other, researchers? (Sarantakos 1993; Neuman 1994; Hall and Hall 1996). A research technique or instrument may be tested for *inter-rater reliability*, i.e. that different raters produce comparable results using the same instrument on the same population, or parallel forms of reliability (a second instrument is constructed equivalent to first) or *internal consistency reliability* where the instrument is divided into halves and the correlation between the total scores of the two halves is assessed (Rubin and Babbie 1993, p.171-2 and 2001, p.190-2).

5.1.4 Controlling for possible vested interests or bias in the researcher.

Given that the researcher for this study was the Manager of the Montrose Program from April 1993 to December 2001, the issue of vested interests or research bias needs to be explicitly addressed. Pecora et al 1995 argue in favour of primary evaluators with "a substantive knowledge of the program area in addition to technical skills" (p.xxiv).

There is a risk of evaluator bias that needs to be recognised and controlled for, whether the researcher is internal or external. External evaluators are potentially subject to the claim of bias, either through wishing to produce a positive report for the organisation that funds the evaluation, or for the sake of the program’s staff and clients if they believe that the program’s future is in jeopardy. Similarly, results may be affected by the amount of funds that

the organisation allocates to the evaluation, which may insufficient to fund a rigorous evaluation (Rubin and Babbie 1993, p.540; 2001, p566). As Hall and Hall (1996) note, "Such research is inevitably value laden, making judgments about how well objectives are met." (p.46)

Rubin and Babbie (1993) caution that internal evaluators may be at risk of bias because commitment to the program, or their supervisors, or their own careers may affect their objectivity and independence in ways that do not affect external evaluators. However, they also note that agency personnel and others with vested interests in the outcome of the research may be required to evaluate services for the purpose of accountability, or when continued program funding is dependent on positive evaluation (p.539). In many cases, program funding does not cover evaluation, meaning that if internal personnel do not conduct evaluation, it will not happen. In addition, Rubin and Babbie (2001) comment that internal evaluators who may have vested interests also often have integrity and a level of concern with learning the best ways to help clients, and so "are able to put their vested interests aside and act in a manner that fosters the most objective, scientific evaluation possible." (Rubin and Babbie 2001, p.566)

In relation to controlling for evaluator bias in this study, the evaluation was undertaken on the author's own initiative, as a research project for a University degree, not on behalf of the Department of Community Services (DoCS). The study was supervised throughout by a senior academic from the University of Newcastle, and once the initial research agreement was negotiated with DoCS, the researcher was required only to make a general report to the Department on the project’s progress annually. The researcher was not subject to comment on research design or analysis of results by any person associated with DoCS, and because the study was done for a part-time degree, even the initial results were not available to the Department for over three years after the period of time addressed in the study. The program was not a pilot and its ongoing funding was not dependent on the outcome of a specific evaluation. Therefore, there was no

pressure on the researcher to produce positive results on the basis of continuation of the program, which is still operating at the time of writing, fourteen years after its commencement.
In terms of benefits from DoCS to the researcher, full access was granted to all necessary child protection data, and a one-off grant of $5,000 was approved at the beginning of the project under DoCS Research Policy, to assist with some of the expenses associated with the study. Leave was granted in line with the DoCS Study Leave policy for employees, which allows 40 days' paid leave for study purposes over the duration of a PhD.

By the time the results were analysed, the researcher had moved from the Montrose Program into a different position within DoCS, related to quality assurance in child protection services. The researcher was then working from the perspective of looking at many Departmental processes and with a view to improving the overall quality of service to children and families. Therefore independence and objectivity in evaluating the Montrose program (as one of many Departmental programs being reviewed) was important for the professional credibility of the researcher. At time of final submission of the thesis, the researcher had left the Department and was working in the non-government sector with no connections with DoCS.

Rubin and Babbie nominate some actual advantages of internal evaluators over external evaluators in terms of "greater access to program information and personnel, more knowledge about program processes that might bear on the design of an evaluation for the measurement of findings, and more sensitivity to the research needs of the program and to the realistic obstacles to the feasibility of certain research designs or methods." (Rubin and Babbie 1993, p.171 and 2001 p.566)

In addition, in relation to a complex human service program such as a child protection service, it could be argued that program knowledge and skills associated with an internal evaluator may assist to determine how well the program is meeting its objectives, in the context of the social and political

climate related to child protection, the status of the wider service delivery system and a knowledge of sociological issues related to the client group. This was certainly the case in this study, where knowledge of Departmental procedures and access to data for over 700 children from the secured Client Information System and from Departmental files and personnel, proved a great asset in gathering the necessary information to conduct the research. The time related to this activity alone may have made the evaluation's cost prohibitive if done by an external researcher.

In research, there is a risk of rater bias towards confirming the hypothesis when scoring or measuring data, especially when the rater is involved with the program being evaluated. 'Blind' ratings, where the rater does not know whether the data being scored comes from the experimental group or the control group, provide the strongest control against the possibility of rater bias. (Rubin and Babbie 1993, p.277; 2001 p.307).

Blind rating was not practically possible in the data *retrieval* phase of this study, because family names were used to access DoCS computerised file information and the names could not be eradicated from every page of all data files concerning over 700 children in the 200 families. In addition, the Assessed Group families were immediately identifiable from the Comparison Group from the departmental documentation, which either contained or did not contain a Montrose Report. However, all child and family data was coded and loaded into an SPSS database against the family's unique code number so that subjects were de-identified in the *analysis* and model building process, addressing some of the issues of rater bias.

This study is still potentially vulnerable to criticism on the grounds of rater bias because the researcher was the sole rater of the two cumulative categories of outcome - Family Outcome and Children's Outcome. The research design attempted to control for potential rater bias by basing the rating of these two Outcome variables on the results of a number of

objective, quantified factors for each child, taken from the DoCS client database (CIS) and not open to subjective interpretation. These were measured before and after the intervention (referral for Montrose assessment), and include:

- the number of child protection notifications and substantiated notifications,
- legal status, and
- placement history.

The researcher's subjective professional judgement was required to assess how these and other factors were combined to achieve the final outcome rating for each child and family. However, the use of these quantitative factors provides a measure of control, given that children or families with a high rate of post-assessment notifications, multiple or long term out of home placements, legal status of wardship or long term custody, or multiple abuse types could not reasonably be rated by any other rater as having a positive outcome, despite any other mitigating factors.

For the Assessed Group, intake history and description of functioning was captured in the Assessment Report and this was used in conjunction with the CIS database information to rate outcome. Because the Comparison Group lacked the depth of family details contained in the Montrose Report, the researcher prepared summaries of the child protection issues for each Comparison Group family before and after referral, and these, together with the CIS database information, formed the basis for the assessment of outcome.

As a further attempt to control for potential bias, examples of Family Outcome and Children's Outcome ratings of Improved, No Different and Worse is given at the beginning of Chapter 7: Results.

5.1.5 Role tension: Researcher vs Practitioner.

A further challenge in this study is the inherent tension between the author's dual roles as clinical practitioner and researcher. Myers-Walls (2000) explains the differences in the two roles thus: "… researchers tend to operate with a long time frame; believe things if they can be proven empirically; respect numbers, logic, and science; have high amounts of professional freedom and flexibility but narrow and restricted parameters in research designs; and use complex technological tools. Practitioners, on the other hand, operate on immediate timeframes; respect intuition, experience, and personal testimonials; have relatively inflexible jobs with close supervision but strive to be responsive and flexible with clientele; and use tools that facilitate communications and personal connections. Researchers are observers who try to understand and predict behavior, and practitioners are hands-on interventionist to try to mold and change behavior." (p.344)

This author recognises these dual roles and the need to balance the expectations of each professional stance. This task was made easier by the fact that the evaluation relates to clients that were referred to the program some years in the past (1993-96), while the evaluation was only commenced in 1997. Sufficient time had already elapsed to eliminate the possibility of any intervention by the researcher that could affect the results. In addition, the process of the follow-up was so time-consuming that the researcher had already left the program by the time the information was mined on the families referred in 1996 and followed up in 1999. Therefore, the two roles were not carried concurrently, but they did present some positives in terms of complementarity. The author's clinical perspective was useful in interpreting results and the research skills proved invaluable in providing an empirical basis for the clinical information.

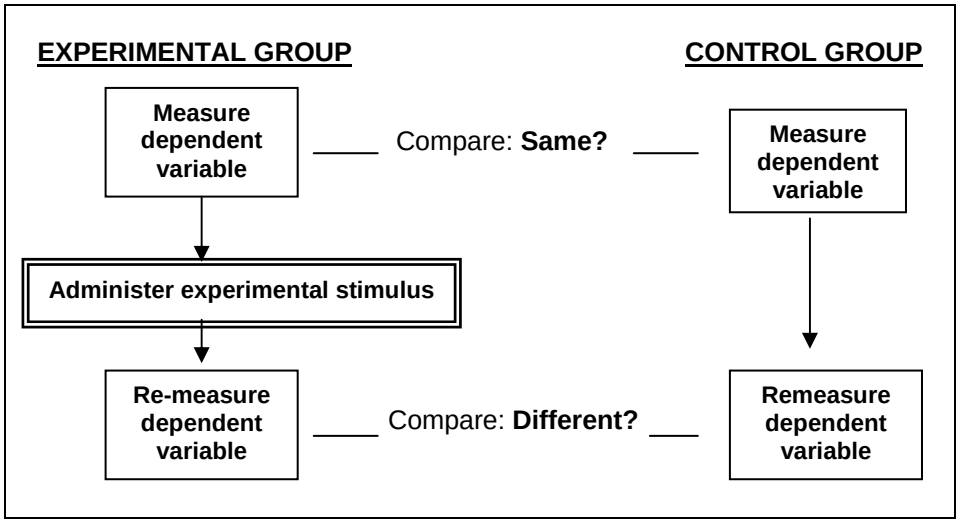
5.2 Experimental Research design

5.2.1 Elements of Experimental Research Designs.

Before describing the research design used in this study, elements of classical experimental design and their applicability to the study will be examined. A classic experimental research design uses two or more groups of subjects which are as similar as possible, measured for the dependent variable. One variable (the independent variable) is manipulated by way of an intervention administered to one of the groups, keeping all extraneous variables constant. The groups are re-measured for the dependent variable and any difference between the groups is inferred to be due to the effects of the independent variable. Experimental designs are therefore methods through which the effect on outcomes of anything other than the treatment provided can logically be ruled out (Fitz-Gibbon and Morris 1987, p.12).

Classic experimental design is the most robust of the designs, and in an ideal situation, gives the greatest ability to control for threats to internal validity and isolate the independent variable by using randomly assigned groups and pre- and post-tests. A diagram of a basic experimental design is represented by Rubin and Babbie (1993; p275)* as follows:

Fig. 5.1: A Classic Experimental Design Model. (Rubin and Babbie, 1993)



* Rubin and Babbie (2001) pp303-5 covers the same models and information.

The Experimental group (E-Group): is defined by the fact that they receive the program or intervention to be tested.

The Control group (C-group): consists of subjects who are as similar as possible to those in the experimental group, but who do not receive intervention to be tested. In a classical experimental design, the control group is formed by random assignment of subjects into groups which should ideally be identical as far as possible. If the control group is formed in this way, it is known as a true control or Equivalent Group. If the control group is *not* formed by random assignment, is referred to as the Comparison Group or Non-equivalent Control Group.

Rubin and Babbie (1993; 2001) emphasise the importance of randomised distribution of subjects into Experimental and Control Groups: "The cardinal rule of experimental design is that the experimental and control groups must be comparable. Ideally the control group represents what the experimental group would have been like if it had not been exposed to the experimental stimulus. " (Rubin and Babbie 1993 p.275; 2001 p305). They state that there is no way to guarantee that the experimental and control groups will be equivalent in all relevant respects, and will not have differences in history, maturational processes, but they emphasise that random assignment of subjects into experimental and control groups is a way to guarantee a high mathematical likelihood that any differences will be insignificant.

Fitz-Gibbon and Morris (1987) also emphasise the importance of using random assignment, to increase the likelihood of a non-biased distribution of the various characteristics and enhance the credibility of the results. "Random assignment of people to programs is the most effective way of eliminating (other) explanations.. ... Randomisation avoids alternative explanations making it likely, when two or more programs are compared, that the factors which influence outcomes … will be more evenly distributed to each program from the beginning." (p.27)

Ideally, robust program evaluation uses a true control group because randomising the groups increases the internal validity of the design and minimises the likelihood that any change in the Experimental group was due to factors other than the intervention (Miller, 1986; Richardson 2004).

However, as discussed earlier in this chapter, the use of randomised groups in human services program evaluations presents ethical dilemmas when a potentially helpful intervention is deliberately withheld from vulnerable participants. In this study, families in the two groups were not allocated by randomised process, but by the fact that some families participated in the Montrose home-based family assessment (Assessed Group), while other families who also met the program's referral criteria did not proceed to assessment (Comparison Group). The Experimental Group families were selected on the basis that they were the first 100 families assessed by the Montrose program. The Comparison Group were the first 100 non-assessed families who met the referral criteria, but did not participate in an assessment, *and* for whom there was sufficient information for the three years before and after assessment to determine the child protection outcome, compared to the child protection history before referral.

The commonality between the families was the fact that they met all referral criteria for the program - they were families registered with the NSW Department of Community Services, with serious or chronic child protection concerns that put the children's ongoing placement in the family at risk, but with no *immediate* safety threats to the children. This procedure fulfils an allocation requirement of Fitz-Gibbon and Morris (1987): "If the experimental group was selected by means of a particular procedure, then the control group should be selected by the procedure which is as nearly as the same as possible." (p.12)

According to Rubin and Babbie (1993), "Whatever randomising method is used, the desired result is the same .... the overall average description of

the experimental group should be the same as that of the control group ... (they should be)... comparable in terms likely to be related to the dependent variable under study." (p.277). In this study, the Experimental Group and the Comparison Group were compared on demographic variables and also on family variables that were likely to relate to the child protection issues for which they had been referred. This analysis of comparability is presented in Chapter 6: The Study Group, where both groups are described in more detail, but it is clear that the two groups were comparable on the major variables to be explored. Further discussion on non-equivalent control groups, or Comparison groups, follows later in this chapter in the section on Quasi-Experimental Designs.

- **Pre-Tests.**

In the experimental design, one or more pre-tests may be conducted before the participants receive the intervention. However, the pre-test should not be used as a way of selecting the participants for the program, because this increases the risk of regression towards the mean in the post-test, which is a potential threat to the internal validity of the model. Ideally, the pre-test is as similar as possible to the post-test. According to Fitz-Gibbon and Morris (1987): "The way to increase the power of a design is to be able to explain ... the variation in results by measuring accurately at the outset the things that are likely to influence the results. …Thus, using a pre-test which is very like the post-test …gives the most precise information about the effectiveness of one program compared with another." (p.42).

In this study, pre-test measurement was done retrospectively using the DoCS computerised client database (CIS) to measure the number of child protection notifications, type of notifications, placement history and legal status for each child, and for each family as a whole, in the period of three years before referral to Montrose. As this data is in 'read-only' form on the CIS, it cannot be manipulated in any way after being entered. It therefore provides an objective baseline against which later outcomes for the child and the family can be measured.

- **Post-tests**

As previously stated, post-tests should be as similar as possible to pre-tests. In this study, the same categories of CIS data were measured three years before and after Montrose referral, so that the results could be objectively compared. This data was available for individual children and whole families.

A classic experimental design, with randomly assigned Experimental and Control Groups, with the experimental intervention administered to only the Experimental Group, and with a Pre-test and Post-test measurement of both Groups could be represented as follows (Fitz-Gibbon and Morris 1987, p.55):

Fig. 5.2: Classic Experimental Design with Pre- and Post-test Measurement. (Fitz-Gibbon and Morris, 1987, p.55)

Time →		1 (Pre)		2 (Post)
E- group	R	O	X	O
C- group	R	O		O
	Random assignment to the 2 groups	Pre-test observation	E-gp gets program X. C-gp gets an equivalent program (or no program)	Post-test observation

Fitz-Gibbon, C. and Morris, L. (1987): *How to Design a Program Evaluation*. Sage Newbury Park. CA Copyright Sage Publications . Reproduced with permission

5.2.2 Quasi-Experimental Designs with Non-Equivalent Control Groups (Comparison Groups).

As discussed earlier, difficulties arise in implementing classical experimental designs with human populations because of the designs' requirement to randomly assign individuals to Experimental and Control groups, and to administer or withhold the intervention (independent variable) from the control group. It is therefore necessary to deal with the issue of randomisation in a way that can be applied to human subjects, especially those in high risk situations, as is the case in this study.

Rubin and Babbie (1993;2001) and Richardson (2004) acknowledge the difficulty of random assignment of subjects to experimental and control groups, citing ethical and political concerns as the reasons for this difficulty. Having accepted this fact, they recommend an alternative approach - the quasi-experimental research design, in which subjects are *not* randomly assigned to experimental and control groups. In quasi-experimental designs, the non-equivalent (non-randomised) control group is known as the Comparison Group. This design has less internal validity than 'true' experiments, but still provides moderate support for drawing causal inferences.

The research design model for the non-equivalent control groups design, pretest-post test is the same as that for the classic experimental design, except that it lacks the **R** for random assignment of subjects (Fig. 5.3).

Fig. 5.3: Quasi-Experimental Research Design: Non-Equivalent Control Group, Pretest, Post-test Design. (Fitz-Gibbon and Morris 1987, p.86)

	Time →		
	1 (Pre)		**2 (Post)**
Experimental Group	**O**	**X**	**O**
*			
Non-Equivalent Control Gp **(Comparison Group)**	**O**		**O**

[*The dotted line separating the Experimental and Control Groups denotes that the Control Group is non-equivalent, i.e. not selected by randomising process.]

Fitz-Gibbon, C. and Morris, L. (1987): *How to Design a Program Evaluation*. Sage Newbury Park. CA Copyright Sage Publications . Reproduced with permission

A critical aspect of quasi-experimental designs is *comparability* of subjects in both groups. Despite the scientific preference for randomly assigned subjects, there is support for the use of comparison groups, provided a pre-test is conducted to ensure initial comparability (Fitz-Gibbon and Morris 1987, p.30; Rubin and Babbie 1993, p.280; 2001 p.311). The way to test for comparability, at least in the variables which the program aims to change, is by the use of the same pre-test on both groups (Fitz-Gibbon and Morris 1987, p.88).

Fitz-Gibbon and Morris (1987) acknowledge the worth of non-equivalent comparison groups in research designs where ethical reasons prevent the random distribution of clients to groups: "The collection of data from a non-equivalent control group can be helpful in assuring the effect of a program and therefore worth attempting in situations in which a true control group cannot be formed. ... it allows you to avoid the problem of randomly depriving … customers of the program, while still providing a means to judge the quality of program progress with respect to others." (p.30). They suggest that the quasi experimental design can be rendered nearly as strong as the classic experimental design if it can be demonstrated that the experimental and comparison groups are so similar that they may as well have been created by random selection.

They also emphasise the usefulness of the comparison group in providing baseline data for comparison purposes: "The no-program group yields a *baseline* from which to judge the results of the program. Provision of the baseline is another important reason why even a no-program comparison is worth making." (p.34). This strategy has relevance for this study, where the Comparison Group was composed of families who fulfilled the referral criteria for the program but did not proceed to assessment. The pre-test was not a way of selecting participants for each of the groups, but a way of measuring comparability between the two groups at the point of referral, and producing baseline information from which to measure outcome three years after referral, for comparison with the Assessed Group who received the Montrose intervention.

Fitz-Gibbon and Morris (1987) hold that the following three conditions should be met when using non-equivalent control groups:

1. If the experimental group was selected by means of a particular procedure, the comparison group should be selected by a procedure as similar as possible**.**

2. The comparison group should be given all the major tests that the experimental group is given (to allow for accustomisation to tests).
3. The researcher should document similarities and differences between the comparison and experimental groups, to maximise the credibility of findings by demonstrating that the experimental and comparison groups were as similar as possible, except for the difference in the program received. (p.31)

This study complied fully with conditions 1 and 3 of the above criteria. Condition 2 was not relevant for the study's research design. However, Pre-test information was measured (retrospectively, because the study post-dated the intervention) for both the Experimental (Assessed) Group and the Comparison Group at the time of referral to Montrose. Measures were based on information sourced from the DoCS computerised child protection database (the CIS), child protection files and referral information.

Objective pre-test measurements included numbers of notifications per child, out of home care placements, legal status and type of abuse/neglect, as well as family demographic information and referral information. The Assessed Group and the Comparison Group proved to be comparable on a number of demographic and family variables significant to the study, as detailed in the next chapter. (Chapter 6: The Study Group.)

5.3: Research Questions and Hypotheses in This Study.

5.3.1 Background

This study was designed to evaluate outcomes of the first 100 families assessed by the Montrose Home-Based Family Assessment Program, comparing their outcomes three years after assessment with 100 Comparison Group families, who met all referral criteria but did not proceed to assessment. All participants were referred to Montrose between 1993 and 1996, and the three year follow-up period concluded in December 1999, and in both the Assessed Group and the Comparison Group the children's ongoing placement in their families was in jeopardy because of serious and/or longstanding child protection concerns. The Comparison Group was not strictly consecutive, but was formed from the first 100 non-assessed families, referred in the same three year period, for whom there was sufficient information on the critical variables to be measured, before and after referral. The Comparison Group did not include families who were referred to Montrose but were rejected because of *immediate* safety risks, as these families would have been significantly different from the Assessed Group in terms of immediate risk factors.

The researcher was also interested in the exploring what family, parent, child and child protection service factors might be associated with positive and negative child protection outcomes for children and families.

The use of randomised versus non-randomised control groups was discussed in the previous section of this chapter. The process of randomisation was not undertaken in this study for the following reasons:

1. The division between the two research groups had already been determined by the time the study commenced, based on those who participated in the assessment process versus those who met the referral criteria but, for a variety of reasons, did not proceed to assessment.

2. For ethical reasons, strict adherence to a formal randomisation process would not have been possible as there was no similar program to which families could be referred, and the serious child protection issues in the referred families precluded the formation of a waiting list which might have provided another form of a true control group.

- **Ethics approval.**

The proposed study was submitted to the University of Newcastle Ethics Committee before implementation. The project was granted University ethics approval,* with the provision that any future research which involved participants who had not yet been assessed should supply written information about the research to the participants, with the assurance that their participation in the research project would be voluntary and a decision not to participate would not affect their access to the Montrose service being offered. This condition was not necessary, as the 200 families in the study had already been selected, the experimental group had completed their Montrose assessments, and no further families were involved in the study. A copy of the University Ethics approval was provided to the DoCS Research Department.

5.3.2 The Research Questions.

Previous investigations into outcomes of child protection interventions have produced a large body of literature regarding the association between child-factors, parent factors, family factors, service factors, demographic, sociological and cultural factors and child protection outcomes. (See Chapter 3).

The primary goal of this study is to evaluate the Montrose Home-based Family Assessment Program, by comparing the outcomes, three years after

* University of Newcastle Ethics Committee Approval No: H434 1297. December 1997

referral, for the 100 Assessed Group families with those of the 100 Comparison Group families.

Primary Research Question.
What impact does the intervention of a home-based family assessment program have on outcomes, three years after referral, for children and families who present as tertiary level child protection cases?

- ***Primary Hypothesis****: that the rate of positive child protection outcomes for children will be significantly higher for families who participate in a comprehensive Montrose home-based family assessment than for families with comparable risk factors that do not take part in the Assessment.*

The hypothesis relates to the proposition that engaging families in the process of defining their own problems and needs, and then assisting them to develop their own solutions, in conjunction with relevant community support services, will increase the likelihood that the families will engage with services to make and maintain positive changes to the way they care for their children, reducing child protection risks and enabling the children to remain in the family.

The secondary research goals of the study relate to discerning any demographic, family or child protection systems-related factors that are predictive of outcome in tertiary level child protection cases. Experience during the first three years of the program had led this researcher to identify some apparent trends in the types of families being referred to Montrose. Specifically, many of the mothers and some of the fathers of referred children had experienced significant childhood abuse themselves, and a number had been brought up either in residential or foster care, or with extended family. Others had experienced periods of time living an itinerant lifestyle, often leaving home early to avoid abusive situations. It became apparent that this group of parents had often been exposed to models of

child rearing that were poor or inadequate at best, and seriously abusive at worst. In addition, in some families there appeared to be an intergenerational pattern where parents' parents had also had disrupted childhoods and/or abuse during their formative years.

The secondary research questions relate to the examining demographic characteristics of families and personal characteristics of parents/carers and children, to determine which factors, individually or in combination, may be predictive of positive or negative child protection outcomes for families at high risk for child abuse and neglect.

Secondary Research Question
Are there any specific demographic or family factors associated with child protection outcomes?

This question is examined under a series of supplementary questions:

- *Are there any identifiable factors associated with positive or negative outcomes for children and families in tertiary level child protection cases?*
- *Are there any specific demographic factors that impact on child protection outcome?*
- *In what ways does a parent's own history of childhood abuse / placement / mental health issues / substance abuse / developmental disability or domestic violence affect the outcome for children and families in tertiary level child protection cases?*

The hypotheses underpinning Research Question 2 are based on the need identified in the literature to investigate and intervene with *multiple* factors associated with child protection risk for secondary and tertiary level families, as summarised by Tomison (1996): "Efforts to target a single risk factor are not likely to be as effective in preventing maltreatment as are programs based on a multivariate, interactionist model, particularly one

focussed directly on the family." (p.9) The hypotheses can be framed as follows:

- ***Secondary Hypothesis (a):*** *That there are some specific parental factors (history of childhood abuse, history of out of home placement, drug and alcohol abuse, mental health issues, developmental disability, domestic violence) that will affect long term outcome for children referred to a tertiary level child protection service.*

- ***Secondary Hypothesis (b):*** *That if a combination of these parental factors is present, the child protection outcomes for the children will be worse than if only one factor is present.*

- ***Secondary Hypothesis (c):*** *That presenting problems, type and severity of abuse and/or neglect, are associated with long term outcome for children.*

The third set of research questions in this study relate to whether any child protection service factors, i.e. the Montrose program, or the families' interaction with the child protection system (DoCS, the Children's Court and the Out of Home Care system), are associated with child protection outcome. The hypothesis underpinning these question relates to the wider ecological (exosystem) factors that may be associated with child protection issues and outcomes.

Other Research Question/s:

Are there factors related to families' contact with child protection services that are associated with outcome?

The primary part of this question aims at exploring any relationship between the family's history of child protection intervention, and interaction with the child protection system, including the Montrose family assessment, and child protection outcome. The goal of the question is to provide feedback to the Program and to the Department on ways in which secondary and tertiary child protection intervention might contribute to more positive

outcomes for referred families. An additional consideration is the relationship between families' previous contact with the child protection system, with or without intervention, and child protection outcome.

Associated questions are:

- *Are there any Montrose Program factors or other child protection service related factors that can be identified as contributing positively or negatively to outcome for this group of families?*
- *Did the Montrose assessment process itself operate as an intervention, independent of whether the recommendations made as a result of the assessment were put into action by the Caseworker and/or the family?*
- *How did the outcomes for families for whom the Montrose recommendations were not implemented compare with families where the recommendations were implemented?*

These questions relate to whether the assessment itself creates change in families, or whether change is related to the implementation of the Montrose recommendations for the family. They relate to issues raised in some Montrose parent evaluation questionnaires (completed before this study commenced) that the recommendations of the Montrose Report had not been actioned immediately after the Case Conference. Some of these families appeared to be progressing well in the short term (from anecdotal evidence), raising a question as to whether the Montrose assessment itself acted as an intervention, regardless of whether the recommendations of the assessment were implemented.

▪ ***Secondary Hypothesis (d):*** *That the assessment process is an intervention in itself, and affects long term outcome in assessed families, regardless of whether the recommendations of the assessment are implemented.*

These research questions and hypotheses form the basis of this study, and the specific evaluation strategy and research design model used to interrogate the data will now be discussed.

5.4 Research Design Model of this Study.

The research design used in this study is a Quasi-Experimental Design, specifically a 'Non-equivalent Control Group, Pretest, Post-test Design'. The model is described in Fig. 5.4 It is defined by Rubin and Babbie (1993) as: "Two groups which are similar but were not formed by random assignment are measured both before and after one of the groups gets the program or experimental treatment." (p.86)

Fig. 5.4: Research Design for this Study: Quasi-experimental, Non-Equivalent Control Group, Pretest, Post-test Design

	Time →		
	1 (Pretest) Measured at Time of Referral to Montrose		2 (Post-test) Measured Three Years After Referral
ASSESSED GROUP	• # Notifications per family • # Confirmed notifications per family • Type of abuse • Legal status of children • Placement / placement history of children	MONTROSE ASSESSMENT	• Family Outcome • Children's Outcome • # Notifications per family • # Confirmed notifications per family • Type of abuse • Legal status of children • Placement / placement history of children
Non-randomised selection.			
COMPARISON GROUP	• # Notifications per family • # Confirmed notifications per family • Type of abuse • Legal status of children • Placement / placement history of children		• Family Outcome • Children's Outcome • # Notifications per family • # Confirmed notifications per family • Type of abuse • Legal status of children • Placement / placement history of children

5.4.1 Internal Validity of the Research Design for this Study.

Rueben and Babbie (1993) suggest that although the level of a study's internal validity is a somewhat subjective judgment, the strength of the validity can be increased if the study controls for a number of specific *threats* to internal validity. The current research study was designed to

address these threats as far as possible, in line with Lazarsfeld's (1959) three specific criteria for establishing inferential causality between two variables. According to Rubin and Babbie (1993): "Any relationship satisfying all these criteria is causal, and these are the only criteria." (p.263)

1. *The cause precedes the effect in time.*

All families in this study were referred to the Montrose Program because of documented pre-existing child protection issues. These issues were quantified in dated lists on the DoCS computerised database (CIS), for number of child protection notifications and type of abuse, child/ren's legal status and placement history. These records are read-only after entry and thus the cause can be absolutely demonstrated to precede the effect in time. Both the Assessed Group and the Comparison Group were subjected to pre-intervention (pre-test) measurements taken from the CIS data. The intervention then took place in the form of a Montrose Assessment for the Assessed Group, and the post-test measure was applied to both groups three years after the date of referral, again based on the CIS data and other documented child protection information, dated post-assessment.

2. *The two variables are empirically correlated with one another.*

This study complies with this criterion. Measurements of covariance were conducted by way of Crosstabulation and Nominal (multivariate) Logistic Regression. Significant correlations between the outcome variables and the pre-test measurements are demonstrated. A more detailed description of the data analysis methods is described later in this chapter, and the results are detailed in Chapter 7.

3. *The observed empirical correlation between two variables cannot be explained away as being due to the influence of some third variable that causes both of them.*

This issue is dealt with in a later section of this chapter, in a discussion on controlling for confounds to the research design. In short, the large number of participants (200 families, over 700 children), the fact that the families resided across the state of New South Wales, and the duration of the study

(six years from the first referral) make it highly unlikely that any one or more external variable could have impacted across one or both of the experimental and comparison groups. Further, the data analysis methodology (multinomial logistic regression) allows for measurement of the individual variables against each other in addition to their correlation with outcome. This issue is discussed in detail in the results section (Chapter 7).

5.4.2 Controlling for Threats to Internal Validity.

Campbell and Stanley (1963) and Cook and Campbell (1979, pp. 51-55) delineate nine threats to internal validity which are listed below, along with the methods used to attempt to control for them in this study:

1. *History - extraneous events that may coincide with the intervention.*

Given the high risk nature of the families in this study, the occurrence of some significant external events affecting the families over a three year period would be expected. The study allowed for up to five major family changes in the follow-up period which may have influenced outcome. These were recorded on the Data Collection Sheet for both Assessed and Comparison Groups, and were taken into account when determining the overall level of change at outcome.

2. *Maturation, or the passage of time.*

The Assessed Group and Comparison Group were referred over the same four year period. (Dec. 1992 – Dec. 1996). While a process of maturation would certainly have affected the families, there is no reason to suppose that maturation factors would have affected one group more or less than the other. The ages of the parents and children at referral are essentially comparable between the two groups, so it can be assumed that the maturation process would be roughly equivalent in both groups.

3. *Influence of testing - results at post-test affected by administering a pre-test, regardless of whether subjects receive the intervention.*

This factor did not apply to this study, as neither the Assessed Group nor the Comparison Group was subject to a pre-test administered directly to them. Pre-test information was derived from a secondary analysis of data from the DoCS Client database (CIS), using the number and type of child protection notifications, previous placements and legal status of the children as the means of assessing functioning before referral to Montrose. Participants do not have direct access to the information entered on the CIS database by Caseworkers, and are not necessarily even aware of the number of notifications on their family prior to referral, as not all notifications are investigated. The post-test applied the same process as the pre-test to the number of notifications, abuse type, legal status and child/ren's out of home placements in the three years after referral. Again, families were not directly involved in this process.

4. *Instrumentation – the use of different measures on pre-test and post test.*

The same measures (listed in point 3) were used on pre-test and post-test data for both the Assessed Group and the Comparison Group. Overall outcome for the family and children was assessed using the pre-and post test variables and also taking into account major change factors impacting on the children or family's lifestyle or functioning (e.g. illness or death, separation, moving, access to treatment.)

While evaluation questionnaires were used after Montrose assessment for the Assessed Group, the information from them related to short term outcomes of up to 6 months after referral, and was used only to augment the information already available on the CIS, and was never used as the sole indicator of outcome as the period measured was for three years after referral. The qualitative data obtained from the questionnaires was used to gauge the families' and referring Caseworkers' views of the process and outcome of the Montrose assessment for future program development purposes. The response rate for the questionnaires was not sufficient to allow them to be seen as a post-test for the Assessed Group, and they

were not sent to the Comparison Group, so could not be used as a post-test in the study as a whole.

5. Statistical regression.

When services are provided only to subjects with the most extreme pre-test problems, retesting may look more positive for this group simply because of natural improvement in the problem over time, rather than because of the intervention. According to Rubin and Babbie (1993): "When we provide services to only those people with the most extreme problematic pretest scores, the odds are that the proportion of service recipients with atypically bad pre-test scores will be higher than the proportion of non recipients with atypically bad pre-test scores. ...Consequently, even without intervention, the group of service recipients is more likely to show some improvement in its average…scores over time than the group that was not referred." *(There is a)* "*…* danger that changes occurring because subjects started out in extreme positions will be attributed erroneously to the effects of the independent variable". (p.266-7)

In this study, this threat was controlled for by the fact that the one subgroup of families – those deemed to be in a higher risk category than both the Assessed or Comparison Group families - was explicitly *excluded* from the study. These families were declined a Montrose assessment on the grounds of immediate safety risks to the children, requiring urgent child protection intervention by the referring Caseworker.

Therefore the Assessed Group was not selected for a Montrose assessment on the grounds that it was more 'negative' or at higher risk at referral than the Comparison Group. Both the groups met the same Montrose referral criteria, and, as will be demonstrated in Chapter 6, were quite similar in terms of most demographics and family factors, and in the baseline measures of the major outcome variables.

6. Selection biases – The groups being studied must be as comparable as possible in all respects - ideally this is achieved in scientific experiments by randomly allocating subjects to each group.

This study has previously addressed the ethical issues involved with randomisation of families in experimental design models when the intervention involves vulnerable groups such as families with serious child protection issues. Rueben and Babbie (1993) stress the usefulness of randomisation as a device for increasing internal validity. However they also acknowledge the ethical dilemma of conducting pure experimental design in social work practice, i.e. randomly assigning subjects to two groups, where one group will receive an intervention and the other will be denied access to the intervention. There are two conflicting values associated with this dilemma - providing immediate help to people who need a service versus ensuring that services offered to clients have had their effects scientifically tested.

Participants in this study were not deliberately assigned to either of the two groups, either as part of a Montrose process or as part of the experimental design. The Assessed Group comprised the first 100 families who proceeded through the referral process to assessment. The families in the Comparison Group comprised the first 100 families who met the referral criteria but did not proceed to assessment, and for whom sufficient data was available to determine pre-referral and outcome child protection status.

The Comparison Group did not proceed to assessment for a variety of reasons, related either to the family's preference not to proceed, or other family circumstances, or to actions (or inaction) associated with the referring Caseworker. Had the referral process proceeded to completion, there is no obvious reason that all families would not have been selected for a Montrose assessment. In fact 30% of these families completed the referral process and were booked to have a Montrose assessment, but withdrew before assessment took place, mainly because of personal or family factors that made the assessment impractical at the allocated time..

7. Experimental mortality - the possibility that subjects may drop out of an experiment before it is completed, therefore statistical comparisons and the conclusions will be affected.

This issue did not arise in this study. For the Assessed Group, once an assessment had begun, even if parents withdrew from the process, the assessment was continued with referring staff and other support agencies, the Report was produced and given to the parents and the referring DoCS staff, and a Case Conference took place, whether or not parents attended.

For the Comparison Group, follow-up for three years after referral took place whether or not the family was actively involved in a referral process. In order to be in the Comparison Group, families needed to have sufficient baseline information on the DoCS child protection database (CIS), and on referral forms, to enable the significant variables to be measured at referral and at outcome.

8. Ambiguity about the direction of causal influence – the a need to avoid the possibility of ambiguity in the time-order of the independent and dependent variables.

This threat to internal validity was not an issue in this study, given that baseline family information was measured at the time of referral. As explained in elsewhere in this chapter, even though the process of collating this information took place after the intervention for the Assessed Group, the quantitative information was derived from an objective secondary data source, the DoCS child protection database, which is clearly dated. While it could be argued that the referral in itself was an intervention, if this is the case, the effect should occur equally in the Comparison Group and the Assessed Group. However, there is no evidence in the follow-up to indicate any major change in either group in the period of time between referral and intervention that would have impacted on the outcome measures in the same way as the Montrose assessment.

9. Diffusion or imitation of treatments-service intervention types may influence each other so that the true effects of the intervention may be blurred.

Referrals to Montrose come from across New South Wales. It is therefore highly unlikely that there would have been diffusion of interventions between any other single service and the Montrose intervention.

Where Assessed Group families are receiving interventions from other services during the assessment, the services are routinely visited as part of the Montrose assessment. The fact that the Montrose assessment process lasts only two weeks, minimises the likelihood of any blurring of the effects of the service types during the assessment period.

We cannot know that some Comparison Group families did not seek or receive other services, outside the statutory child protection service, with similar goals and philosophy to those of Montrose. However, if such interventions took place and had an effect on the outcome for these families, the contacts are not recorded in the DoCS child protection files.

In summary, the study has attempted to address all nine threats to internal validity as far as possible, in order to increase the strength of the research design model.

5.4.3 External Validity in the Research Design - Ability to Generalise Results

External validity refers essentially to the ability to generalise the findings of a study to like situations or populations. (Cozby 1981; Rubin and Babbie 1993, p.264).

One threat to external validity occurs when a study has conditions that could not reasonably be expected to be replicated in the 'real world'. In this study, because the intervention (Montrose assessment) is home-based, with children and families being assessed and their local community, it takes place very much in the real world. Montrose staff are required to incorporate real world circumstances and events into the assessment process, and not to disrupt or substantially alter family behaviour considered 'normal' by the family being assessed. The assessment process is very much reality based, and easily transferable to other settings, other states and other countries, (bearing in mind cultural differences).

A second threat to external validity is the lack of sufficient information about the client group, the setting or the study method for the research to be replicated. In this study, there is detailed information provided about the client group (Chapter 6: The Study Group), the program/intervention (Chapter 4: The Montrose Program) and the research methodology (this chapter) to enable the study to be repeated with similar client groups, to test the efficacy of the home-based family assessment model on other client groups, e.g. as an early intervention strategy with families who are identified as having risk factors for child maltreatment, but for whom there are no current child protection concerns.

A third threat to external validity, the 'placebo effect' was not applicable in this study, because there was no 'placebo'. All families in the Experimental group (Assessed Group) received the Montrose assessment, and no families in the Comparison Group received it.

The research design therefore attempts to adequately address these three threats to external validity.

5.4.4 Reliability of the Research Design.

This measure relates to the ability of results of a particular test to be replicated if applied more than once to the same subjects, by different researchers, under the same conditions (Hall and Hall 1996, p.44).

In line with Montrose policy, no family was re-assessed by the Montrose program during the period of the study. Therefore it is not possible to test whether different researchers would have been able to replicate the same results with the same subjects. It is in fact a moot point, since having had an assessment would have prepared families for what to expect and would have affected the outcome the second time.

However, in a sense, there was a concurrent test of reliability being conducted with the 100 Assessed Group families by virtue of the fact that the assessment process was delivered virtually in the same way over the four year period of the referrals (January 1993-December 1996). During this time, given the demands on the staff in terms of workload and travel, there was some turnover of staff (although less than might have been anticipated). The changes of staff over the four year period ensured that the assessment process, not the staff, was the constant and unchanging factor.

In addition the Montrose staff, who were conducting the assessment in pairs, were rotated to ensure that no two staff constantly worked together. This was done deliberately, to ensure that the Montrose assessment process was the constant, not the combination of staff. Hence, it could be said that the changing teams were acting as different agents applying the same process to the same group of subjects. At any time, two families may be being assessed by two different Montrose teams, using the same assessment process. Therefore the reliability of the intervention process was being tested constantly throughout the study.

In terms of the reliability of outcome measures, the study compares child protection outcomes against pre-intervention history for 100 families using a standard set of criteria. The measures include objective data - number of child protection notifications, type of abuse, legal status, placement history, as well as family and demographic information, all documented in the DoCS computerised child protection database. The same measures were applied to 100 Comparison Group families, who did not participate in the intervention, but whose histories and outcomes were measured using the same data information source. For the majority of the outcome categories, as the data are concrete, and not open to a range of interpretations, it would be expected that a different researcher would define the outcomes in exactly the same way as the original researcher.

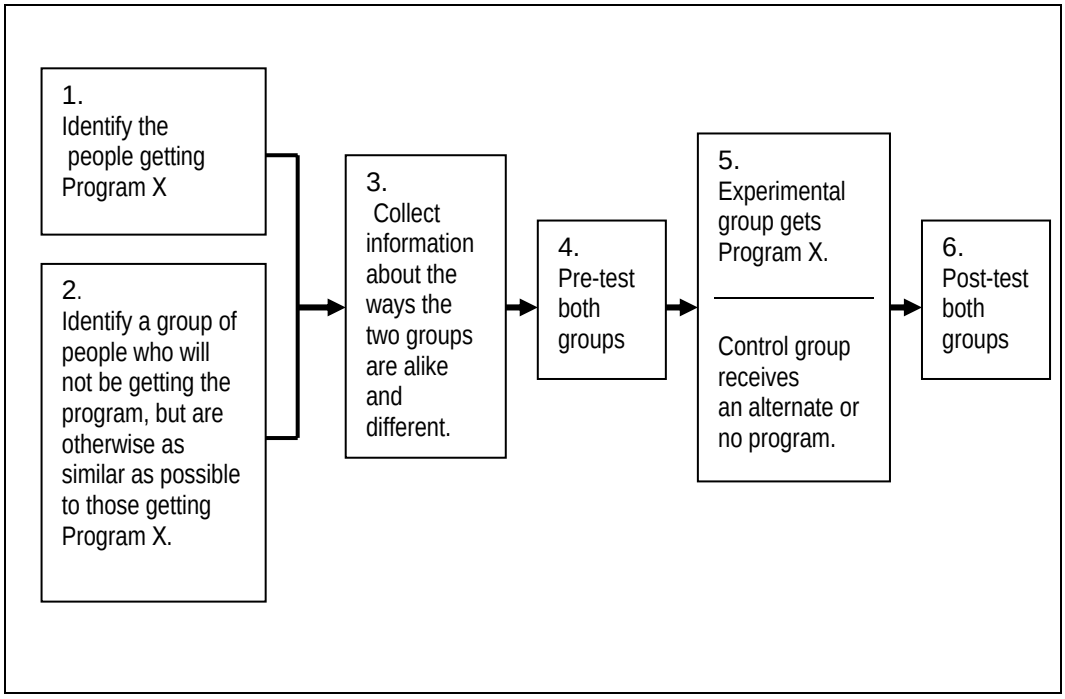
Two of the outcome categories - Family Outcome and Children's Outcome - are based on interpretation of the cumulative effects of all other data categories, assessed in the context of all existing file documentation in the three years before and after referral for the intervention. This documentation includes case reviews, professional reports and parents' and referring caseworkers' feedback from outcome surveys. While the final assessment of these two measures was subjective in nature, it is based on the combination of the other concrete measures, and other factual information. Family Outcome and Children's Outcome were divided into three categories - Improved, No Different and Worse, and the combination of all post-referral information enabled families to be categorised with relative ease, and with little ambiguity. In the very small number of cases where there was insufficient information to make a determination of outcome, no determination was made. The measure was utilised with the Assessed Group and then with the Comparison Group, and demonstrated internal consistency reliability.

5.4.5 Implementation of the Research Design.

Figure 5.5 demonstrates the way in which the *Pre-Test, Post-Test Design with a Non-equivalent Control Group* is ideally implemented:

- The Experimental and Comparison Groups are defined by those who will receive the intervention and those who will not.
- The similarities and differences between the two groups are documented before the intervention.
- A pre-test is administered to both groups to measure them in relation to the variable of interest.
- The intervention is administered to the Experimental group only
- Both groups are re-tested to see if there is a difference between them which can be attributed to the effect of the intervention.

Fig. 5.5: Essential Steps in Implementing Pre-Test Post Test Design with a Non-equivalent Control Group (Fitz-Gibbon and Morris 1987, p.86)



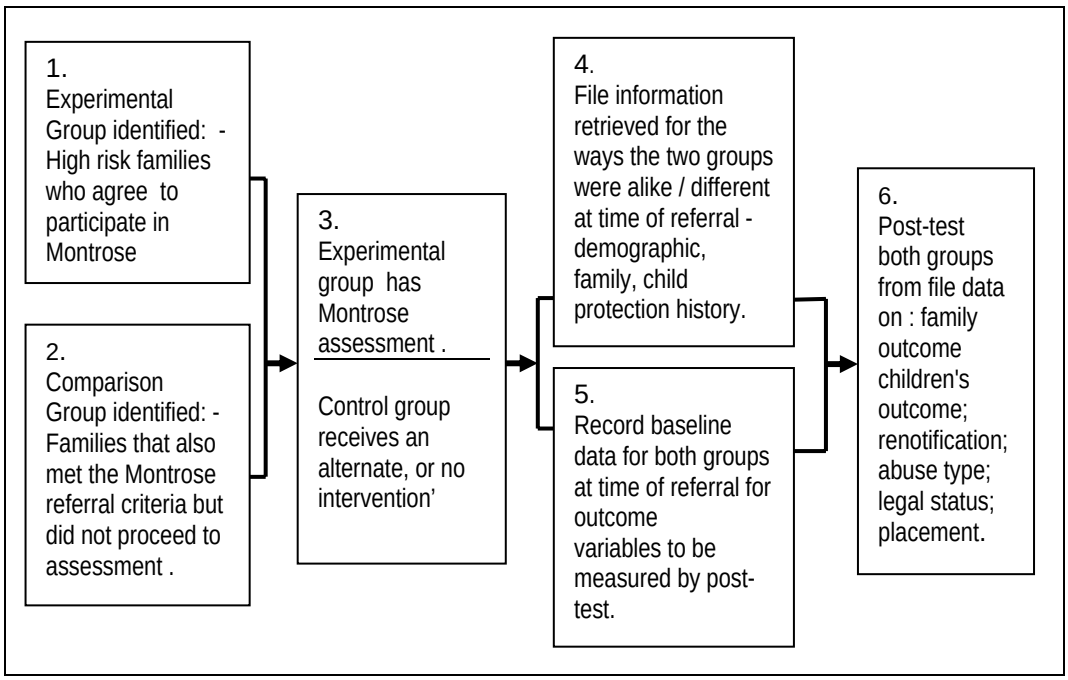
The process for implementing the Research design in this study is described in Fig. 5.6. The program had already been in operation for over four years prior to the research project commencing. The two groups of participants had already been selected, according to whether or not they

participated in an assessment, and the intervention (the Montrose assessment) had been implemented with the experimental group (Assessed Group).

When the study commenced, retrospective demographic information and family information was gathered for all families in the study, from the DoCS computerised child protection database files (CIS) and from Montrose referral forms. Secondary analysis of this data was used to measure comparability of Comparison Group with the Assessed Group at the time of referral to Montrose.

Using this information, it was also possible to retrospectively collect objective baseline data regarding families for the variables to be tested at post-test, without compromising the measurement although the intervention had already occurred. Post-test secondary analysis was carried out three years after referral, again using the DoCS Client Information System, for the particular variables related to child protection outcome for the families and children.

Fig. 5.6: Steps In Implementing the Montrose Research Design with a Non-Equivalent Control Group



5.4.6 Threats to the Implementation of the Research Design.

Fitz-Gibbon and Morris (1987, p.62) describe a number of threats to design implementation which could affect the robustness of a research model. The following section demonstrates the attempts made to adequately address threats to the implementation of the research design in this study.

- *Differences between Experimental and Comparison groups in time spent on the program.*

Because the Montrose intervention is home based, there is no 'program' in terms of length of attendance, whereby some families could spend more and others less time on the program. The assessment period is two weeks, and Assessed Group families participated in the assessment process for that period, while Comparison Group did not participate in the assessment at all.

Because of the different ages of children in the 200 families in the study, the length of the child protection history measured at referral may be different for some families, but there is no indication that this is related to whether the family was in the Assessed Group or the Comparison Group. Baseline data was collected for both groups at the same point in the process (at referral) and families in both groups were followed up for the same period (three years after referral). Hence there was no difference in the time families spent as part of the follow-up study - a total period of three years, from referral to follow-up.

- *Attrition (drop outs).*

There were no "drop outs" in this study. Once a Montrose assessment had commenced for the Assessed Group, it was carried through to completion. Even if the family discontinued during the assessment week, (a very rare occurrence, a report was written from the information gained during the time spent with the family, and from agencies that had been seen before the family withdrew consent. Recommendations were made and a Case

Conference was held. Where possible, the recommendations were actioned.

The Comparison Group was made up of families that did not proceed to assessment, but for whom sufficient pre- and post-referral information existed for outcome variables to be measured, after 3 years, against the baseline situation at referral. Hence, program drop-out was not a factor in this study.

- *Confounds.*

A confound is defined by Fitz-Gibbon and Morris (1987, p.3) as: "something that happens to one group that does not happen to the other, that could influence the outcome measures for the program." They state that a sample with large numbers of subjects provides some protection against confounds because differences in what happens to them, apart from the program itself, will tend to average out.

This study contains 200 families, and over 700 children. Families from both the Assessed and Comparison Groups resided across the state of New South Wales, hence it is highly unlikely that any single factor could have affected all the families in one group, let alone affecting all of one group and none of the other. In addition, the heterogeneity of family structure, background and life situation within each of the groups affords some protection against any one factor impacting on a substantial number of cases in one group and not the other in the period after referral to Montrose.

The possible effects of confounds were also addressed in this study by the collection of data on up to five family changes per family, these changes being recorded on the family data collection sheet, so that they could be factored into the data analysis if required.

- *Contamination*.

This refers to the possibility that elements of the intervention used with the Assessed Group could inadvertently be carried across to the Comparison Group. Given that the Comparison Group families did not participate in the assessment, there was no contact between the Montrose team and the Comparison Group families after the referral process was closed. In addition, the number of cases, their diversity, and their wide distribution across the state, and the unique nature of the Montrose Program, make it highly unlikely that any aspects of the Montrose assessment for Assessed Group families could have impacted on Comparison Group families.

In summary, this section demonstrates the theoretical and practical background to the development of the research design for this study - a Quasi-Experimental Design, specifically a Non-equivalent Control Group, Pre-test, Post-test Design - and details the ways in which the research design has attempted to control for threats to validity and reliability.

The design model has elements of both summative and formative evaluation, and also attempts to apply rigorous research principles and maximise internal validity. All possible efforts have been made to ensure that the design is robust, within the limitation that the high risk nature of the participants precludes randomly assigning families to the assessed group and non-assessed group. Threats to internal and external validity have been identified and addressed as far as possible.

5.4.7 Data Sources.

The family baseline and outcome measurement in this study relies heavily on secondary analysis of statutory child protection files, sourced from the NSW Department of Community Services' (DoCS) computerised statewide child protection database, the Client Information System (CIS). The CIS records case information for all children reported to the Department,

including numbers and details of notifications, investigative action and outcome, legal intervention, placements and legal status.

Qualitative data was also available via the CIS for both Assessed and Comparison groups. This data was in the form of information contained in court and professional reports, case conferences, reviews and placement assessments. Other information came from referral and intake information from Montrose files, and, for assessed families, from the Montrose Report. Feedback on short term outcomes was taken from questionnaires sent to the families and the referring Caseworker and Manager three months after the assessment.

- **DoCS Client Information System (CIS).**

The Client Information System is the mainframe data base which was the system operating at the time of the study. It had been in operation for over 10 years at the time of the study, and also included some child protection data brought forward from the previous system, including number and type of notifications. DoCS introduced a new database system ('KiDS') in 2003, but all the information used in this study was gathered from the CIS.

A limitation of the CIS occurs when Caseworkers do not record sufficient detail onto the CIS, sometimes preferring to record details onto the locally held paper file. Another limitation is that, as a *statewide* database, it does not record events which take place outside of New South Wales. This can prove difficult with clients who live close to the NSW borders with Queensland, Victoria and South Australia, who may move across the border on occasion, (sometimes to avoid the intervention of NSW DoCS). Although the numbers are small (less than 5 families in this study), information on these clients may be lost to the CIS while they are outside New South Wales, unless information is sought by the statutory agency in another state, related to new child protection concerns. Finally, in a large organisation like DoCS, staff turnover results in a number of Caseworkers

working with a family over a period of time, which may result in inconsistencies in Caseworker information on the CIS.

Despite these limitations, the CIS proved invaluable, in most cases providing the researcher with sufficient information to provide baseline measurements for the outcome variables, to determine the child protection outcomes, and to make judgments as to the effectiveness of the interventions. Where insufficient information on outcomes was available from the CIS data, the researcher sought information from the appropriate Manager or Caseworker in the Community Services Centre responsible for the case.

Other detailed information regarding parents' childhood backgrounds of abuse and out of home placement, and/or additional information about parental substance abuse, mental health issues, and family relationships including bonding and attachment issues and domestic violence was obtained from the Montrose referral forms, and/or from professional reports, records of interview and case conference minutes recorded on the CIS.

This study used the CIS *Event History* as a template for investigating all significant child protection events for every child from the 200 families in the study who had a child protection history with DoCS. The Event History provides a unique longitudinal overview of all reports and/or interventions regarding the child.

When completed as intended, the Event History provides an extremely effective record for tracking major child protection events and interventions. An example of a full Event History record for a child can be seen in Appendix 4.3. Actual event histories in this study often continued for many A4 pages, (i.e. 10 or more). A brief sample extract is displayed in Fig. 5.7.

Fig. 5.7: Sample Extract of a DoCS Client Information System (CIS) Event History.

EVENT HISTORY

SMITH, John D.O.B: 7/12/1987 MALE 'XXX' CSC

DATE	EVENT	DESCRIPTION
25/09/96	CASE PLAN	Goal - Resolve Family Conflict
15/08/95	EXIT FROM CARE	Reason:E01 - Planned Exit To Care Of Parent
15/08/95	PLACEMENT EXIT	Reason:L01 - Child Exits From Care System
03/08/95	CASE PLAN	Goal 2-Maintain Child In/Or Restore To Family
03/08/95	ENTRY INTO CARE	Reason: Mo4, Planned Term:, Suburb A - C
03/08/95	PLACEMENT ENTRY	Type: P20 Agency Foster Care, Purpose: R40
20/05/95	REGISTRATION DECISION	Decision: 1 - Confirmed, Register
03/05/95	INVESTIGATIVE INTERVIEW	Interviewed By District Officer # 5
28/04/95	ACTUAL ABUSE	Actual Abuse: N82 Failure To Provide Food
28/04/95	ALLEGED ABUSE	Alleged Abuse: N82 Failure To Provide Food
28/04/95	NOTIFICATION	Notified At Suburb 'A' By School: Pr 2
03/09/93	REGISTRATION DECISION	Decision: 2 - Confirmed, Referred, Closed
03/09/93	EXIT FROM CARE	Reason:E01 - Planned Exit To Care Of Parent
03/09/93	PLACEMENT EXIT	Reason:L01 - Child Exits From Care System
20/08/93	PLACEMENT ENTRY	Type: P01 Foster Care, Purpose: R01
20/08/93	INVESTIGATIVE INTERVIEW	Interviewed By District Officer # 5
20/08/93	ENTRY INTO CARE	Reason: Ao4, Planned Term:, Suburb A
17/08/93	ACTUAL ABUSE	No 1 No Abuse
17/08/93	ALLEGED ABUSE	Alleged Abuse: P22 Request For Assistance
17/08/93	NOTIFICATION	Notified At Suburb 'A' By Parent 3
18/02/92	REGISTRATION CLOSURE	Closure: 1 - Child No Longer At Risk.
21/05/91	REGISTRATION DECISION	Decision: 1 - Confirmed, Register
17/05/91	ACTUAL ABUSE	N99 Other Neglect
17/05/91	ALLEGED ABUSE	Alleged Abuse: N99 Other Neglect
17/05/91	NOTIFICATION	Notified At Suburb 'B' By Police- 0- 1

The sample extract demonstrates the major child protection events in one child's DoCS child protection history, including notifications (child protection reports) , alleged reason for the notification, actual abuse type confirmed by investigation, registration (outcome) decisions relating to the notification, entry into Departmental care and placement into out of home care. Each line of the history acts as a hyperlink to further information on the CIS related to that event, with notifications and investigative interview notes often covering numerous pages.

The CIS data mining process was very productive, but also very time consuming. A practical challenge for the researcher was that because of the age and structure of the CIS database, the Client Event History printed only ten lines of information per page, requiring the researcher to print, then literally cut and paste ten to twelve pages of paper output to achieve one consolidated A4 page of history. This was an extremely time consuming

task for over 700 children in the study. Fortunately, detailed pages such as reports and interviews printed in full from the CIS and did not require the same laborious cut and paste process. Because of the laborious nature of the data mining, collating family files from the CIS for each of the 200 families in the study, and for the 744 children in those families (past and present) and analysing the information contained in those files took the researcher the best part of four years (part-time).

- **Referral / Intake Information Forms.**

All referrals to Montrose are initially made by telephone the referring DoCS Caseworker. Information is recorded by Montrose workers onto intake forms (See Appendix A) and includes demographic, parent and child information, and child protection history, e.g.:

- date and area of referral
- primary and secondary presenting problems
- parent marital status, ethnicity/cultural affiliation, socioeconomic status
- parent history of mental illness and/or drug and alcohol abuse
- history of domestic violence in the family
- number and ages of the children in the family.

Some information is also noted about children who had previously lived in the family, but were out of home during the study period, especially where there had been previous children's court action or child protection interventions.

After the telephone intake process, a more detailed referral form is completed by the referring DoCS Caseworker (*Caseworker Checklist* - See Appendix 4.2), providing more details about family history, presenting problems, previous departmental interventions and other agencies and services currently or previously involved with the family, along with the perceived strengths of the family and the Caseworker's current concerns about the family.

These forms provided information required by this study to determine the Primary and Secondary Reasons for Referral, demographic information regarding the family, ages and sexes of the children, their legal status and previous placement history, and some family background history. The researcher then used the CIS history on each child in the family (including children not currently placed with the family) to fill in any information that was not forthcoming on the referral / intake forms.

- **The Montrose Assessment Report.**

For Assessed Group families, the Montrose Report provides detailed information, from file information and from the parents themselves, regarding the past and current functioning of the family as a whole, the parent/s' own history, relationships, physical and mental health, childhood abuse, current and past substance abuse, out of home placement and/or DoCS intervention. This information was helpful in filling in gaps or augmenting the information available from the CIS and the referral forms. In addition, the Report summarises all known information regarding the developmental, child protection and placement histories of the children.

Equivalent information for the Comparison Group families came from the CIS records. Sufficient factual information was collected to provide the baseline measure of the parents, the children, the family and their child protection history at the time of referral to Montrose, and then to gauge family and children's outcome, as well as the number of notifications, type of abuse, legal status and placement history in the three years after referral.

- **Montrose Follow-up Questionnaires.**

Qualitative information was available for the Assessed Group via Montrose prepaid questionnaires routinely administered to all assessed families and their referring DoCS staff. Two separate questionnaires are used; the first (Part A) is sent immediately after the assessment, and seeks feedback on the assessment process and immediate outcomes, the second survey (Part B) is sent three months after assessment, to determine the uptake of the

recommendations of the Assessment Report and to measure short term outcome. Unanswered questionnaires are followed up once only with a duplicate questionnaire and a prompting letter. The response rate (Fig. 5.8) demonstrates that completed questionnaires provided useful outcome information for a large number of families, from the Caseworker or the family or both sources, although only a small number of families had information from both sources on both occasions.

Fig. 5.8: Response Rate for Montrose Evaluation Questionnaires for the First 100 Families Assessed: Jan 1993 – Dec 1996.

MANAGER	CASEWORKER PART A	FAMILY PART A	CASEWORKER PART B	FAMILY PART B	TOTAL RETURNS
63%	64%	38%	25%	26%	*216 / 500* = 43%

5.4.8 Data Collection Method.

Families are the major unit of analysis for the study**,** each family representing one case on an SPSS database. However, analysis of many variables was also possible at the level of individual children or parents. The file construction process was in line with the methodological principles outlines by Sarantakos (1993, pp.2-3) for case study research. Information was acquired from *multiple sources of evidence* within the casefile histories and from professional and other reports as available and a *case study data book* (family file) was created for each family, containing all material used in the analysis of child protection history and outcome for every child in the family, and for the family as a whole. Finally, the researcher *maintained a chain of evidence*, via an data summary sheet for each family, which can be used to track the source of the evidence in each family file. Other principles suggested by Sarantakos (1993) were also followed:

" - Maintain high standards of objectivity.
- Obey the code of ethics.
- Be accurate and systematic.
- Consider data collection as an element of research and not an end in itself. ……

- Avoid action that could generate distortions and errors.
- Be fair and honest…" (p.293)

A paper file was constructed by the researcher for each family. To protect the privacy of the participants, all cases (families) were given a unique identifying code number and all relevant case file data was coded and transferred onto Family Data Sheets, identified only by the case code number. Information from these family data sheets was then transferred to an SPSS* data base, each case being identified only by its allocated code number. The family file included copies of CIS documentation for every notification made on each child in the family. These extracts, including records of investigative interviews also provided information regarding the parents, and in many cases, siblings. Caseplan and Case Conference notes also provided information regarding the child and family before and after referral to Montrose.

Information on relevant variables for analysis was transferred onto the SPSS database constructed for the study and included:

- demographic variables related to the *family* - e.g. socioeconomic status, ethnicity, marital status, domestic violence;
- variables related to the history and life situation of the *parents* - e.g. age, sex, attained educational level of primary carer, history of childhood abuse, history of childhood placement, mental health status, drug and alcohol issues
- variables related to the *children,* e.g. age, sex, ordinal position, legal status, history of out of home placement, number and type of notifications of risk of harm.

* Statistical Package for the Social Sciences: Version 10. SPSS® ; SPSS Inc (1989-2002): SPSS for Windows Release 11.5.0 (Sept 2002)

Individual children's *child protection history* was obtained from the child's CIS Event History (See Appendix 4.3) and included:

- the number of notifications of risk of harm or alleged maltreatment.
- the reason for notification/alleged abuse and outcome of investigation.
- legal status.
- children's out of home placements

For comparison purposes in the analysis of data, the researcher marked a line on each child's Event History at the date of referral to Montrose. The child protection history was then bracketed three years before and after this point, creating a six year event history for each child. Data was then collated for the relevant variables for pre-referral and outcome comparison. Relevant variables included the number of notifications for each child in the three years before referral, the type of abuse or neglect being alleged, outcome of investigation (whether the abuse was confirmed or not), legal status and out of home care placement details. This information was used as baseline data for comparison with the same variables three years after referral.

A potential limitation with the data collection methodology relates to the counting of 'confirmed' and 'unconfirmed' allegations of maltreatment as pre-test and outcome measures. In practice, the DoCS Caseworker's Confirmation of an allegation of child maltreatment relies on a number of factors:

- **Priority given at local management level as to whether an investigation will be conducted into the allegation of maltreatment.** This decision is taken in the context of competing workload demands, requiring prioritisation of all incoming notifications, against those perceived to involve greater immediate risk or more highly vulnerable children. During the period of this study, less urgent or lower risk notifications could be rated 'unallocated' and held for a period of time, after which they could be closed without investigation if no further notification was received. These

notifications would then be closed as 'not confirmed', even though no investigation took place.

- **Locating and interviewing the relevant family members**. With highly mobile families and sometimes insufficient information in the original notification, some families are not located. These allegations would be classified 'not located, not confirmed'.

- **Insufficient evidence of abuse**. In cases where the investigation commences, in the absence of an admission by the perpetrator or physical evidence, confirmation of abuse may rely on a number of factors related to the presentation of the adults, and/or the ability of the child to provide coherent information related to the alleged abuse. The young age of some notified children, together with their often limited communication skills can disadvantage them, leaving the final decision as to whether to confirm abuse to be decided on a number of subjective factors. Therefore, a notification may not be confirmed because there is insufficient first hand evidence, even though the same concerns may be reported by a number of different notifiers.

These limitations have been noted by other researchers. In a large study of child protection re-referrals in the US, English et al (1999) found that the rate of substantiation is affected by the rate of *investigation* of notifications, which in turn is impacted by workload capacity, screening criteria and standard of proof, rather than whether maltreatment has actually occurred. In order to deal with the above limitation, this study operates on the principle of counting *all* notifications, whether confirmed or not. However, both sets of data were collected for comparison purposes.

Information regarding dates and circumstances of previous Children's Court orders or voluntary undertakings were clearly available on the CIS. Similarly, respite care, temporary foster care (both voluntary) or court ordered placements were all listed in the event history and in more detail in the CIS file notes. Some information regarding the parents' history and life

circumstances could be obtained from the CIS records of investigative interviews, and from court papers, professional reports, case conferences and reviews from the CIS or accompanying the referral documentation.

5.4.9 Outcome Measures.

Overall outcomes for the Assessed three years after referral were compared with those of the Comparison Group, using the Montrose assessment as the independent variable. Other independent variables - demographic, family, parent, child, and child protection service related - were also selected for testing against the various measures of child and/or family outcome. To evaluate the Montrose program and other results, seven major outcome variables were measured three years after referral. These are:

1. Family Outcome.
2. Children's Outcome.
3. Children's Legal Status.
4. Children's Placement.
5. Number of Notifications.
6. Number of Confirmed Notifications.
7. Type of Abuse.

Most outcome information was obtained from the CIS data for each notified child in the family, via the Event History, notification summaries, case conferences and reviews, file reviews, court papers and medical, psychological, educational or other professional reports. In many cases, the Case Conference following the Montrose assessment was documented, or, at least, a Case Plan was entered onto the system, outlining the actions to be taken, by whom, and a review timetable.

The CIS information often provided updates regarding family structure, current life circumstances of the individual child and his/her family, and information regarding other family members related to the reported child, including siblings who may not reside in the family home but have a child

protection history. From this information, it was often possible to determine whether circumstances improved, were unchanged or became worse, for each child within the family, and for the family as a whole.

If the data is entered by caseworkers as required, it is possible to track family relocations via the CIS, which lists the current address for the child at a given date. Additionally, if families or individual children move within the state of NSW, record should be noted on the CIS regarding a file transfer to the DoCS Community Services Centre responsible for the case in the new location. In some cases, finding no further information entered onto the CIS may indicate that the family has left the state of NSW, as Australia currently has no national child protection reporting database. However, unless there is positive change in relation to child protection issues, the type of high risk families in this study tend to come to the attention of the welfare (or justice) system in the new state. In two such cases in this study, the Child Protection agency in the receiving state made a request to DoCS for information about the family's history in NSW. From this request, which was noted on the child's CIS file, it was possible to determine some information about the family's current structure and circumstances and its progress.

No new information or notifications on the CIS for any child in the family in the three year follow-up period could indicate that there have been no further child protection concerns reported to the Department. This can be clearly established if the case is formally closed on the CIS with a closure summary. In other cases where there were no further entries on the system, it was possible for this researcher to seek information directly from the last DoCS Community Services Centre (CSC) to have dealt with the family, to confirm that although the case had not been formally closed, the family was still in the area, but not raising child protection concerns for the Department.

Changes in legal status are recorded on the CIS database for each child. It is therefore possible to determine whether a child moved out of the parental

responsibility of his/her parent, for what period of time, and whether the child is restored to his or her parent's responsibility in the follow-up period. The outcome results noted the numbers of families with children entering and exiting state care in the three years following referral.

The CIS also lists the out of home care placements, voluntary or non-voluntary, for each child, so that number and types of out of home placements per family could be compared before and after referral. Restoration of children from placements to their family homes could also be tracked. Where available, qualitative data from evaluation questionnaires from Assessed families was also used for short term outcome information and to determine if the Montrose recommendations had been put into action.

The Family Outcome and Children's Outcome variables are both composite variables, rated by the researcher, based on all documented file information, and the family's results in the other Outcome categories (Number of notifications per family; Number of confirmed notifications per family; Type of abuse reported per child and per family since referral; Legal status of the child/ren during the follow-up period; Placement history of the children since referral). Methods of controlling for rater bias and internal evaluator bias have been discussed earlier in this chapter.

Up to five *'Family Changes'* variables were recorded per family, and these also contributed to the rating of Family Outcome and Children's Outcome. These involved changes in family circumstances since the referral to Montrose, and their positive or negative impact on the wellbeing of children within that family. They include changes in children or parent/s' life situation, family structure changes, relocation, physical or emotional illness (or death) of child or parent, positive effects of interventions or in parent/s' care of the children, and negative events or lack of change in the parent/s' parenting capacity. Appendix 4.8 lists all Family Changes for the 200 families in the study, by Assessed Group and Comparison Group. This list

of Family Changes shows how these could be used to assist the researcher in rating overall Family Outcome and Children's Outcome. Fig.5.9 describes some examples of Family Changes in this study which affected children's life situations in positive and negative ways.

Fig. 5.9: Examples of some Family Changes and their Positive and Negative Impact on Children's Life Situation: Assessed Group and Comparison Group.

FAMILY CHANGES: POSITIVE IMPACT ON CH/N'S LIFE SITUATION	MONTROSE (ASSD GP)	COMP. GROUP
Children restored to family	5.7%	4.4%
Improvement in parents' care of Child/ren	12.6%	0.21%
Interagency Intervention with positive outcome	5.7%	1.8%
Parent psychiatric treatment with positive outcome	2.0%	0.7%
Improvement in parents' relationship – positive for chn.	1.4%	0.7%

FAMILY CHANGES: NEGATIVE IMPACT ON CH/N'S LIFE SITUATION	MONTROSE (ASSESSED GP)	COMP. GROUP
Children removed from family (S/T or L/T)	5.9%	8.1%
Multiple supports, but no change in quality of parenting	1.5%	4.4%
Parent Drug/alcohol abuse direct impact on ch/n	2.5%	6.0%
Domestic Violence +/- Court Order (AVO)	0.5%	2.1%

The Family Outcome and Children's Outcome variables each represent an overall picture of the child or family's functioning against outcome measures of *safety, permanency*, and *family and child wellbeing* suggested by Usher 2004:.

"*Safety:*

- Children are… protected from abuse and neglect.
- Children are maintained in their homes whenever possible and appropriate.

Permanency

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.

Family and Child Well-being

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.

- Children receive appropriate services to meet their physical and mental health needs." (Usher 2004, p.425)

The rating of Family Outcome is measured in terms of documented change in the family's situation, lifestyle and child protection issues, compared with the situation at the time of the family's referral to Montrose. Change is viewed in the context of the primary presenting problem and secondary representing problems at referral, and measured in terms of improvement in the parent/s' ability to provide a satisfactory level of safety, welfare and wellbeing for their children.

Rating of Children's Outcome takes into account physical factors related to safety and wellbeing, and also how well the children's emotional and developmental needs are being met by their parents or carers three years after referral.

It is important to note that the rating of Children's Outcome is a more conservative measure than that for Family Outcome. A major goal of the Montrose Program is to try to prevent the child/ren's placement outside their family. Therefore, given the impact on the child's life of any period of involuntary separation from his/her parent/s and siblings, even a short term out of home care placement (up to 6 months) following Montrose referral is seen as a negative outcome for that child. The child's situation would therefore be rated as 'Worse'. If parents (or children) make significant changes, or their lifestyle or circumstances permits successful restoration within three years of the Montrose referral, and the child's safety, welfare and wellbeing needs are then able to be met within the family, this positive outcome would be reflected in a Family Outcome rating of 'Improved.'

5.4.10 Factors that may Impact on Outcomes.

- *For Assessed Group Families:*

Time is a critical issue when considering how long the process and outcomes of the Montrose assessment can still be presumed to be having an impact on the family. The families referred to Montrose typically have a

fairly 'eventful' lifestyle. Many changes, planned and unforseen may occur in family members' lives and impact on individuals and on the family as a whole. The longer the period of time since the referral to Montrose, the more likely that some significant environmental or relationship changes will have occurred in the family. The types of issues that may have an impact on the child or family's outcome following Montrose assessment include:

- One or both parents not following through with the recommendations of the assessment.
- Child Protection Caseworker supervising the family does not follow through with the recommendations, or does not implement them quickly enough after the assessment.
- Recommended services are not available to provide the requested service in the required time period.
- The referral to the support agency breaks down before the family is fully engaged with the recommended service.
- There is insufficient funding available to provide the level of service and support required by the family.
- Services commence but the caseplan is not regularly reviewed to ensure it continues to meet the family's changing needs.

- *For Assessed Group <u>and</u> Comparison Group Families:*
  - Parent relationship breakdown.
  - Parent forming a new relationship.
  - Birth of a new child.
  - A parent resumes drug or alcohol abuse.
  - A parent suffers physical or mental health problems.
  - Domestic violence issues emerge (or re-emerge) in the same or subsequent parental relationship.
  - Housing difficulties or other family crisis.
  - Family relocates out of area and there is a delay in the file being transferred to or picked up by the new supervising Department of Community Services office.

Additional limitations to the ability to follow up families via the CIS include the potential for inconsistency in recording events as constituting or not constituting a notification. For instance, an incident may be considered to constitute a notification if the family is not already involved in a treatment or counselling program. The same incident reported to DoCS may not be considered to require a new registration and investigation if support services are already in place as a result of the referral to Montrose, and these can address the child protection concerns as part of the service.

Similarly, the recording of new notifications may be affected in either direction if the child protection Caseworker has already put a lot of time and effort into a family. There is a chance that both Assessed Group and Comparison Group families may be seen as having exhausted all available resources after referral to Montrose, with the effect that the Caseworker 'gives up' and does not respond with the same vigour to subsequent notifications for the same reasons as previously notified. The converse may also occur, i.e. the Caseworker may be frustrated by the apparent lack of progress through less intensive interventions and move to court action.

5.5 Data Analysis Method Used in This Study.

5.5.1 Multinomial Logistic Regression (MNLR).

In this study Multinomial Logistic Regression was used to analyse the relationships between the dependent (outcome) variables and a number of independent variables (Hosmer and Lemeshow 1989, 2000; Schwab 2003; Garson 2003). Multinomial Logistic Regression is the appropriate data analysis technique for data which is primarily *nominal* (categorical), as is the case in this study, rather than ordinal or higher levels of measurement. It is used when the dependent variable is non-metric, however, the independent variables may be metric or nominal.

The dependent variables in this study are child protection Outcome categories three years after referral: Family Outcome; Children's Outcome; Legal Status; Out of Home Care Placement; Number of Notifications; Number of Confirmed Notifications; Type of Abuse. The independent variables include demographic, family, parent, child and child protection service and child protection history-related variables.

MNLR describes a relationship between the dependent (Outcome) variable and a *combination* of significant independent variables. It is a statistical technique which creates a "Main Effects" Model, produced by the combination of independent variables that are most strongly associated with the dependent variable. Using MNLR, groups of independent variables can be compared to the same dependent variable, by designating one category of the dependent variable as a *reference* category. This technique allows for n -1 comparisons, where n=number of categories of the dependent variable (Schwab 2003).

In SPSS*, the Main Effects Model is produced by a standardised technique of data analysis, and is displayed in an output which includes:

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* SPSS Inc (1989-2002): SPSS for Windows Release 11.5.0 (Sept 2002)) and SPSS Inc (2003): SPSS v.12.0.

- a case processing summary of the Independent and Dependent variables.
- the Chi Square significance of the model.
- the Likelihood Ratio Test of each of the independent variables in the model.
- the predictive relationship between independent variables and the dependent variable (displayed in the Parameter Estimates table.)

Multinomial Logistic Regression does not estimate the relationship between the independent variables in the model, (although the overall measure of this relationship can be seen to a degree in the Pseudo R-square table of the SPSS MNLR output.)

5.5.2 The Multinomial Logistic Regression Model-Building Procedure.

Using the guidelines developed by Hosmer and Lemeshow (1989, pp.25-35; 106-118), Collett (1994, p.80), and Garson (2003, pp.1-21) and using SPSS v.11.5 and v 12.0*, the method of model-building used in this study is as follows:

1. An initial run using MNLR tests all relevant independent variables in the database for a bivariate relationship between the independent variable and the relevant dependent (outcome) variable at the level of significance of $p=0.10$ or less (Collett 1994, p.81).

2. Sets of significant independent variables from Step 1 are combined with each other, using the SPSS MNLR stepwise forward entry main effects method to construct models with strong relationships ($p<0.05$) between the dependent variable and a number of independent variables.

3. The forward entry method starts with no variables in the model, and at each step, adds the most significant variable until none of the variables left

* SPSS Inc (1989-2002): SPSS for Windows 11.5.0 (Sept 2002) and SPSS Inc (2003): SPSS v.12

out of the model would have a statistical contribution if added to the model (SPSS Inc. Help 2003).

4. The statistical evidence for a relationship between the dependent variable and the combination of all independent variables that comprise the tentative Main Effects Model is found in significance of $p<0.05$ in the final Model Chi-square, based on the Likelihood Ratio Test (LRT). This information is found in the Model Fitting Information table in the SPSS MNLR output. e.g.

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	454.557			
Final	388.338	66.220	16	.000

5. The significance of removing each of the initial independent variables from the final model is found in the Likelihood Ratio Tests table in the SPSS MNLR output. e.g:

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	81.490[a]	.000	0	.
MONTROSE	134.636	53.146	2	.000
ADDHDYN	90.905	9.415	2	.009
TB4CNTC2	90.662	9.172	2	.010
MALECH2C	89.070	7.580	2	.023

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

6. For the tentative final model above, all four independent variables are significant at the level of $p<0.05$ or better.

7. The number of significant independent variables retained in the final model is determined in line with the number of parameters (Hosmer and Lemeshow 2000, pp.346-7). This requires a minimum of 10 events per parameter for either the number of occurrences for the event of interest <u>or</u> the reference group (whichever is smaller). A categorical variable with k levels is considered to have (k-1) parameters, e.g. the categorical variable

"Sex: male/female" has 2 levels and therefore one parameter. A continuous variable has one parameter, e.g. the continuous variable "Age in years" has one parameter.

8. Tests are run for interactions between the significant variables in the model, and any significant interactional effect constitutes a new variable in the model.

9. Previously non-significant variables at Step 1, or variables that were significant at Step 1 but dropped out at Step 2, and variables that theory would suggest might be significant, are tested again against the existing variables in the model.

10. The final model/s are tested for possible numerical problems using the Standard Error section of the Parameter Estimates Table. Numbers greater than 2.0 suggest possible numerical problems (Schwab 2003, p.14).

11. The final model/s are then tested for utility of the model by ensuring that the overall percentage accuracy rate for the dependent variable[*] exceeds the proportional "by-chance" accuracy rate by 25%.[#]

The resulting Main Effects Model/s are determined to be the strongest valid models possible for the data and sample size in this study.

5.5.3 Odds Ratios in Multinomial Logistic Regression.

MNLR can be used to estimate the probability that a subject who is a member of one group (category) in an independent variable will be a member of a particular group (category) in the dependent variable. This probability can then be used to express the relationships between the independent and dependent variables in odds ratios.

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[*] Found in SPSS MNLR Classification Table Output.

[#] Computed by summing the squared proportion of cases in each category of the dependent variable and multiplying the result by 1.25%.

For example, in this study, if the dependent variable of interest is FAMILY OUTCOME, with outcome categories *Improved, No Different* and *Worse*, the reference category could be designated as '*Worse*', and two sets of comparisons can be made: *Improved* vs *Worse* and *No Different* vs *Worse*.

The equation can then also include the odds for the Assessed Group to be *Improved* vs *Worse* relative to the Comparison Group being *Improved* vs *Worse* (Fig. 5.10).

Fig. 5.10: Formula for Odds ratio (Likelihood) of Montrose Assessed Group Families being in the Improved rather than Worse Outcome Category, relative to Comparison Group families.

$$\textbf{ODDS RATIO} = \frac{\dfrac{\text{Probability (IMPROVED)}}{\text{Probability (WORSE)}}}{\dfrac{\text{Probability (IMPROVED)}}{\text{Probability (WORSE)}}} \quad \begin{matrix}\text{MONTROSE ASSESSED GROUP} \\ \hline \text{COMPARISON GROUP}\end{matrix}$$

The Odds Ratios for the relationship of each independent variable to the dependent variable are *specific to each individual model*, and the combination of the dependent variable and independent variables within that model.

5.5.4 An Example of Multinomial Logistic Regression.

Fig. 5.11 (below) describes an example where the Dependent Variable FAMILY OUTCOME has three categories: *Improved, No Different* and *Worse.* In this example, *Worse* is the reference category, against which the other two categories - (*Improved* and *No Different*) are measured.

Each independent variable has a dummy coded category, to which the other categories of that independent variable are compared.
e.g. In Fig.5.11, the independent variable 'Montrose' has two categories:

- Montrose=1 (the Assessed Group) and
- Montrose=2 (the Comparison Group).

Montrose=2 (the Comparison Group) is the *reference variable*, against which Montrose=1 (the Assessed Group) is compared.

Using the information in Fig. 5.11, MNLR provides the following information:

1 There is a significant relationship (p=0.000) between the dependent variable (Family Outcome) category *Improved* and the independent variable category *Montrose=1* (Assessed Group). This relationship is relative to the dependent variable reference category Family Outcome *Worse* and the independent variable reference category *Montrose=2* (Comparison Group).

This relationship could be expressed by the proposition that Assessed Group families are significantly more likely to have an *Improved,* rather than a *Worse* Family Outcome, relative to Comparison Group families (p<0.001).

Fig. 5.11: Multinomial Logistic Regression: SPSS Parameter Estimates Output for Family Outcome (Dependent Variable) and Montrose Assessment vs No Assessment (Independent Variable).

Parameter Estimates

FAM OUTCOME 3 YRS AFT REFERRAL REF: WORSE		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT IMPVD	Intercept	-1.041	.336	9.620	1	.002			
	[MONTROSE=1]	2.604	.454	32.940	1	.000	13.51	5.55	32.9
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
FAM SIT NO DIFF	Intercept	.111	.236	.222	1	.638			
	[MONTROSE=1]	.415	.422	.966	1	.326	1.514	.662	3.46
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Again using the information in Fig. 5.11, MNLR provides the following information:

2 For families who participated in a Montrose Assessment - *Montrose=1* (Assessed Group) - the likelihood (odds ratio) of being in the *Improved* category of Family Outcome is **13.51 times greater** than for being in the *Worse* group (reference category), *relative to* Families who did not have a Montrose assessment, i.e. *Montrose=2* (Comparison Group families).

While the strictly correct form of reporting requires reference to the odds ratios for each set of relationships, for ease of reading, the above form of reporting results in terms of *likelihood* is used throughout this thesis.

In summary, the appropriate model for analysing the type of research data in this study is Multinomial Logistic Regression. This procedure is able to analyse the relationships between categorical (nominal) independent variables and the dependent (outcome) variable in the same way that logistic regression would be used if the independent variables are numerical (numbers, means etc). It expresses the relationships between a number of independent variables and one dependent (outcome) variable, in the context of a specific Main Effects Model, formed from the statistically strongest *combination* of independent variables and the dependent variable. MNLR does *not* describe the relationship between the independent variables *within* the model.

Equations in MNLR can be used to estimate the probability (i.e. likelihood or odds) that a subject who is a member of one group or category in an independent variable will be a member of a particular group or category in the dependent variable.

In addition to the Main Effects Models, the study also includes an examination of the significance of bivariate relationships between many independent variables and the Outcome variables.

5.6 Summary: Research Questions and Methodology

The Primary Research Question for this study relates to evaluating the child protection outcome three years after referral for families who participate in a Montrose Home-based Family Assessment, compared with equivalent Comparison Group families who do not participate in the assessment. The major research hypothesis is that incidence of positive child protection outcomes for children will be higher in families who participate in the

Montrose assessment than for the Comparison Group families. The hypothesis is based on the belief that engaging families in defining their own problems and needs, and in developing solutions, will increase the likelihood of the families engaging with services that assist them to make and maintain positive change.

The other Research Questions and Hypotheses reflect an ecological perspective that individual, family, and child protection systems based factors impact on child protection outcomes in tertiary level families, and that child protection outcomes will be worse if a combination of these factors is present.

The research design used in this study is a Quasi-Experimental Pretest, Post-test Design, with a non randomly selected Comparison group. Outcomes for the 100 Assessed Group families and the 100 Comparison Group families are compared using a number of specific Outcome variables three years after referral - Family Outcome; Children's outcome; Number of notifications per family; Number of confirmed notifications per family; Type of abuse reported; Legal status of the child/ren during the follow-up period; and Placement history of the children since referral.

Multinomial Logistic Regression is used to determine Main Effects Models, comprised of the set of factors - demographic, family, parent, child or child protection service variables - that are most significantly associated with each of the outcome variables, and therefore predictive of positive and negative child protection outcomes.

Chapter 6 describes the Study Group in general and the Assessed Group and Comparison Group in detail, in order to assess their comparability on all major variables at the time of the families' referral to Montrose.

CHAPTER 6: THE STUDY GROUP.

The study group consists of 200 families, referred from 84 different Department of Community Services offices across NSW to the Montrose Home Based Family Assessment Program, between its inception in January 1993 and December 1996. The families all met the Montrose criteria for referral, i.e. that:

- the children's ongoing placement in the family is in jeopardy because of serious and/or chronic child protection issues,
- there is a DoCS Caseworker currently assigned to the family,
- there are no immediate safety risks to the children and
- there are some areas of strength identified within the family.

The **Assessed Group** comprises the first 100 families who participated in a Montrose home-based family assessment from January 1993. The **Comparison Group** is made up of 100 families who were referred to the Program during the same period as the Assessed Group, and met all criteria for referral, but for various reasons, did not proceed to an assessment. The Comparison Group is not a strictly consecutive list of referrals, but contains the first 100 families in the non-assessed group for whom sufficient objective referral information was available to provide a baseline measurement on the specific variables measured when each family's outcome was reviewed three years after referral.

It is important to note that this study does <u>not</u> include those families who were referred to Montrose, but where the level of immediate risk to the children was regarded by Montrose as too great to allow the children to remain in the family home, even for the 5 day period of the assessment. In these cases, the referral was declined, often with a recommendation of immediate removal, to ensure the children's safety. Because of the higher level of immediate risk to the children the time of referral, this subgroup would not have been comparable with either the Assessed and Comparison groups.

It is also important to establish that although lack of parental motivation may have been a factor in determining why some Comparison Group families did not choose to proceed to assessment, a number of Assessed Group families stated during the assessment that they were not initially motivated to participate in the assessment, but decide to do so because they found it the least undesirable of the available options offered by the referring Caseworker. Therefore, lack of parental motivation alone is not a distinguishing feature between the Assessed Group and the Comparison Group.

This chapter examines the two groups in detail for comparability at time of referral, and for baseline (pre-test) measures on the major variables that were used to measure outcome (post-test).

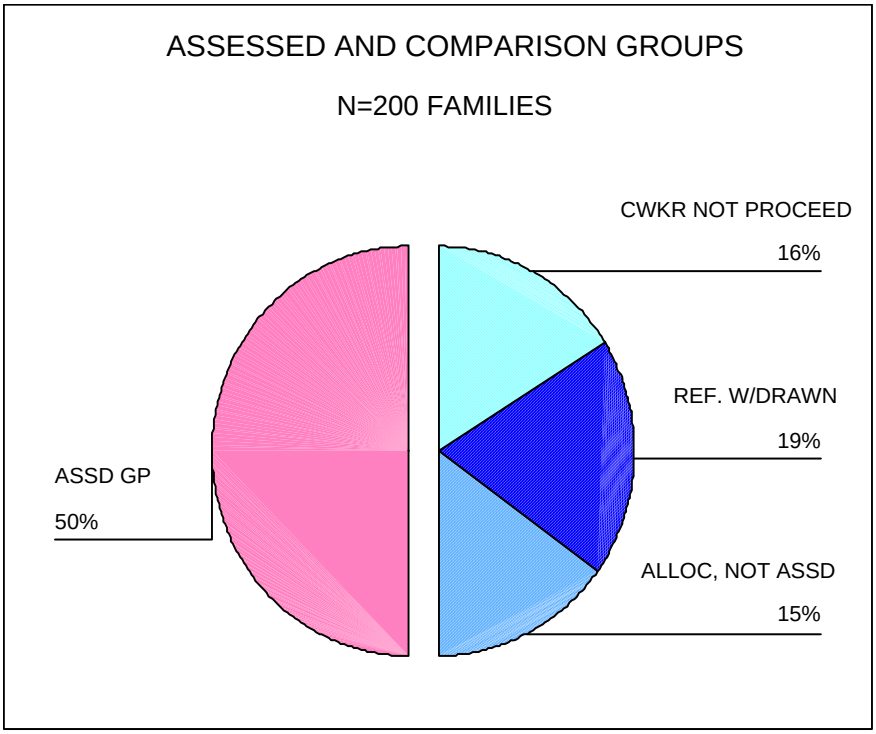
6.1 Referral Information.

6.1.1 The Assessed Group and Comparison Group.

The Study Group comprises 100 Assessed Group and 100 Comparison Group families. The Montrose program is voluntary and parents can withdraw from either the referral or the assessment process at any time. In addition, referring Caseworkers do not always complete the referral process.

The Comparison Group is comprised of families who chose to withdraw during the referral process (38%), families where the referral process was not completed by the referring Caseworker (32%), and families who were accepted by Montrose and scheduled for assessment, but withdrew before the assessment took place (30%). Figure 6.1 depicts the Study Group.

Fig. 6.1: The Study group. (N=200 Families.)
Assessed Group n=100; Comparison Group n=100.



The Comparison Group families did not complete the referral process for a variety of reasons, including:

- One or both of the parents unwilling to participate in the assessment.
- One or both parents unable or unwilling to take time from work to participate in the assessment.
- The parent/s' legal representative advised against participation.
- The family was undergoing a significant change or crisis at the time of referral, e.g. accident, illness, family being evicted.
- The family relocated, sometimes interstate.
- The children were unwilling to participate in the assessment.
- The Caseworker decided not to proceed with the referral process:
  - preferring to use a less intrusive intervention, or
  - preferring to use a more intrusive intervention (Court).
- The case changed hands and was not allocated to a Caseworker, or the new Caseworker did not continue with the referral.

6.1.2 Date of Referral.

All families in the study were referred to Montrose between January 1993 and December 1996. There is no significant difference between the Assessed Group and Comparison Group in the distribution by years. The number of Assessed Group families was greater in 1993 and the number of Comparison Group families was greater in 1996. The numbers were the same in the other two years. The total number of assessment and referrals was lower in 1993 because this was the first year of the program's operation and referrals were slower in this year until the program was promoted across the Department.

As Montrose staff numbers and the amount of time allocated to an assessment are finite, only a certain number of assessments can be conducted each year. Families who are accepted for assessment but drop out before the assessment negatively affect the number of assessments that can be completed in any year, as the date for these assessments is set, and time is lost in renegotiating another family to be available for that assessment period.

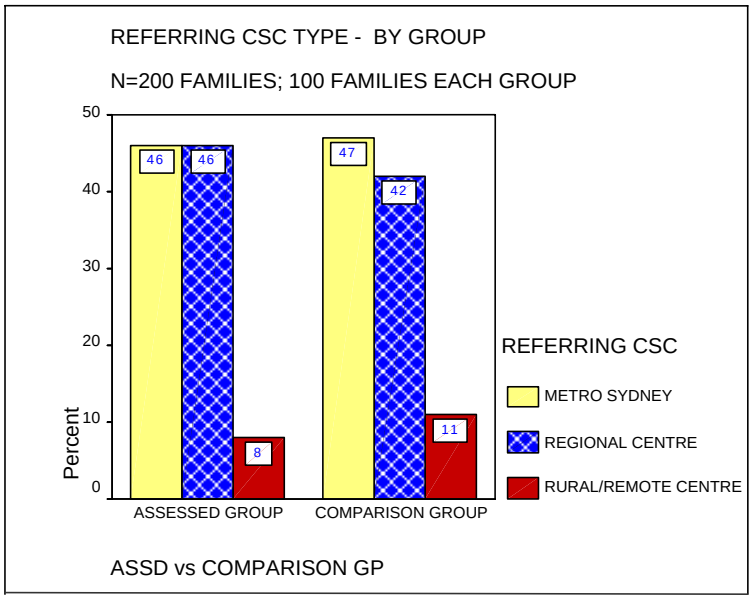
6.1.3 Home Location of Families (Referring CSC).

Montrose is a statewide service, receiving referrals from Community Services Centres (CSCs) located in all parts of New South Wales. The population of New South Wales is heavily concentrated in the Sydney metropolitan area and some seaboard regional centres, as well as a number of other large regional centres throughout the state.

The distribution of referral location is almost identical for the Assessed Group and the Comparison Group (Fig. 6.2). The referring Community Services Centres were located across the Sydney Metropolitan area, within state Regional centres, and in some major rural and remote centres. Referrals in the study are almost evenly distributed between Metropolitan Sydney

(46.5%) and the rest of NSW (53.5%), the latter being comprised of regional centres 44% and rural and remote centres 9.5%.

Fig. 6.2: Referring CSC Location. (N= 200 Families.)
Assessed Group n=100; Comparison Group n=100.

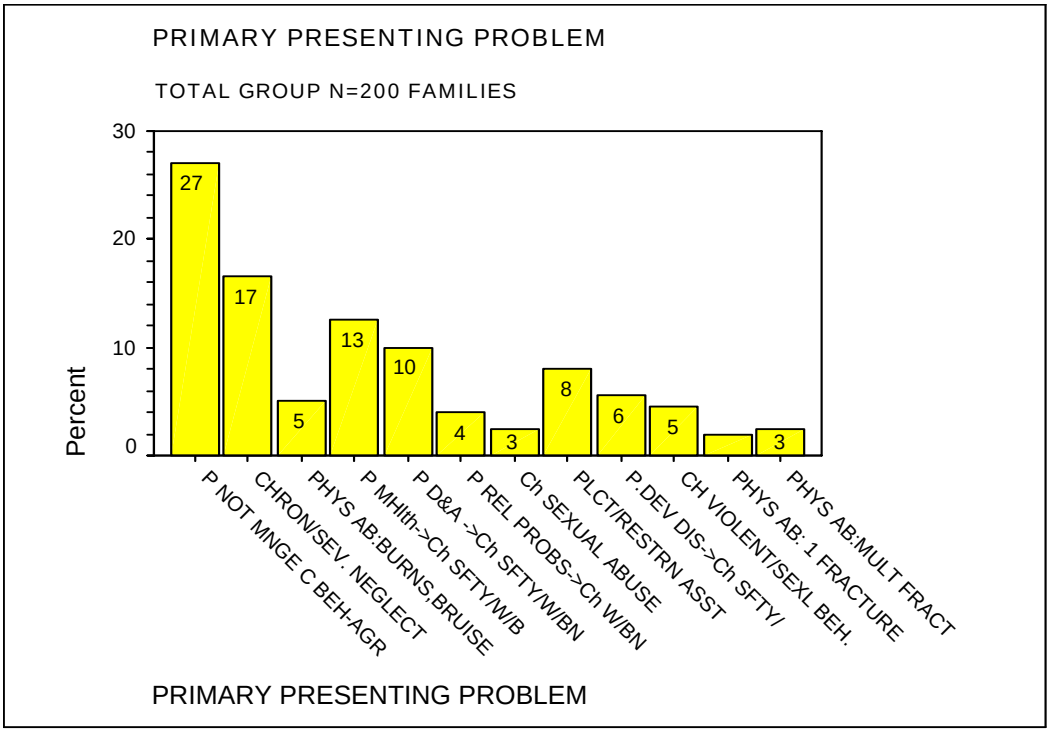


At the time of this study, DoCS was divided into 8 Areas covering NSW. Metropolitan South-West Sydney was the highest referring source for the Assessed Group and the equal highest (with Metro West) for the Comparison Group. This may be explained by family pressures associated with the general demographics of this area, which is characterised by low socio-economic status, high unemployment, and a high proportion of newly arrived and established migrant families, many from non-English speaking backgrounds.

6.1.4 Primary Presenting Problem at Referral.

In this study, the Primary Presenting Problem relates to the main reason for referral, as designated by the referring DoCS Caseworker. One Primary Presenting Problem per family was collected for the study, with up to three Secondary Presenting Problems, as designated by the referring Caseworker, and/or in the Montrose Referral and Intake forms. Fig. 6.3 represents the distribution of Primary Presenting Problems for the 200 families in the study.

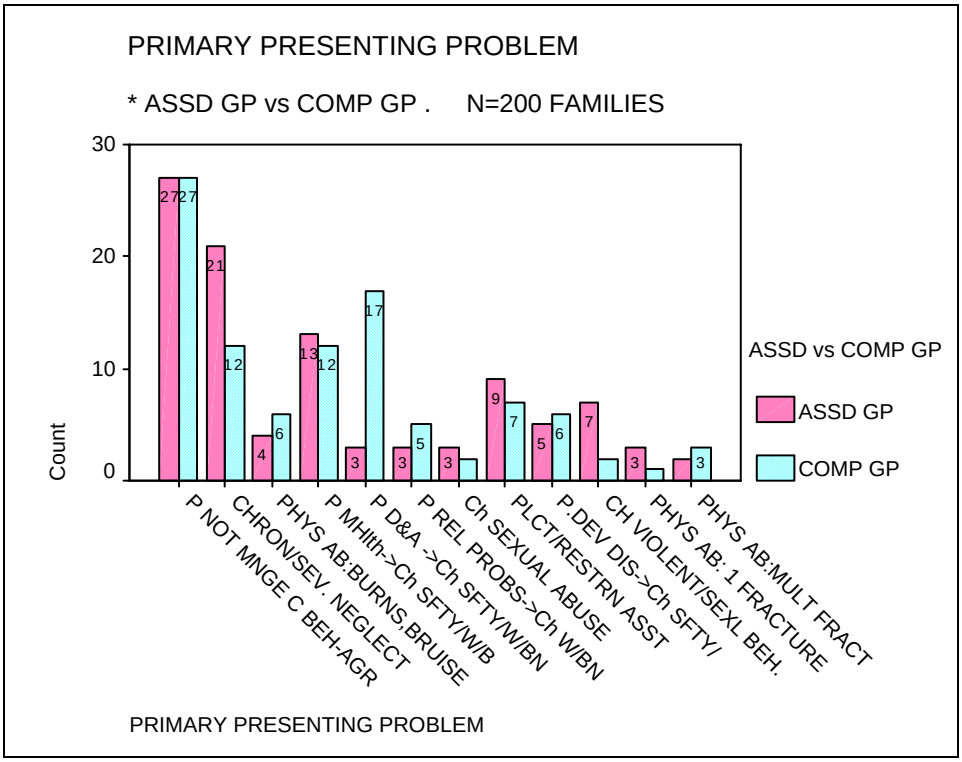
Fig. 6.3: Primary Presenting Problem: Total Study Group. (N=200 Families).



Parental inability to manage their children's aggressive or risktaking behaviour is the most frequent reason for referral (27%), followed by chronic or severe neglect (17%). Parent mental health issues (13%) or substance abuse (10%) affecting the children's safety, welfare and wellbeing are the next most frequent Primary Presenting Problems. Various types of serious physical abuse (fractures, burns and bruising) account for a total of 9% of referrals.

When Primary Presenting Problem is compared by Assessed Group and Comparison Group, there is general congruence across most categories (Fig. 6.4). The most frequent category, "Parent Not Manage Child/ren's Behaviour-Aggressive, Risk-taking" accounts for 27% of the study group, and is equally represented in the Assessed and Comparison groups. Chronic / Severe Neglect" is the next highest presenting problem overall, with 16.5% of the total study group, 10.5% in the Assessed Group, and 6% in the Comparison Group.

Fig. 6.4: Primary Presenting Problem at Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



There is one noticeable difference between the Assessed Group and Comparison Groups, in the category relating to Parent'/s Drug and Alcohol Abuse affecting Child/ren's Safety or Wellbeing. This category accounts for 10% of the total study group, but interestingly 17% of the Comparison Group, compared with only 3% of the Assessed Group. The difference is not significant at the $p<0.08$ level, but is also reflected in the figures for parent/caregiver substance abuse referred to later in this chapter.

A clearer picture of parental substance abuse in the Assessed Group may be seen when the Secondary Presenting Problems are taken into account, but the problem is also slightly higher in the Comparison Group's Secondary Presenting Problems. A crosstabulation of "Parent Drug and/or Alcohol" as a Secondary Presenting Problems with all Primary Presenting Problems demonstrates that there is a level of association between Parent Substance Abuse as a Secondary Presenting Problem and Chronic/Severe Neglect as a Primary Presenting Problem. It may be that parental substance abuse is

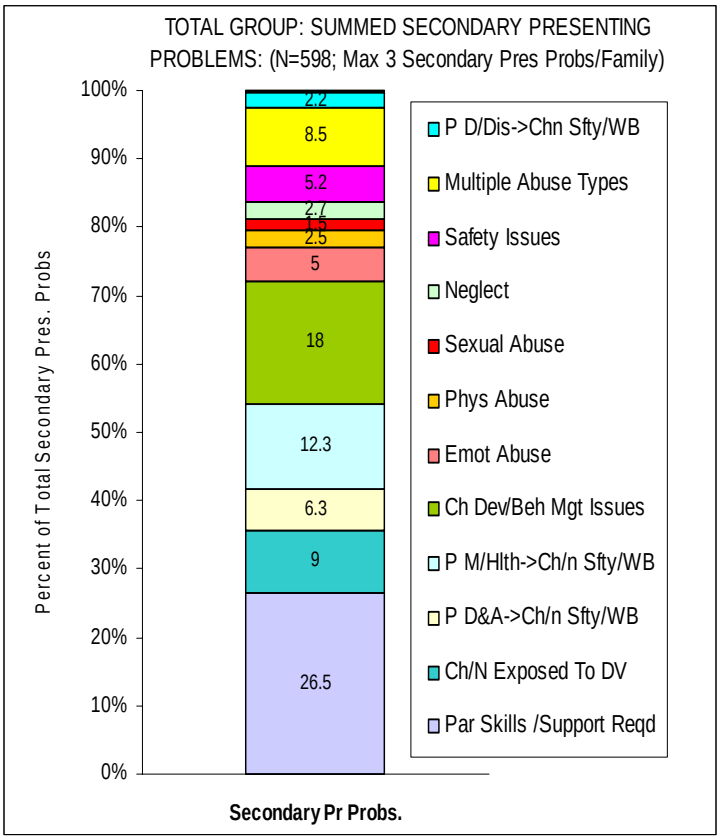
captured in its effect on the parent/s' ability to provide adequate care for the children in Assessed Group families.

6.1.5 Secondary Presenting Problems at Referral.

Up to three Secondary Presenting Problems are documented for each family, using information from the referring Caseworker, and/or from the Montrose Referral and Intake forms. Fig. 6.5 demonstrates the distribution of summed Secondary Presenting Problems for the study group.

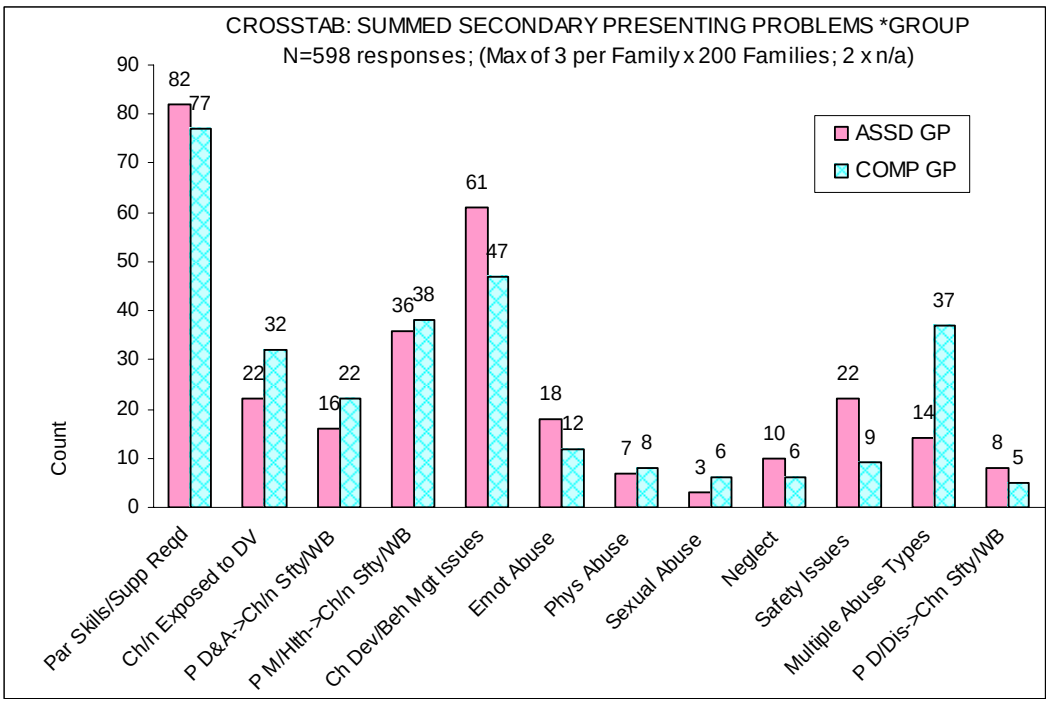
The most frequent Secondary Presenting Problem in both the Assessed and Comparison Groups is "Parent Skills or Support Required", which represents 26.5% of the total Secondary Presenting Problems variable. "Child/ren's Developmental or Behavioural Issues" is the next most frequent category (18%), followed by "Parent/s' Mental Health Affects Child/ren's Safety / Wellbeing" (12.3%).

Fig. 6.5 : Secondary Presenting Problems/Family at Referral: Total Study Group. (N=200 Families x up to 3 Problems per Family)



A comparison of the summed Secondary Presenting Problems (Fig. 6.6), indicates a comparable distribution between the Assessed Group and the Comparison Group, except in the categories of "Multiple Abuse Types" and "Child/ren Exposed to Domestic Violence", which are higher in the Comparison Group and "Children's Developmental Problems or Behavioural Management Issues", where the Assessed Group is over-represented.

Fig. 6.6: Secondary Presenting Problems/Family at Referral.
(N = 200 families x up to 3 problems per family.)
Assessed Group n=100; Comparison Group n=100.



6.2 Family Demographic Factors.

6.2.1 Country of Origin / Cultural Group of Parents/Carers.

Australia is the reported country of origin for 71.5% of the study group parents/carers. This is consistent with the figure of 76.9% Australian born reported in the 2001 Australian Census (Australian Bureau of Statistics 2001; 2001a). While the population of metropolitan Sydney is quite ethnically diverse, the bias towards Australian-born parents/carers in this study may be explained by the fact that referrals to Montrose come from all over the state of NSW, and just over half of the referrals emanate from Regional and

Rural/Remote NSW, which still reflect a predominantly Anglo-Australian background.

Across 17% of the study group (34 families), parents and carers listed 25 different countries as their countries of origin. For the whole study group, 9.5% of families have one Australian born parent, with the other parent born in an overseas country, while 7.5% of families have both parents born in another country. This diversity reflects largely reflects the multicultural nature of metropolitan Sydney, which is often the first port of call for new arrivals, many of whom settle in Sydney. Because of the diverse range of other countries represented by only small individual numbers, a collated version of Parent/Carers' Country of Origin or Cultural Affiliation is listed in Table 6.1.

Table 6.1: Parent/Carer/s' Country of Origin / Cultural Affiliation: Total Study Group. (N=200 families)

PARENT COUNTRY OF ORIGIN / CULTURAL AFFILIATION

		Frequency	Percent
Valid	NOT STATED	2	1.0
	AUSTRALIA	143	71.5
	IDENTIFIES AS ABORIGINAL/TSI	21	10.5
	OTHR COUNTRY + AUST.	19	9.5
	OTHER COUNTRY	15	7.5
	Total	200	100.0

6.2.2 Indigenous status.

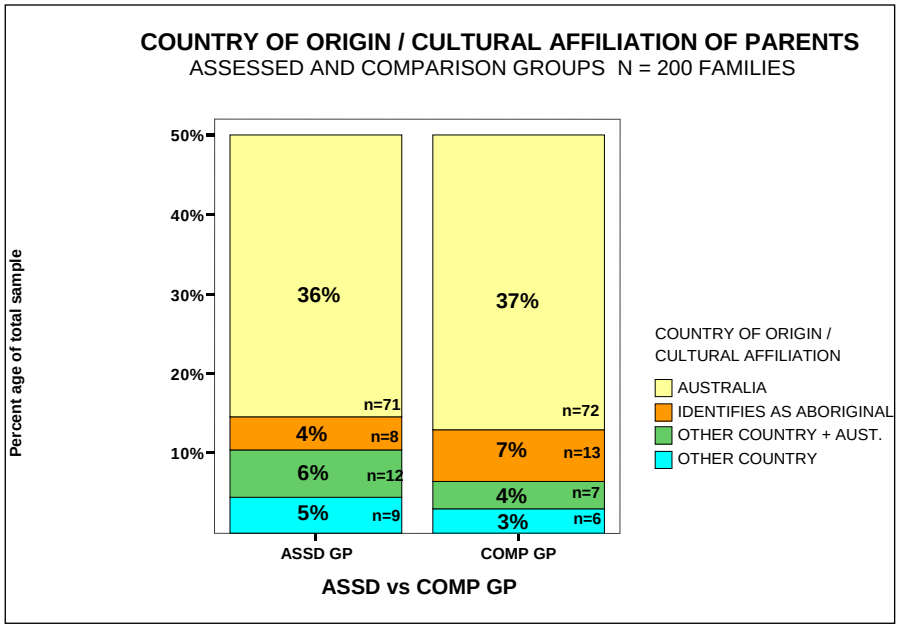
Indigenous status is of particular interest in this study because of its relevance for the NSW legislation*, which, for historical reasons related to the previous welfare approach to placement of indigenous children in white families, now has strict principles governing the placement of indigenous children with extended family or with members of their relevant community if they must be removed from their parents' care.

* *Children (Care and Protection) Act, 1987 and the Children and Young Persons (Care and Protection) Act, 1998.*

As per Table 6.1 above, parents/carers who identified as having Aboriginal or Torres Strait Island heritage account for 10.5% of the study group. This is a clear over-representation compared with the 2.4% of adults in the current Australian population who identify as indigenous. (ABS 2004, p.2). However, it is consistent with the rate of indigenous families' over-representation in child protection statistics in Australia (Thorpe 1994, pp.154-169), the national figure in 1995-6 (during this study) being cited as 10% of all substantiated cases, although indigenous people made up only 3% of the total population at that time (Angus and Hall 1996).

When parent/carer country of origin is compared for the Assessed Group and Comparison Group, there is no significant difference between the two Groups (Fig. 6.7). The proportion of Australian-born parents is roughly equal in the two groups, as is the proportion of families with both parents born overseas. The number of parents who identify as indigenous is somewhat higher in the Comparison Group, and the number from a combined Australian and Other Country background is slightly higher in the Assessed Group, however the actual numbers involved are small.

Fig. 6.7: Country of Origin / Cultural Affiliation. (N=180 Families). Assessed Group n=100; Comparison Group n=100.

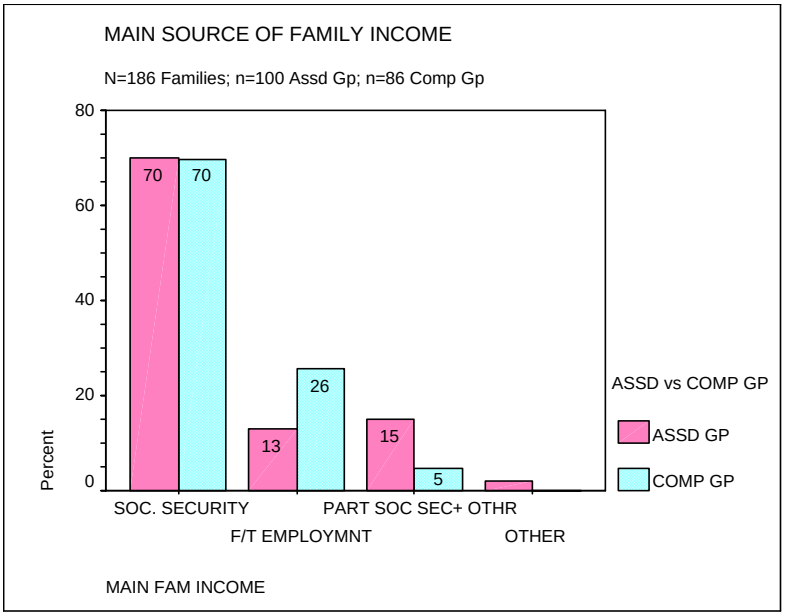


6.2.3 Main Family Income Source

Almost 70% of the referred families where income level was known received their main source of family income from Social Security benefits, and equal proportions of Assessed Group and Comparison Group families are in the Social Security category for main source of income (70%) (Fig. 6.8).

The Comparison Group is significantly over-represented in the proportion of parents in full time employment (p=0.015), while the Assessed has more families with partial Social Security payments in conjunction with other income sources. This difference, while significant, represents a relatively small number of families and would theoretically slightly advantage the Comparison Group in terms of family income status.

Fig. 6.8: Main Family Income Source. (N=186 Families with known Income Source.) Assessed Group n=100; Comparison Group n=86.



6.2.4 Marital Status and Relationship of Carers to Child/ren: Overview.

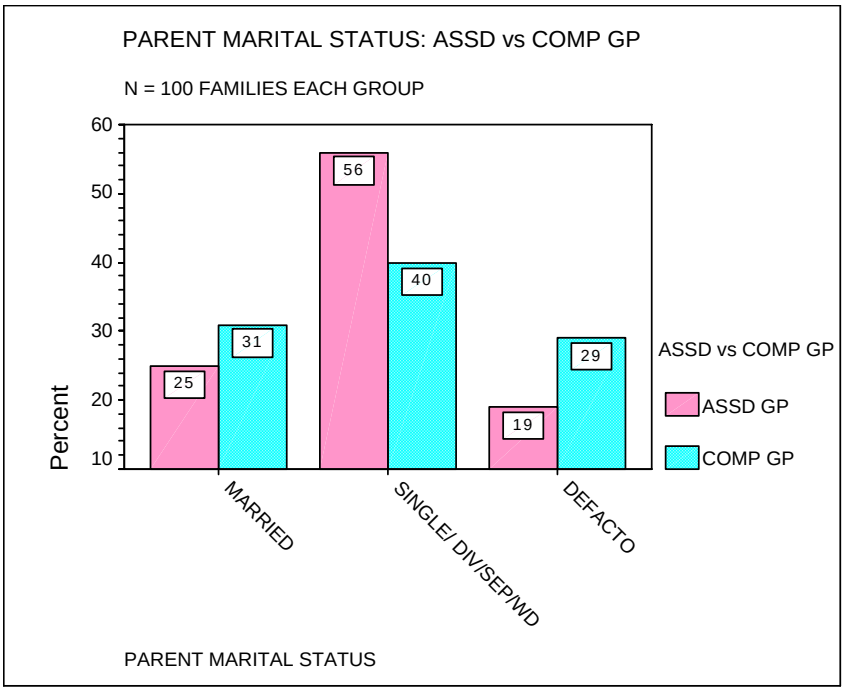
Traditional definitions of marital status for the parents and carers of the children do not adequately describe the wide variety of relationships in this study - between the parents/carers and their partners and between the carer or parent's partner and the children living in the family. The complexity of relationships between partners and between the carers and the various

children in the family is often a source of stress in families. The data analysis in this study is conducted on a data set that has collapsed all the relationship types into a smaller number categories. Appendix 6.1 lists the combinations of relationships in the 200 families in the study, and is presented so that the level of complexity of the study group family structures can be fully appreciated.

6.2.5 Parent Marital Status.

For the purposes of analysis, marital status was recoded into a smaller number of more frequently occurring categories (Fig. 6.9).

Fig. 6.9: Parent/Carer Marital Status at Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



Across the total study group, single parents account for 48% of households, with married parents (28%) and defacto partners (24%) accounting for the rest. When compared with Australian Bureau of Statistics figures for family structures in Australia at the time of the study, single parent and defacto families in the study group are overrepresented, and households with two married parents are underrepresented (Australian Bureau of Statistics 1995).. In Australia in 1992, approximately 81% of children under 15 years of age lived with their biological parents, 14% lived with a single parent and 4% lived

in stepfamilies (with one natural parent and a married or defacto partner) (ABS 1995).

When the Assessed Group and Comparison Group are compared by parent marital status, the distribution of category types is the same in each of the groups - i.e. single parents most common, followed by married parents, then defacto parents (Fig. 6.9). The proportion of households headed by married parents is comparable in the two groups. There are some differences between the two groups, with the Assessed Group having more single parent households and the Comparison Group having more defacto parents, these differences being significant at the level of $p=0.067$.

6.2.6 Relationship of Carer/s to Children.

In this study, 23% of households referred to Montrose are headed by two (married or defacto) parents of all the children in the family, and a further 48% by the single parent of all the children, meaning that 71% of households are headed by the biological parent/s of the children.

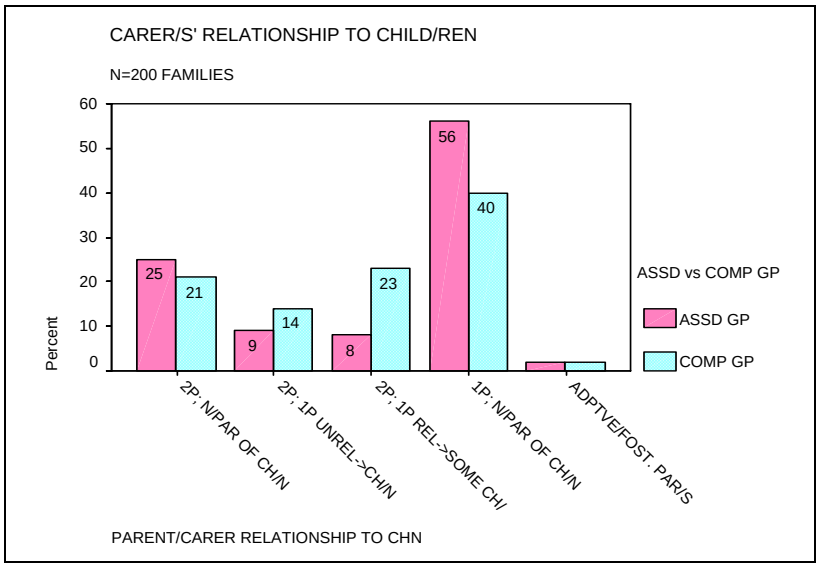
In 27% of the families, the primary carer's partner is not the biological parent of all the children, and in a further 11.5% of families the partner is unrelated to *any* child in the family. In 2% of cases in each Group, the caregivers are adoptive or foster carers, not biologically related to the child/ren.

The significant number of sole parent households in the Assessed Group ($p<0.023$), skews the proportion of families headed by natural parents of all the children towards that Group, while the Comparison Group has 23% of families where partners are biologically related to only some of the children and 14% where the partner is unrelated to any child in the family. (Fig.6.10)

The proportion of single parent and blended family households with a non-biological carer in this study reflects the findings of other studies associating family structure with increased child protection risks, although the level of association is by no means direct, and may be mitigated by other factors,

such as the gender of the single parent and the non-related carer, social disadvantage and family dysfunction (Tomison 1996, pp.2-5).

Fig. 6.10: Parent/Carer Relationship to Children in Family. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



6.2.7 Sex of Primary Carer

Given the child protection focus of this study, the Primary Carer is designated as the parent or carer who has primary responsibility for the safety, welfare and wellbeing of the child, and who may also have responsibility for his/her basic physical and emotional care. As would be expected, female Primary Carers significantly outnumber male Primary Carers in both the Assessed Group and Comparison Group, but are significantly more numerous in the Assessed Group (83% of families) compared with the Comparison Group (64% of families) (p.=0.002) (Table 6.2).

Table 6.2: Sex of Primary Carer by Marital Status. (N=200 Families). Assessed Group n=100; Comparison Group n=100.

(R) PARENT MARITAL STATUS * SEX OF PRIMARY CARER * ASSD vs COMP GP Crosstabulation

Count

ASSD vs COMP GP		SEX OF PRIMARY CARER		
		MALE	FEMALE	Total
ASSD GP	MARRIED	12	13	25
	SINGLE/ DIV/SEP/WD	2	54	56
	DEFACTO	3	16	19
	Total	17	83	100
COMP GP	MARRIED	24	7	31
	SINGLE/ DIV/SEP/WD	3	37	40
	DEFACTO	9	20	29
	Total	36	64	100

This is related to the number of female sole parent households in the Assessed Group, but it may also be related to the number of two-carer households where the male partner is not the biological parent of some or all of the children, and where the mother/female carer is the designated Primary Carer for all the children.

Male Primary Carers are more highly represented in the study than would perhaps normally be expected in the general population. The crosstabulation of parent marital status by sex of Primary Carer provides a number of possible reasons for this:

- In the Comparison Group two parent married families, the proportion of males nominated as Primary Carers is much greater (24%) than females (7%). This may be a factor related to the smaller amount of information available for Comparison Group families regarding the day to day responsibility for the children.

- In 9% of Comparison Group two parent defacto households, the male partners were taking responsibility for the discipline and/or care of the children, whether not they were actually related to the children.

- In these and other two-carer families, where the female carer has a mental health or substance abuse problem, the male carer may have assumed the role of primary carer for the children.

A further compounding factor may be the high proportion of Assessed Group families whose primary source of income was derived from social security benefits in conjunction with part-time work. In these families, female partners may have taken the part time work, with non-working male partners potentially taking on a primary child caring role.

6.2.8 Number of Children per Family.

There are a total of 744 children and young persons in the 200 families in the study. Some of the children were born in the three years after the referral to Montrose, three had died before referral and three died in the follow-up period (one from the Assessed Group and two from the Comparison Group). Not all the children were living in the family home at the time of referral. Some were young adults (18 years and over) living independently, some were in various types of out of home care placements, and some were living with non-resident parents or extended family. There is no significant difference between the Assessed Group and Comparison Group in either the total number of children per family or the number of children under 18 years living in the family home at time of referral to Montrose (Table 6.3).

Table. 6.3: Total No. Children Per Family; and No. Children under 18 Years in Family Home at Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.

Statistics ASSESSED GROUP: NO. CHN/FAMILY AND NO. CHN BIRTH TO 17YRS/FAM.

		TOTAL NO. CHN IN STUDY -LIVING IN HOME OR OTHER	NO. CHN / FAMILY 0-17YRS AT REF.
N	Valid	100	100
	Missing	0	0
Mean		3.81	3.43
Median		3.00	3.00
Mode		3	3
Minimum		1	1
Maximum		11	10
Sum		381	343

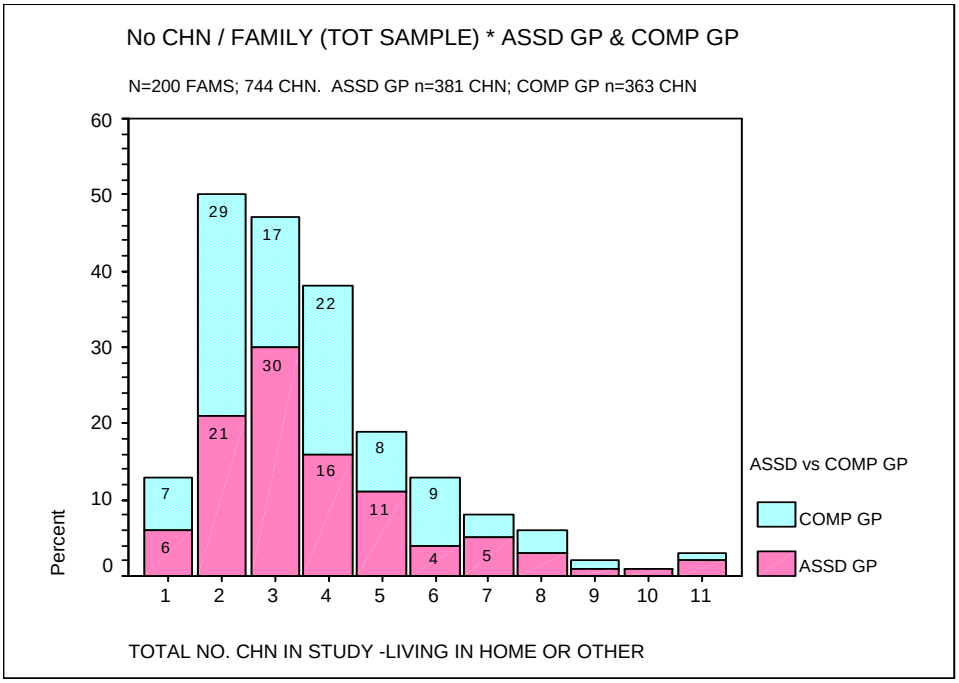
Statistics: COMP GP- CHN PER FAMILY AND CHN 0-17 PER FAMILY.

		TOTAL NO. CHN IN STUDY -LIVING IN HOME OR OTHER	NO. CHN / FAMILY 0-17YRS AT REF.
N	Valid	100	100
	Missing	0	0
Mean		3.63	3.09
Median		3.00	3.00
Mode		2	2
Minimum		1	1
Maximum		11	7
Sum		363	309

The Assessed Group contains 381 children and the Comparison Group 363 (Fig. 6.11). There are a number of large families, including three with 11

children, one with 10, two with 9 and six with 8. The mean number of children is 3.7 per family. The modal family size is two children (50 families), closely followed by 3 children (49 families). The most common family size is three children for the Assessed Group and two children in the Comparison Group, but the difference between the groups is not significant.

Fig. 6.11: Total No. Children per Family. (N= 200 Families; 744 children.)
Assessed Group n=100 Families; 381 children.
Comparison Group n=100 families; 363 children.



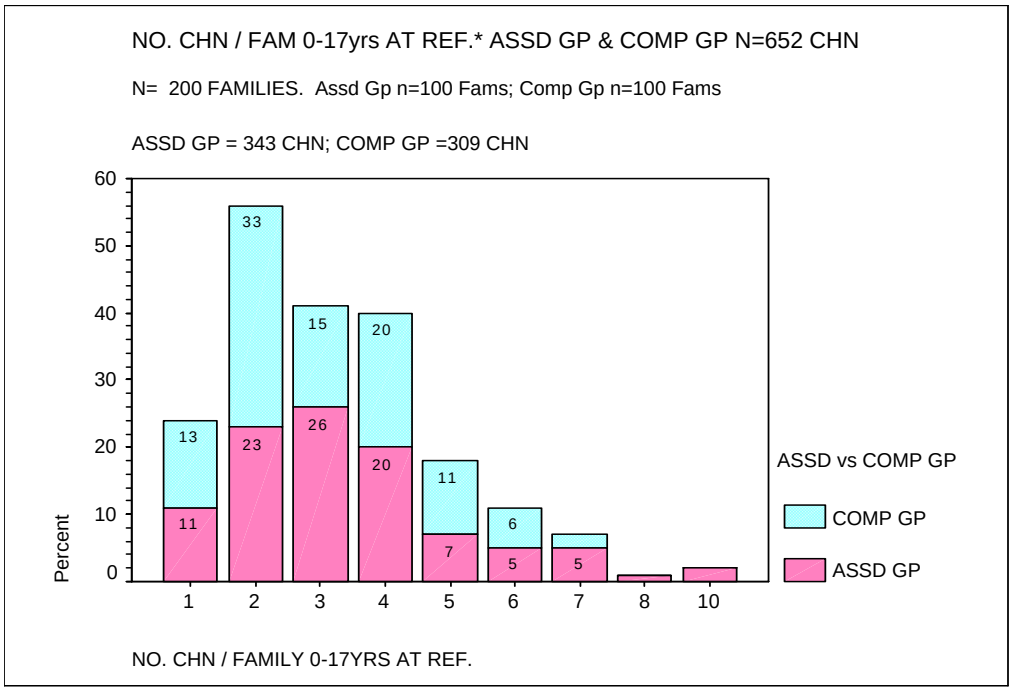
6.2.9 Number of Children, Birth-17 years, in Family at Referral.

The legislation relevant at the time of this study defined a 'child' as a person under 18 years of age. The figures for children in the family at time of referral therefore excludes young people 18 years and over, even if living in the family home, as well as children and young people living outside the family (adult children or youths living independently, children with extended family or in alternate care), and those born in the three years after the referral to Montrose.

Across the 200 study group families, 652 children aged 17 years or under were living in the family home at time of referral, 343 in the Assessed Group

and 309 in the Comparison Group (Fig. 6.12). There is a range between one and 10 children in the family at the time of referral, the most common number of children being two in both the Assessed Group and Comparison Group. The mean number of children per family is three, with no significant difference between the Assessed Group and Comparison Group in overall number of children (birth-17years) per family at time of referral, although the Assessed Group has a number of large families with seven to 10 children.

Fig. 6.12: No. Children Birth-17 years in Family Home at Referral.
(N=200 Families; 652 children).
Assessed Group n=100 families; 343 children.
Comparison Group n=100 families; 309 children.



6.3 Family Related Factors

6.3.1 Domestic Violence.

The definition of domestic violence spans a wide range of behaviours including physical abuse; psychological, emotional and verbal abuse; social abuse (isolating the victim); sexual abuse; and financial or economic abuse (NSW Child protection Council 1996; Tomison 2000; Grayson 2001).

Domestic violence has strong associations with child abuse and child protection (National Committee on Violence 1990; Perry 1997; Grayson 2001; Folsom et al 2003; NSW Health 2003). Apart from direct physical abuse of children or injury received by children accidentally or when intervening between the perpetrator and victim, exposure to domestic violence is deemed to be psychologically abusive in its own right and is now a nominated reason for child protection notification. Exposure to domestic violence in children is not limited to witnessing or intervening in the abuse, but includes hearing conflict from another room, seeing the after-effects of violence (on property or persons), modifying normal behaviour to avoid provoking the perpetrator of violence, and having a parent whose attention is diverted away from the children's welfare by the need to minimise conflict and protect themselves and the children from assault.

In 1993 when the Montrose program began taking referrals, exposure to domestic violence was not seen as having the same level of impact on children's welfare as it is today. While domestic violence was not nominated frequently enough to rate a Primary Presenting Problem category in this study, it was reported as a secondary presenting problem in 24% of referred families.

In this section, domestic violence is examined in terms of three categories – *Incidence* (Past and/or Current), *Type* (physical, verbal, financial, etc) and *Perpetrator and Victim/s*.

- **Incidence of Past / Current Domestic Violence.**

Past and/or current domestic violence was reported in 78.5% of the 200 families in this study (Table 6.4). The highly concerning corollary is that only one fifth of families did <u>not</u> report having experienced some form of domestic violence. Equally disturbing is the fact that over 40% of the families reported experiencing *current* domestic violence (with or without past domestic violence).

There is a significant difference between the Assessed Group and Comparison Group in the incidence of reported domestic violence. The Comparison Group has twice as many families with "no known domestic violence", twice as many families with current (but without past) domestic violence, and fewer families with only past domestic violence. There is also a difference between the Assessed and Comparison Groups in the category "Current and Past Domestic Violence", with the Assessed Group being overrepresented in this category.

Table 6.4: Incidence of Past and/or Current Domestic Violence: Study Group. (N=200 Families). Assessed Group n=100; Comparison Group n=100.

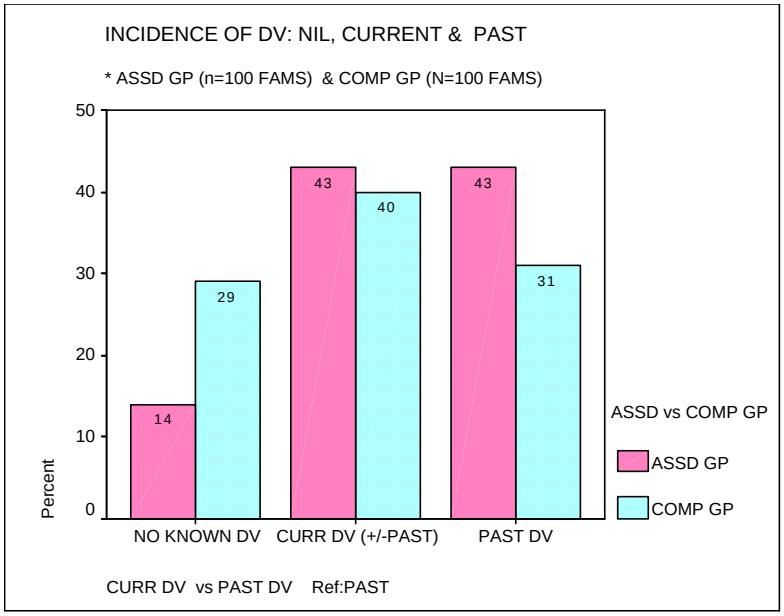
PAST &/OR CURRENT DOMESTIC VIOLENCE (4) * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
PAST &/OR CURRENT DOMESTIC VIOLENCE (4)	NO KNOWN DV	Count	14	29	43
		% within ASSD vs COMP GP	14.0%	29.0%	21.5%
	PAST DV	Count	43	31	74
		% within ASSD vs COMP GP	43.0%	31.0%	37.0%
	CURRENT DV	Count	14	29	43
		% within ASSD vs COMP GP	14.0%	29.0%	21.5%
	CURR & PAST DV	Count	29	11	40
		% within ASSD vs COMP GP	29.0%	11.0%	20.0%
Total		Count	100	100	200
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

The difference between the two groups relates mainly to the lack of reported *history* of domestic violence, and may be affected by the referring Caseworker's knowledge about the family history, (particularly of previous parental relationships), rather than actual incidence. The Montrose intake and assessment process involves a detailed file review, which accesses the child protection history of every child in the family. This may not have been completed if the referral was withdrawn during the process. Referring Caseworkers usually do not have the time to thoroughly check files before referral, so it is possible that past domestic violence may not be obvious, whereas current domestic violence would precipitate an intervention, possibly culminating in a referral to Montrose.

This explanation is supported by the process of combining the category "Current and Past Domestic Violence" with "Current Domestic Violence" (Fig. 6.13). This reduces the differences between the groups, with 43% of Assessed Group families, and 40% of Comparison Group families having currently reported domestic violence, with or without a history of domestic violence. The groups are then more comparable in distribution of current and past domestic violence, although the Assessed Group still has significantly fewer families with no known domestic violence (p=0.026).

Fig. 6.13: Incidence of Current vs Past Domestic Violence per Family. (N =200 Families). Assessed Group n=100; Comparison Group n=100.



- **Domestic Violence Type.**

The category Domestic Violence Type demonstrates the severity of this issue in the study group as a whole. (Table 6.5) Only 21.5% of referred families reported *no* past or current domestic violence. Physical violence in varying degrees of severity (moderate to severe) was reported in 74% of the of 200 families. In 29% of families, this violence resulted in criminal charges being laid or an Apprehended Violence Order (AVO) being sought by the adult victim or on behalf of the children. In a further 11% of families, severe physical violence had occurred but no legal action was taken. This is unfortunately a relatively common situation, with victims often being unwilling

(or afraid) to report the abuse or charge the perpetrator until the violence brings the family to the notice of a third party - police, health services or DoCS. Physical violence as well as non-consensual sex occurred in a further 5% of the families but surprisingly, domestic violence in the form of emotional, or verbal abuse or financial control was the most infrequent type reported, at 4.5%.

Table 6.5 Type of Domestic Violence per Family. (N=200 Families). Assessed Group n=100; Comparison Group n=100.

DV:TYPE & SEVERITY (6) * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
DV: TYPE & SEVERITY	NO KNOWN DV	Count	14	29	43
		% within ASSD vs COMP GP	14.0%	29.0%	21.5%
	SEV PHYS: AVO/ CRIM CHRGE	Count	27	31	58
		% within ASSD vs COMP GP	27.0%	31.0%	29.0%
	MOD PHYS	Count	33	25	58
		% within ASSD vs COMP GP	33.0%	25.0%	29.0%
	SEV PHYS: NO AVO / CHRG	Count	14	8	22
		% within ASSD vs COMP GP	14.0%	8.0%	11.0%
	SEXL+PHYS	Count	8	2	10
		% within ASSD vs COMP GP	8.0%	2.0%	5.0%
	VERB/ EMOT/ FINANCL	Count	4	5	9
		% within ASSD vs COMP GP	4.0%	5.0%	4.5%
Total		Count	100	100	200
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

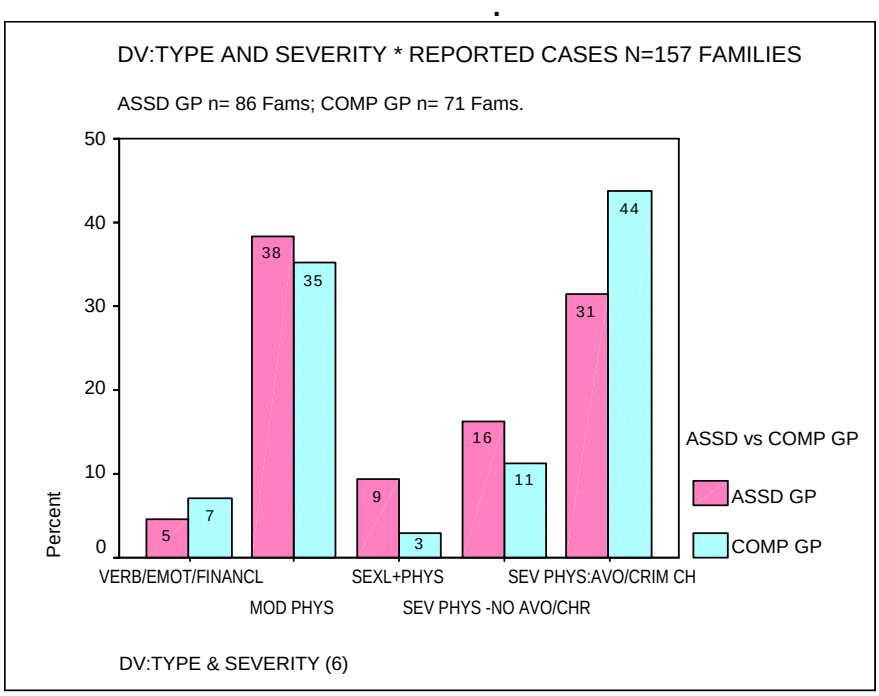
If the figures are re-examined, excluding families where no domestic violence was reported, in the 157 families in which domestic violence was reported, serious physical violence of various types (including sexual violence) accounts for a staggering 94% of the total reported domestic violence (Fig. 6.14). Only 6% of cases involve emotional abuse, verbal abuse and/or financial control *without* physical violence.

Where domestic violence is reported, the overall rate of physical violence is 95% in the Assessed Group and 93% in the Comparison Group. Severe violence, with or without criminal charges or an AVO and including sexual violence, accounts for 57% of the reported domestic violence in the

Assessed Group and 58% of the Comparison Group, while moderate violence accounts for 38% and 35% respectively.

Having controlled for the over-representation in the Comparison Group of families with no reported domestic violence, there is no significant difference between the Assessed Group and the Comparison Group in the types of domestic violence reported, with moderate to severe physical violence predominating.

Fig. 6.14: Type of Domestic Violence. (Controlled for families with no domestic violence reported.) **(N=157 Families).**
Assessed Group n= 87; Comparison Group n=71.



- **Domestic Violence Perpetrator and Target.**

Most perpetrators of domestic violence are male, and most victims are women (Widom 1989; 1992), but children are affected by the exposure to domestic violence and in some cases may also be perpetrators of violence against their parents or siblings (Tomison 2000; Grayson 2001). In this study, domestic violence might be better called "family violence", given the range of permutations of perpetrators and victims. (Table 6.6) While parent to parent violence is the most frequent situation (38%), violence in many families was

incremental, extending from partners to child victims (17%), and being emulated by at least one child in the family in a further 17% of families across 4 categories in Table 6.6.

Table. 6.6: Perpetrator and Target of Domestic Violence. (N=200 Families.)

DV PERP & TARGET (7)

		Frequency	Percent
Valid	NO KNOWN DV	43	21.5
	ADULT -->ADULT	76	38.0
	ADULT-->ADULT&CH/N	34	17.0
	ADLT->ADLT, + CH->AD&/orCH/N	5	2.5
	ADLT->ADLT & CHN, + CH->AD&/orCH/N	29	14.5
	ADULT <--> CH	2	1.0
	ADULT->CHN	6	3.0
	CH-->ADULT &/or CH	5	2.5
	Total	200	100.0

As distinct from aggressive conduct disorders or tantrums, children's domestic violence to adults and siblings is only reported in this study when it shows the classic signs of domestic violence perpetrator behaviour. This behaviour includes strong elements of control, bullying and gender issues, and the boundaries between mother and child are often faulty or inconsistent. Children's domestic violence is relatively rare in the absence of a violent parent role model. Interestingly, it appears in this study that it is not the child or young person who *witnesses* domestic violence that emulates the behaviour, but those who are themselves *victims* of violence. Anecdotally, many of these cases involve families where the adult perpetrator has left the home, and a teenage or pre-teen son begins to exhibit the same behaviour with his mother and sometimes his siblings. Many mothers in this situation respond to their sons' behaviour the same way as they had previously done with their abusive partners.

The few cases listed as "adult to child" domestic violence differ from physical or emotional abuse in that the behavioural profile of the perpetrator is more consistent with the control issues underpinning domestic violence behaviour than with child maltreatment behaviour.

In terms of comparability of the Assessed Group and Comparison Group on the issue of domestic violence perpetrator and victims, when the category "No Reported Domestic Violence" is controlled for, the Assessed Group and Comparison Group are comparable in the category of adult to adult violence. (Table 6.7)

Table. 6.7: Perpetrator and Target of Domestic Violence, excluding the Category "No Reported Domestic Violence". (N=157 Families.) Assessed Group n =86; Comparison Group n = 71.

DV PERP & TARGET (CONTROLLED FOR "NO DV") * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
DV PERP & TARGET (7)	ADULT -->ADULT	Count	39	37	76
		% within ASSD vs COMP GP	45.3%	52.1%	48.4%
	ADULT-->ADULT&CH/N	Count	12	22	34
		% within ASSD vs COMP GP	14.0%	31.0%	21.7%
	ADLT->ADLT, + CH->AD&/orCH/N	Count	3	2	5
		% within ASSD vs COMP GP	3.5%	2.8%	3.2%
	ADLT->ADLT & CHN, + CH->AD&/orCH/N	Count	23	6	29
		% within ASSD vs COMP GP	26.7%	8.5%	18.5%
	ADULT->CHN	Count	2	4	6
		% within ASSD vs COMP GP	2.3%	5.6%	3.8%
	ADULT <--> CH	Count	2	0	2
		% within ASSD vs COMP GP	2.3%	.0%	1.3%
	CH-->ADULT &/or CH	Count	5	0	5
		% within ASSD vs COMP GP	5.8%	.0%	3.2%
Total		Count	86	71	157
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

The Comparison Group is over-represented in the category that relates to adult violence towards children as well as partners, and is under-represented in the four categories that involve children's violence to adults and sibs. Given the consistency of the under-representation here, it is quite possible that, similar to the category of 'History of Domestic Violence', this is an issue of under-reporting rather than of incidence. It may also be a semantic issue, with children's behaviour being more often categorised by the reporter as aggression and behavioural problems than as domestic violence.

6.4 Parent / Caregiver Related Factors.

It should be noted that in the following categories of parent/caregiver factors, the number of single parent families in this study has some impact on the information available for male parent/caregivers. If the mother has a current partner, or if there is a non-resident biological parent who has contact with the family, the information is more likely to be present. If the mother has no current partner and no contact with the father/s of her children, the category of "not stated" is likely to be over-represented.

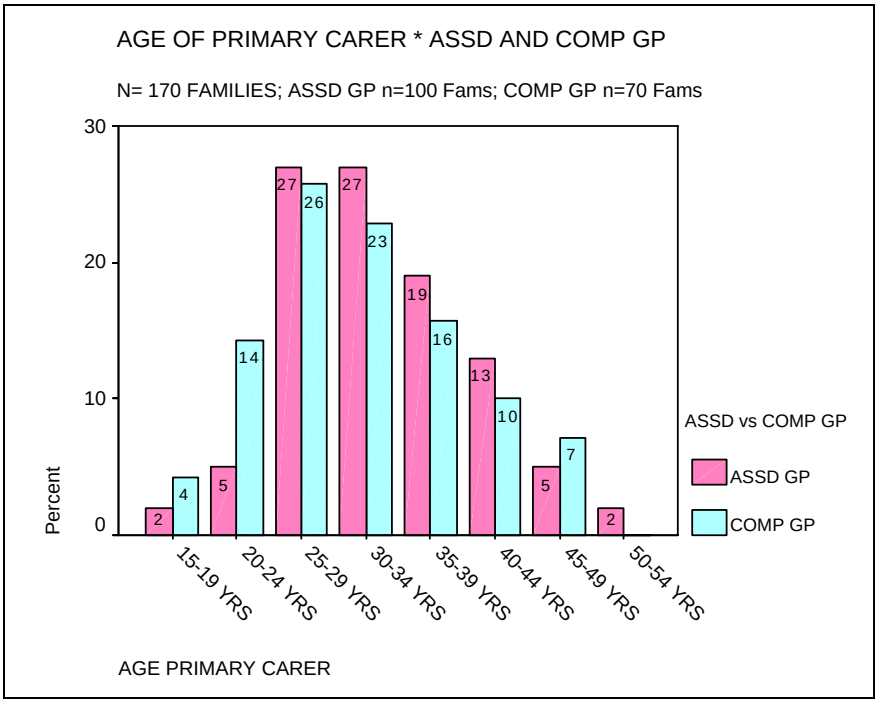
6.4.1 Age of Primary Carer.

In this study, the Primary Carer is designated as the parent or carer who has primary responsibility for the safety, welfare and wellbeing of the child, and who may also have responsibility for his/her basic physical and emotional care.

Information on the Primary Caregiver's age was available for all 100 Assessed Group families and for 70 Comparison Group families. The most common age group was 25-29 years and the median age group was 30-34 years.

A comparison of the Assessed Group and Comparison Groups indicates no significant difference between the groups. The Primary Caregiver in the Assessed Group is most frequently 25-29 or 30-34 years of age, while the modal age for the Comparison Group is 25-29 years. The Comparison Group has more families in the 20-24 years age group than the Assessed Group, but the other age groups are comparable (Fig. 6.15).

Fig. 6.15: Age of Primary Carer at Referral. (N=170 Families.) Assessed Group n=100; Comparison Group n=70.



6.4.2 Age of Primary Carer's Partner.

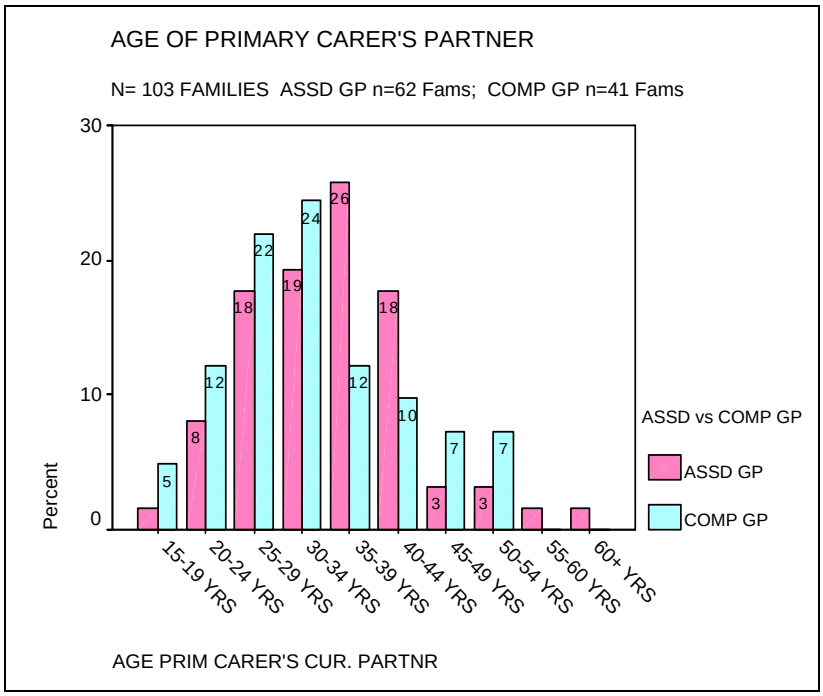
The age group of a Primary Carer's current partner or a non-resident parent was known in 103 families. The age range for the available data is bimodal at the age groups 30-34 years and 35-39 years (21%), with the median age group also being the 30-34 year old group. It is difficult to extrapolate much more from this data, given that the available information describes only just over half of the total study group.

There is no significant difference between the Assessed Group and Comparison Group for the age of the Primary Carer's partner. The most frequent age group for the Assessed Group is 35-39 years and for the Comparison Group is 30-34 years. (Fig. 6.16)

A crosstabulation of the age of the Primary Carer and Primary Carer's current partner, indicates that for the 103 cases where this information was available both the Assessed and Comparison Group partners generally tended to be in

the same age group as the Primary Carer or one or two age groups (i.e. 5-10 years) older or younger.

Fig. 6.16: Age of Primary Carer's Partner. (N=103 Families). Assessed Group n=62; Comparison Group n= 41.



6.4.3 Parent/Caregiver Substance Abuse.

Parent/caregiver substance abuse* is defined in terms of current and/or past abuse of alcohol and/or drugs♦, by the parent, or any of the parent's current or past partner/s who have had a significant caregiving role with the children, and where the substance abuse has affected the children's safety, welfare and wellbeing.

- **Incidence of Parent/Caregiver Substance Abuse.**

Past or present Parental Substance Abuse was reported in 42% of the 200 families in the study, 16% of families with one caregiver and 26% with two caregivers having a substance abuse problem. The number of families with parental substance abuse issues is concerning in terms of the safety, welfare

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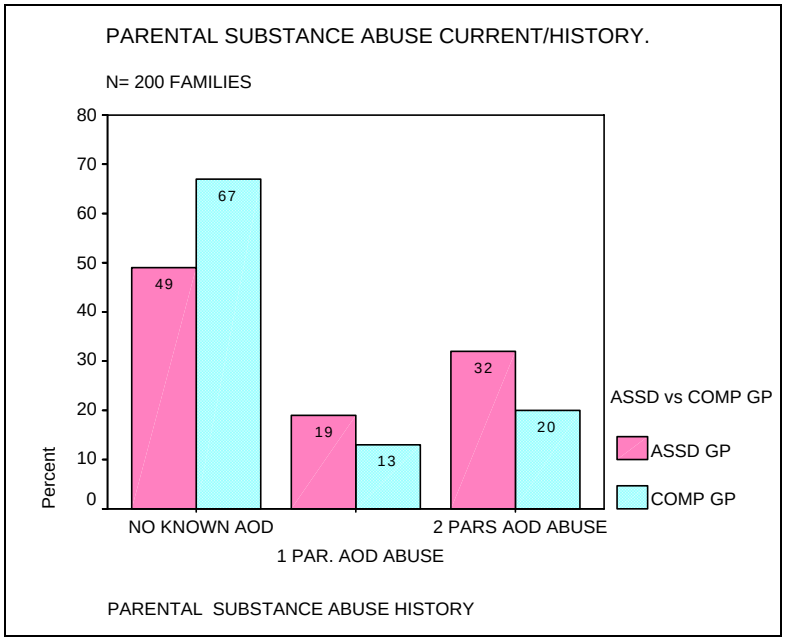
* The term *alcohol or other drug abuse* (AOD) is used interchangeably with the term *substance abuse*.

♦Substance abuse involving "drugs" refers to all illicit drugs, and also to prescription drugs and methadone if not taken in the prescribed manner.

and wellbeing of the children, and is clearly over-representative compared with the general population.

The incidence of families with no reported parent/caregiver substance abuse is significantly higher in the Comparison Group (67%), compared with 49% in the Assessed Group (p=0.035). The proportion of families with two parent/caregivers with substance abuse problems is also notably higher in the Assessed Group, at 32%, compared with 20% in the Comparison Group. (Fig. 6.17). Similar to the reporting of a history of domestic violence, the lower numbers for the Comparison Group may be related to the less detailed file information available for past partners of the Primary Caregiver, compared with the more detailed file review associated with Assessed Group families.

Fig. 6.17: Parent/Caregiver Substance Abuse, Past or Current. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



- **Substance abuse type**.

Substance abuse was reported in 42% of the male caregivers, and 44.5% of female caregivers in the total study group (Table 6.8). Assessed Group male caregivers have a significantly higher rate of combined alcohol and drug

abuse (p=0.001) and of substance abuse overall. Again, this may be a factor of more information being available for past partners of female Primary Caregivers in the Assessed Group than in the Comparison Group. There is no significant difference between types of substance abuse among the female parent/caregivers.

Table 6.8: Parent / Caregiver Substance Abuse Type. (N = 200 Families.) Assessed Group n=100; Comparison Group n=100.

Substance Abuse Type	Male caregiver - Total Group. N = 200 families	Female caregiver - Total Group. N = 200 families	Male caregiver Assd Group. n = 100 families	Male caregiver Comp. Group. n = 100 families	Female caregiver Assd Group. n = 100 families	Female caregiver Comp. Group. n = 100 families
No reported AOD	58%	55.5%	49%	67%	51%	60%
Alcohol only	17%	8.5%	20%	14%	9%	8%
Drug/s only	11.5%	14.0%	9%	14%	17%	11%
Alcohol & drug/s	13.5%	22%	22%	5%	23%	21%
	100%	100%	100%	100%	100%	100%

6.4.4 Parent / Caregiver Mental Health.

This category is not limited to diagnosed mental health problems, but also includes emotional issues such as low self esteem, anxiety and temper control, if they occur at a level serious enough to be seen by the referring Caseworker as affecting the children's safety, welfare or wellbeing.

Parent/caregiver mental health issues were reported in 80% of the referred families, as either the primary presenting problem or a secondary presenting problem. The Assessed Group and Comparison Group are comparable with regard to incidence, as measured by presenting problem alone.

When the files, reports and assessments were searched for evidence of current or past mental health problems, 76.5% of female parent/caregivers have one or more reported mental health issue (Assessed Group 84%; Comparison Group 67%), while the rate for male caregivers is 26% (Assessed Group 32%; Comparison Group 20%). (Table 6.9)

Table 6.9: Parent / Caregiver Mental Health Issues. (N=200 Families). Assessed Group n=100; Comparison Group n=100.

Reported mental health / emotional issue	Male Parent / caregiver Total Group. N=200 Families	Female Parent / caregiver Total Group. N=200 Families	Male Parent / caregiver Assd Group. n= 100 Families	Male Parent / caregiver Comp. Group. n= 100 Families	Female Parent / caregiver Assd Group. n= 100 Families	Female Parent / caregiver Comp. Group. n= 100 Families
No reported mental health or emotional issues	74%	24.5%	68%	80%	16%	33%
Multiple Types	11%	55.5%	9%	13%	65%	46%
Severe Depression	5%	9%	9%	1%	8%	10%
Serious anger control prob. / Antisocial. Pers. Disorder	10%	0	14%	6%	0	0
Other emotional problem	0	7.5%	0	0	7%	8%
Low self Esteem	0	3.5%	0	0	4%	3%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The Assessed Group has a higher rate of the reported mental health problems for both males and females, however, this may be related to the amount of information accessed during the referral process. While diagnosed mental health conditions are known at referral, as with substance abuse and domestic violence, the extent of mental health and emotional problems, particularly for partners of the Primary Caregiver, may not be accessible at the referral stage.

Across the study group, male caregivers are most commonly associated with multiple types of mental health issues, serious anger control problems or antisocial personality disorder and severe depression. The rates are comparable across the Assessed Group and Comparison Group, but Assessed Group has more instances of anger control and antisocial personality disorder problems, and depression, while the Comparison Group scores higher for multiple type mental health problems.

Female caregivers in the study also score high on multiple types of mental health or emotional issues, followed by severe depression, which may

include post natal depression and suicidal ideation, then low self esteem and a range of other single mental health issues. Within the Assessed Group and Comparison Group, female caregivers with multiple types of mental health or emotional issues predominate, with 65% of the families falling into this category, compared with 46% of the Comparison Group. The rates for the other categories are comparable.

6.4.5 Parent / Caregiver History of Childhood Abuse.

This category is based on the summed information for up to two categories of abuse per parent for each of the families in the study. Information was collected from the files and referral forms and in the case of Assessed Group families, from the parent/caregivers themselves.

No abuse was reported in 89.6% of the male caregivers, as opposed to only 49.9% of the female caregivers. This is possibly an issue of information not being as readily available on file for non-resident fathers as much as for mothers who had custody of the children, or for co-habiting male partners of the mothers of the subject children.

Physical abuse is the most frequently reported abuse type for the male parent/caregivers followed by a combination of one or more type of abuse plus neglect and sexual abuse. The reported level of abuse in male caregivers is higher in the Assessed Group than the Comparison Group, but not significantly so. In the total study group, female parent/caregivers report an equal percentage of instances of physical abuse and a combination of abuse types, followed by combination of abuse plus neglect, and sexual abuse (Table 6.10).

Table 6.10: Parent / Caregiver History of Childhood Abuse. (N=200 Families.) Assessed Group n=100; Comparison Group n=100.

Reported childhood abuse type	Male parent/ caregiver Total Group. N=200 Families	Female parent/ caregiver Total Group. N=200 Families	Male parent/ caregiver Assd Group. n=100 Families	Male parent/ caregiver Comp. Group. n=100 Families	Female parent/ caregiver Assd Group. n=100 Families	Female parent/ caregiver Comp. Group. n=100 Families
No reported childhood abuse	**86%**	**49.9%**	77%	95%	22.5%	66%
Physical	**3.7%**	**14.4%**	6.5%	1%	12.5%	13%
Sexual	**2.2%**	**8.7%**	4%	0.5%	13.5%	2%
Emotional	**0.3%**	**0.6%**	0%	0.5%	0.5%	0.5%
Neglect	**0%**	**1.7%**	0%	0%	2%	1%
Combination of abuse types.	**1.5%**	**14.4%**	2%	1%	23.5%	2%
Combination of abuse types, plus neglect.	**2.3%**	**10.3%**	4%	0.5%	12.5%	6%
No other abuse*	**4%**	**0**	6.5%	1.5%	13%	9.5%
	100%	**100%**	100%	100%	100%	100%

When compared by Assessed Group and Comparison Group, there is a significant difference in reporting rates of childhood abuse in female parent/caregivers, with only 22.5% of Assessed Group mothers/ caregivers reporting no abuse, compared with 66% of the Comparison Group. A combination of abuse types is the most frequently reported type for Assessed Group female parent/caregivers, followed by sexual abuse, physical abuse, and combination of abuse and neglect. Physical abuse is most commonly reported by Comparison Group mothers/caregivers, followed by a combination of abuse and neglect.

In this category, females generally and Assessed Group mothers/caregivers specifically clearly have more reported instances of childhood abuse. This would indicate a potentially higher risk factor with regard to the children in the Assessed Group, as a proportion of parents who abuse their children are reported to have had some childhood experience of maltreatment (Widom 1992; Higgins and McCabe 2000).

* Because there were 2 possible abuse types allocated for each parent/caregiver, the category "no other abuse" was used where there was only one type of abuse reported.

6.4.6 Parent / Caregiver History of Out of Home Placement.

Parental history of childhood out of home placement (including homelessness) has been associated in the literature with higher rates of child maltreatment (Saville-Smith 2000). This category examines each parent/ caregiver's referral or reported information for history of childhood placements and also for placement as an adult, including treatment centres (mental health and drug and alcohol), correctional facilities (juvenile detention centres and jail) and also itinerant lifestyle, including homelessness. An additional category of interest, based on an observed trend in referred families, is the parent/caregiver reporting that s/he formed an intimate relationship at a young age, specifically or largely for the purpose of escaping the family of origin (sometimes related to childhood maltreatment).

The data in this variable is based on the summed information from up to three categories of placement per parent, for each of the families in the study. Information comes from the files and referral forms for both groups, and from the parent/caregivers themselves for Assessed Group families. No information regarding placements is available for 59% of the male and 31% of the female caregivers in the study, which affects the relative usefulness of this variable for males.

Overall, the placement histories for the Assessed Group and Comparison Group male parent/caregivers is comparable (Table 6.11).

Across the whole study group, 15.5% of the male caregivers and 20.5% of the females reported having had no placements. The rate of "no reported placements" is markedly lower for the Assessed Group males and females than for the Comparison Group. This may be the result of a more thorough process for obtaining information about the history of placements in the Assessed Group parents and their partners, and may be offset by the higher rate of "Not Stated" in the Comparison Group.

Table 6.11: Parent / Caregiver History of Placement. N=200 Families.) Assessed Group n=100; Comparison Group n=100.

Reported placement type/out of home experience.	Male Parent / caregiver Total Group. N= 200 Families	Female Parent / caregiver Total Group. N= 200 Families	Male Parent / caregiver Assessed Group. n= 100 Families	Male Parent / caregiver Comp. Group. n= 100 Families	Female Parent / caregiver Assessed Group. n= 100 Families	Female Parent / caregiver Comp. Group. n= 100 Families
Not stated	**59.2%**	**31.3%**	41.6%	77%	2.7%	60%
No reported placements	**15.5%**	**20.5%**	23.3%	8%	29%	12%
Wardship	**0.2%**	**2.5%**	0.3%	0%	3.0%	2.0%
Foster care	**0.2%**	**2.3%**	0.3%	0%	3.3%	1.3%
Residential care	**0.7%**	**3.2%**	1.0%	0.3%	4.7%	1.7%
Extended family	**0.8%**	**2.3%**	1.3%	0.3%	4.0%	0.7%
Adopted into family	**0.5%**	**1.3%**	0.7%	0.3%	2.0%	0.7%
Streets / itinerant	**1.3%**	**3.3%**	2.0%	0.7%	4.0%	2.7%
Juvenile detention / jail	**5.8%**	**2.7%**	5.3%	6.4%	3.0%	2.3%
Psychiatric unit	**0.2%**	**3.8%**	0.3%	0%	3.3%	4.3%
Other placement	**1.0%**	**3.5%**	2.0%	0%	6.7%	0.3%
Multiple placements	**0.7%**	**1.2%**	1.3%	0%	2.3%	0%
D&A detox / rehab unit	**0.2%**	**1.7%**	0.3%	0%	1.7%	1.7%
Entered relationship young to leave home	**0.2%**	**3.5%**	0.3%	0%	6.3%	0.7%
No other placement*	**13.5%**	**16.9%**	20%	7%	24%	9.6%
	100%	100%	100%	100%	100%	100%

Interestingly, the most common reported placement category among the male parent / caregivers is juvenile detention and/or jail (5.8%). Comparison Group males have a slightly higher incidence in this category than those in the Assessed Group. The next most frequent categories are homelessness (1.3%), and other, non-specific placement types that are not part of the official out of home care system or extended family (1%). Numbers of males in the traditional categories of out of home care placement are relatively low.

* Because there were 3 possible placement types allocated for each parent/caregiver, the category "no other placement type" was used where there was only one or two type of abuse reported, and is counted with "not stated" for the other two or one categories.

For female parent / caregivers in the study, there is a greater incidence and range of placements, the most frequently reported being a psychiatric inpatient unit (3.8%) followed by other non-specific placements and (perhaps related) entering into a relationship at a young age to escape the family of origin, possibly related to abuse (3.5%). Homelessness is the next most common (3.3%), perhaps also related to escaping the family home in some cases. The incidence of these factors, as well as residential care (3.2%), juvenile detention or jail (2.7%) wardship (2.5%) and foster care or extended family (2.3%) and drug and alcohol treatment centre (1.7%) indicates that a number of the female parent/caregivers in the study have had a disrupted childhood and early adult life.

The Comparison Group has a higher incidence of psychiatric inpatient care (4.3%) and lower rates of extended family, other placements and leaving home early than the Assessed Group, but overall the trends are relatively comparable for the Assessed Group and the subgroup of the Comparison Group for whom information was available. The Assessed Group female caregivers most frequently reported "other" placement types, residential care (4.7%) and extended family or itinerant lifestyles (4%). Foster care and psychiatric units each account for 3.3% of the group, with 3% having spent time in juvenile detention or jail.

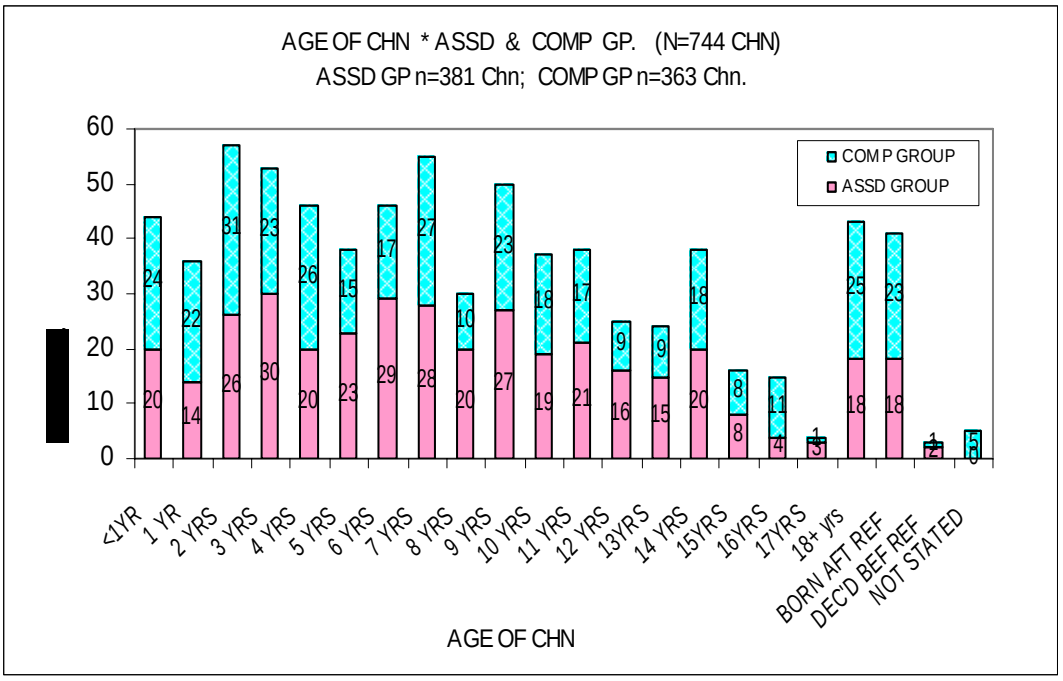
6.5 Child related factors.

6.5.1 Ages of Children.

The ages of all children who were, or had been, part of the referred families, including adult offspring, children living elsewhere, and children born after the referral to Montrose is depicted in Fig.6.18. Adult children (18 years and over) and those of any age who were no longer living with the family at referral are relevant in terms of previous child protection and/or placement history, which assists to provide baseline data for comparing the family situation before and after referral.

The Assessed Group and Comparison Group are comparable for the distribution of children's ages. The mode for the Comparison Group is two years old and for the Assessed Group, three years old. The Comparison Group has more babies under the age of 6 months, and less infants from 6-12 months, but when the figures are combined into all infants under 1 year old, the Comparison Group and Assessed Group are similar. (Appendix 6.2)

Fig. 6.18: Ages of All Children per Family. (N= 200 Families; 744 children.)
Assessed Group n=100 families; 381 children
Comparison Group n=100 families; 363 children.



6.5.2 Children Aged from Birth to 17 years Living in the Family Home at Referral to Montrose.

The age limit of 17 years is in accordance with the Montrose referral criteria, and based on NSW child protection legislation[♦] at the time of this study, where a "child" was defined as being a person under the age of 18 years.[*] There were 652 children aged from birth to 17 years living in the study group families at time of referral to Montrose. This includes 343 (54.6%) children in

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[♦] *Children (Care and Protection) Act 1987* p.3

[*] The NSW child protection legislation in at time of writing is the *Children and Young Persons (Care and Protection) Act 1998*, which defines the status of a "child" as a person under 16 years and a "young person" as 16 years or above but under 18 years.

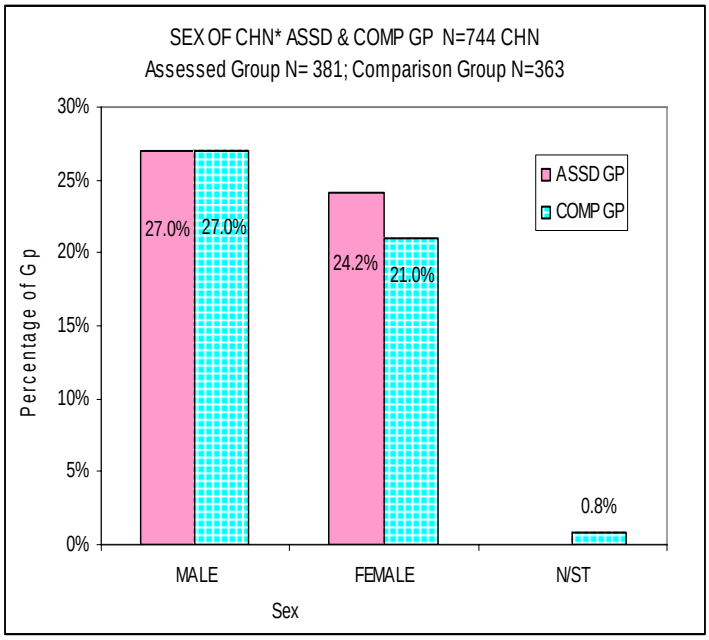
the Assessed Group and 309 (47.4%) children in the Comparison Group. The most common ages of children in the 200 families at time of referral to Montrose are 2 years old (8.7%) and seven years old (8.4%), followed by three years old (8.1%) (Appendix 6.3).

The Assessed Group and Comparison Group have a comparable distribution of ages. The distribution is the subset (<1yr - 17 yrs) of the ages of all children in the study, as depicted in Fig. 6.18 (above).

6.5.3 Sex of Children in the Study Group.

Overall, a total of 402 male children (54%) and 336 female children (45.2%) were born to the 200 families in the study (Fig.6.19). For 6 children (0.8%), all from the Comparison Group, gender was not reported.

Fig. 6.19: Sex of Children in Study Group. (N=200 families)
Study Group: 744 children: 402 male; 336 female; 6 n/s.
Assessed Group n=100 families; 381 chn: 201 male; 180 female.
Comparison Group n=100 Families; 363 chn: 201 male; 156 female.



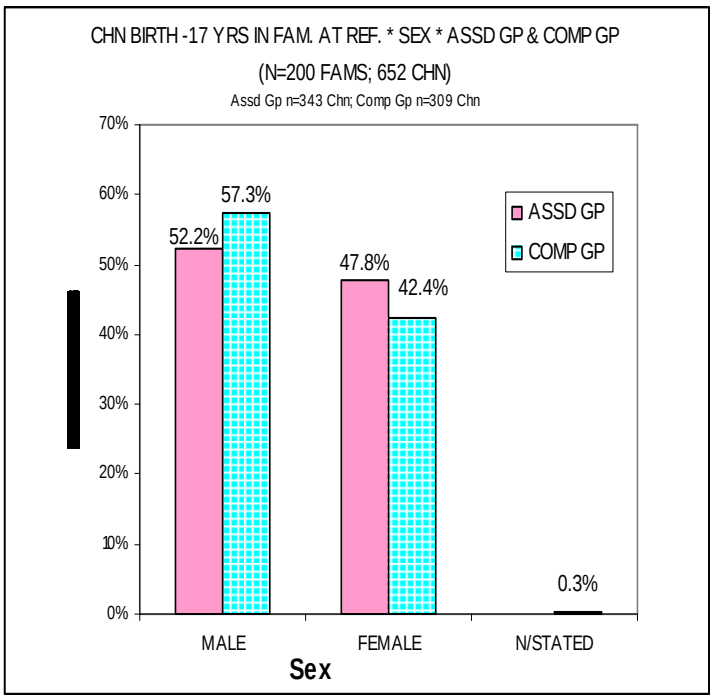
The distribution by sex is very similar between the Assessed Group and Comparison Group. In fact, the number of male children (201) is exactly the same for the two groups. The Assessed Group has 180 female children while

the Comparison Group has 156 females, the difference not statistically significant.

6.5.4 Sex of Children from Birth to 17 years Living in Family Home at Referral.

Of the 652 children aged 17 years and under living in the 200 study group families at the time of referral to Montrose, male children account for 356 (54.6%) and female children for 295 (45.2%). The gender was not specified for the remaining child (0.2%).

Fig. 6.20: Sex of Children: Birth - 17 years Living in Family Home at Referral.
Study Group: N=200 Families; 652 chn: 356 male; 295 female; 1u/k.
Assessed Group n=100 families; 343 chn: 179 male; 164 female.
Comparison Group n=100 Families; 309 chn: 177 male; 131 female.



There is no significant difference between the Assessed Group and Comparison Group in distribution by sex. The Assessed Group has 179 male children (52.2%) and 164 female children (47.8%) while the Comparison Group has 177 males (57.3%) and 131 females (42.4%), and also one child whose sex was not disclosed. (Fig.6.20)

6.5.5 Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (ADD/HD)*.

The incidence of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) is of interest in this study because it was noted early in the Montrose Program that greater than expected numbers of children in referred families had been diagnosed as having ADD or ADHD, and were being treated with various forms of medication.

In the 200 study group families, there are 56 families (28%) where one or more of the children has been diagnosed with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder. This rate of diagnosis is many times greater than the incidence of diagnosed ADD/HD in the general population of children and youth in New South Wales, which is estimated to be between 2.5% and 6% (NSW Dept of Health 1996). The number of families with children diagnosed with ADD or ADHD does not include families where the parent/s asserted that the children's aggressive or uncontrollable behaviour was the result of undiagnosed or untreated ADD/HD.

There is no significant difference between the groups in terms of proportion of families with one child or more diagnosed with ADD/HD, the Assessed Group having 27 families and the Comparison Group 29 families.

6.6 Summary: The Study Group.

In terms of meeting the criteria for a control group, although the Comparison Group was not formed by random selection, it is comparable with the Assessed Group in most of the variables that are of interest in this study (Table 6.12), and is therefore suitable for the purposes of comparing outcomes for families who participated in a Montrose assessment with those who did not.

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* Incidence of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) is jointly described in this study as ADD/HD.

Table 6.12: Summary of Comparability of Assessed and Comparison Groups on Demographic, Family, Parent and Child Related Variables.

Variable	AG / CG com-parable?	Comment
DEMOGRAPHIC		
Year of referral	Yes	
Family Location: Metro Sydney / Regional / Rural-remote NSW	Yes	
Primary presenting problem	Yes	
Secondary presenting problem	Yes	
Parent/Carer country of origin	Yes	
Main family income source	Yes	- Comparable for largest category (Soc.Sec.) - More Comp Gp fams with f/t employment; - More Assd Gp fams with SocSec+P/t emplt.
FAMILY RELATED		
Marital status	No	- More single parents in Assd Gp. - More defacto parents in Comp Gp
Relationship of carers to chn	No	- More Assd Gp families with only biolog. parent - effect of higher no. of single mothers
Sex of primary caregiver	No	- More female caregivers in Assd Gp – effect of higher no. of single mothers
Number of children per family	Yes	
Number of children birth-17 years in family home at referral.	Yes	
Domestic violence - Incidence	No*	- More Comp Gp families with "no rep. DV". - More Comp Gp families with current (but not past) DV. - Fewer Comp Gp families with only past DV. - More Assd Gp fams in category "Current and Past Domestic Violence".
Domestic violence - Type	Yes	- After controlling for number of families with no reported history of DV.
Domestic violence - Perpetrator and victim	Yes	
PARENT RELATED		
Age of primary caregiver	Yes	
Age of partner	Yes	
Parent past / current substance abuse	No*	- More 'No rep. sub. abuse' in Comp Gp. - More rep. sub. abuse in both parents in Assd Gp. - More combined drug and alcohol abuse in Assd Gp male caregivers.
Parent mental health	Yes	
Parent history of childhood abuse	No*	- More reported childhood abuse in Assd Gp.
Parent childhood abuse - type	Yes	
Parent history of placement	Yes	
CHILD RELATED		
Age range of children	Yes	
Sex of children	Yes	
Incidence of Diagnosis of ADD/HD	Yes	

* These three categories may be affected by the lower rate of reported / documented incidence in Comparison Group families, rather than actual incidence.

Where there are differences between the two groups, they tend to relate to lower incidence in the Comparison Group, which may be due to lack of detailed history (e.g. history of domestic violence, substance abuse in partners, etc). This may be due to the more thorough file review that takes place for families who participate in a Montrose assessment, whereas referring caseworkers do not usually have time to go through the files at the same level of detail for referred families who do not complete the referral process. One exception to the reported incidence rates is in the area of family structure, where the Assessed Group has more single parent (female headed) families. This sometimes reduces the amount of information available regarding biological fathers or ex-partners, where they are no longer in the family.

In the few instances where there are significant differences between the Assessed Group and Comparison Group, the differences describe more favourable levels in the Comparison Group families and place the Assessed Group families at a higher level of concern.

It could not therefore be said that the Comparison Group comprises families at a higher level of risk for family breakdown than the Assessed Group families. In this sense, the Comparison Group provides a very reasonable control group for the purpose of exploring the outcomes of the Montrose assessment and other variables predictive of child protection outcome that are discussed in Chapter 7: Results.

CHAPTER 7: RESULTS

7.1 Introduction: Goals of the Study

The analysis of results in this study involves two major goals:

1. To compare the difference in outcomes three years after referral between a group of 100 families who participated in a Montrose home based family assessment (Assessed Group), and an equivalent group of 100 families who met all referral criteria but did not have the assessment (Comparison Group).

2. To explore the relationships between a number of different variables, (demographic, family, individual, and child protection service related), and the child protection outcomes for families and children.

7.2 Overview of Results.

In order to compare the outcomes for families who participated in the Montrose Assessment (the intervention) with outcomes for families who received no intervention, six major outcome variables were analysed three years after referral for each of the 200 families, and the results were compared with the family's presentation at referral.

The Outcome (dependent) variables are:

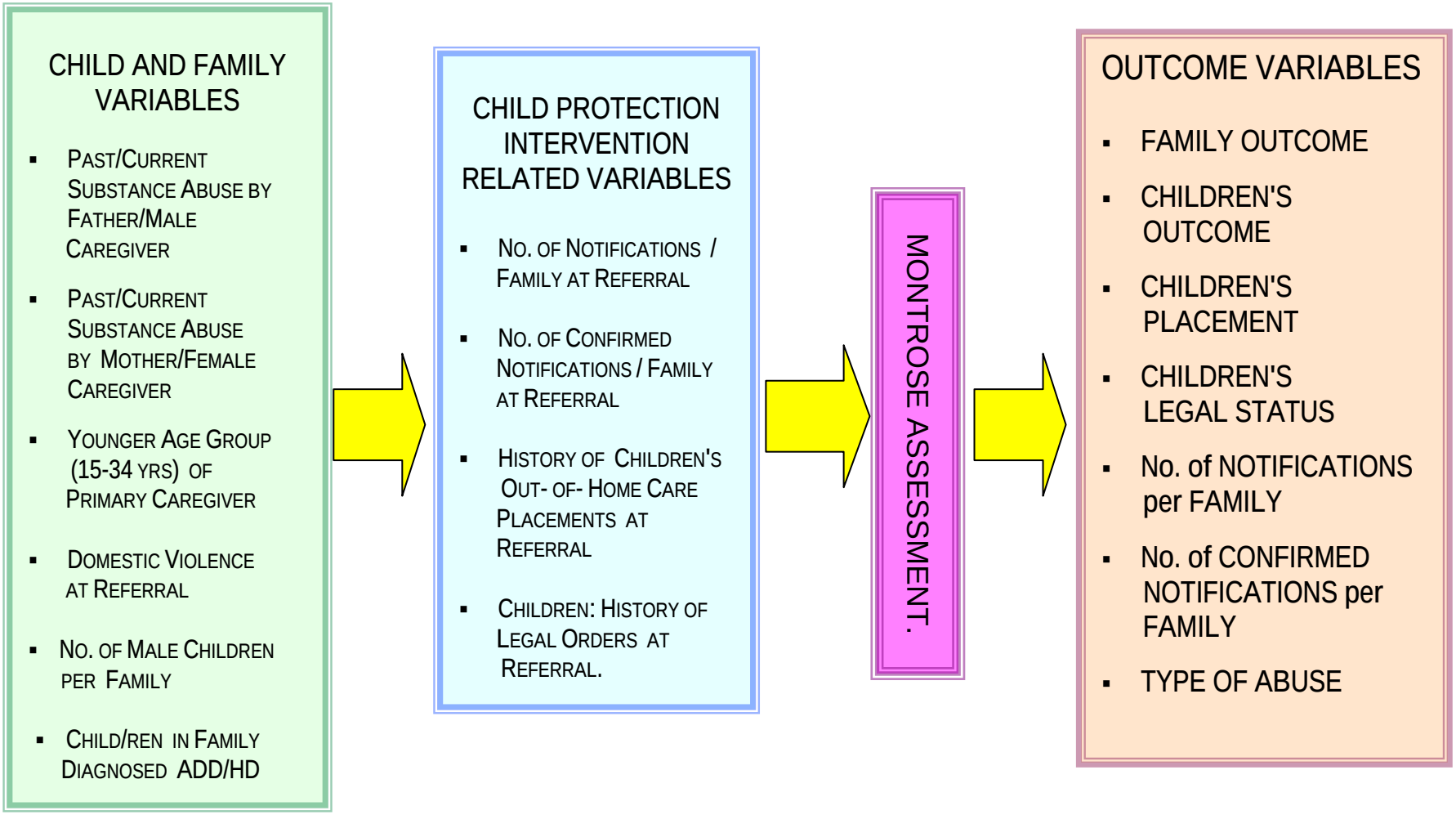
- Family Outcome.
- Children's Outcome.
- Children's Legal Status.
- Children's Placement.
- Number of Notifications.[#]
- Number of Confirmed[♦] Notifications.
- Type of Abuse.

[#] Notifications of child abuse or neglect

[♦] Confirmed = Substantiated after DoCS investigation

In addition to the intervention of the Montrose assessment, the study found that a number of other variables – child, parent and child protection service related - were present in different combinations in the Main Effects Models for each of the specific Outcome variables listed above. These will be described in detail later in this chapter, but Figure 7.2 presents a summary of the most relevant variables for predicting child protection outcome over all the outcome categories.

Fig. 7.2: Summary of Main Effects Models' Strongest Predictive Factors of Outcomes for Families and Children, 3 Years after Referral for Montrose Assessment.



7.3 Rating of Family Outcome and Children's Outcome.

Both Family Outcome and Children's Outcome are composite variables, rated by the author, taking into consideration the family's rating on the four other outcome categories and also an overview of the living situation and changes that occurred within the family over the three years after referral (Family Changes variable). Some of these family changes are unplanned and unavoidable, e.g. parental physical illness or mental health problems, child or parent's death through accident or illness. However, other family changes occur as a result of negative or positive lifestyle choices by the parents or in some cases the adolescent children, e.g. antisocial rather than prosocial behaviour; retaining relationships where there is domestic violence, or continuing with substance abuse rather than choosing an intervention (detox or counselling).

In the three years after referral, there are more family changes overall in both the Assessed and Comparison Groups that resulted in Negative (65%) rather than Positive (28%) consequences for children's life situations. (Table 7.1) This figure is in part due to the fact that children's removal from the family home is treated in this study as a negative factor, and although the children may have later successfully returned to the family home in many cases (rated as a positive factor), the effect of the return does not negate the trauma associated with the child's removal from family and community, even if it is in the best interests of the child at the time.

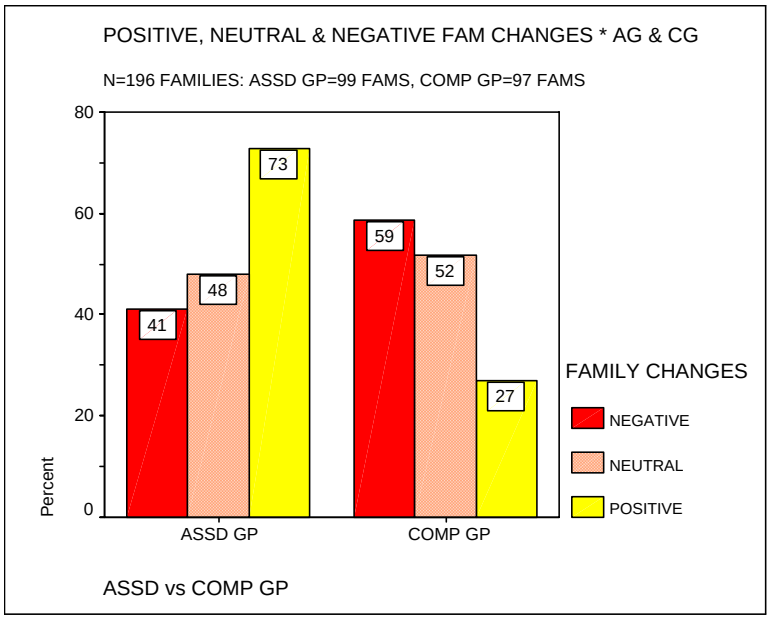
Table 7.1: Effect on Child/ren's Life Situation of Family Changes since Referral. (N = 775 Valid Changes: Up to 5 changes x 196 Families).
Assd Gp n = 99 Families; 391 Family changes.
Comp Gp n=97 Families; 384 Family changes. No other change / No info. n= 225.

Effect Of Change On Child/ren's Life Situation	Assd Gp	Comp. Group	Total
Positive	40.0%	15%	28%
Neutral	7%	7%	7.0%
Negative	53%	78%	65%
Total	100.0%	100.0%	100.0%

While the total *number* of Family Changes is remarkably similar for the Assessed Group (391 changes) and Comparison Group (384 changes), there is a significant difference between the two groups when comparing the *effects* of all family changes on children's life situations ($p < 0.001$). Montrose Assessed Group families have fewer changes with negative impact (53% vs Comparison Group 78%) and more changes with positive impact, (40% vs Comparison Group 15%).

In terms of the distribution within each category of family change - Negative, Neutral and Positive - the Positive impact category was overwhelmingly located within the Assessed Group (73%) (Fig. 7.1). This means that Assessed Group families are much more likely than Comparison Group families to have family changes that impact positively on the child/ren's life situation. Changes with neutral impact on the children's life situation are about evenly distributed between the Assessed Group and Comparison Group, while nearly 60% of family changes with negative effects for the children are located in the Comparison Group.

Fig. 7.1: Effect of Family Changes on Children's Situation Three Years After Referral. (N=200 Families).
Assessed Group n=100; Comparison Group n=100.



Several of the changes with Positive Effects in Assessed Group families are

related to specific interventions with the family, e.g. interagency intervention, mental health counselling, relationship counselling, drug and alcohol counselling, family support intervention. In many cases, these interventions were the direct result of recommendations made in the Montrose Assessment Report. Therefore, the positive impact on the children's life situation in these families can be attributed to family changes initiated by the Montrose assessment.

The difference between overall Family Outcome and Children's Outcome results for the Assessed Group and Comparison Group may be related to the fact that although there were family changes that impacted negatively on the children's life situation in both groups, in some Assessed Group families, the quality or strength of one positive family change or intervention actually mitigated against the effects of a number of negative family events, producing a Positive overall outcome for the children within the family.

7.3.1 Procedure for Rating Family Outcome.

The rating of the variable Family Outcome Three Years after Referral consists of three categories:

1. Family Situation Improved.
2. Family Situation No Different.
3. Family Situation Worse.

Family Outcome is a composite variable, which was rated by the researcher from outcome information for all family members three years after the family's referral for a Montrose assessment. Family Outcome is rated using information from the DoCS computerised child protection files for each child, together with results for the following variables:

- Number of Notifications, per child and per family.
- Confirmed Notifications per child and per family.
- Type of Abuse reported.
- Legal Status of the child/ren.

- Placement History of the child/ren.
- Up to five Family Changes variables per family.

7.3.2 Procedure for Rating Children's Outcome.

The variable Children's Outcome is a complex one, because although the data is collected for each individual child or young person, the unit of measurement in this study is the *family*, not the individual *child*, and outcome may be different for different children in a family. The reasons for this may be situational, or may involve personal characteristics of the child or a parent/carer's relationship with a particular child, for example:

- one child in the family may be scapegoated
- children who are not biologically related to one of the caregivers may be treated differently or targeted for abuse
- difficult behaviour of one child may create discipline issues leading to physical abuse that does not apply to other children
- a male child or biological child may not be targeted for sexual abuse when other children in the family are abused
- a child may be similar in appearance or manner to a previous partner, or a reminder of an unsuccessful relationship
- older children may not be as affected by physical neglect issues, where an infant or young child would be at increased risk.

Children's Outcome was rated using information from the DoCS computerised child protection database (CIS) for each child, and the outcomes three years after referral in the following variables:

- Number of Notifications, per child.
- Confirmed Notifications per child.
- Type of Abuse reported.
- Legal Status of the child.
- Placement History of the child.
- Up to five Family Changes variables per family.

Children's Outcome is a composite rating, based on the life circumstances for *all* the children of the family. The researcher in this study took a conservative approach to the rating of Children's Outcome, so an *Improved* Outcome was only applied if there was an improvement in the wellbeing of *all* the children in the family, while the rating of *Worse* was applied if the life situation of *any* child from the family was worse in the years after the referral to Montrose.

Children's Outcome measures the effect of the Montrose assessment (or no assessment) on the situation of the child/ren only in the family referred to Montrose and not any out of home placement in the follow-up period, which, even if positive, is outside the sphere of influence of the Montrose assessment.

In addition, the rating of Children's Outcome is based on the goal of the Montrose assessment, which is to prevent the need to place children outside the family if possible. Therefore, if children were removed from a referred family (even if this was the recommendation of the Montrose assessment) the Children's Outcome was rated as *Worse*, because the Montrose intervention had not sufficiently improved the family situation to allow the child/ren to safely remain in the home. In most cases, even where there has been maltreatment, removal from the family constitutes a negative experience for a child, even if a short or long term placement has a positive effect on his/her later life circumstances.

It is acknowledged that the risk in applying this rigorous and conservative approach to the rating of Children's Outcome is that it may understate the results for families where there is positive change for a number of children but a worse or unchanged outcome for one child. However, this researcher believes that it is more useful to set a firm baseline for change that has actually occurred in the family, rather than to "average" outcomes across a number of children, and risk overstating the gains made by the family in respect of all the children's welfare.

7.3.3 Case Examples Demonstrating Family and Children's Outcome Ratings.

The following case examples demonstrate the types of Family Outcomes and Children's Outcomes associated with ratings of *Improved*, *No Different* and *Worse* in this study.

Case Number: 11036 (Assessed Group)

FAMILY OUTCOME: Worse
CHILDREN'S OUTCOME: Worse

Family: B/Fa# 25 years, B/Mo* 27 years and three children aged 5, 3 and 2 years.

Eleven notifications on children due to both parents' drug and alcohol abuse, physical abuse, children behaving in a sexually inappropriate manner, and inadequate supervision. The children had been removed from the parents and placed in foster care on a 1 Year Wardship order.

History of serious domestic violence from B/Fa to B/Mo, resulting in a 2-year, in-home AVO*. B/Fa then spent 3 months in jail for assault on B/Mo and they subsequently separated.

B/Mo requested a Montrose assessment to try to regain custody of children. They were restored to her care for 3 weeks prior to Montrose assessment, during which period B/Fa also unexpectedly moved back into the family home.

Both parents had extensive histories of alcohol and polydrug use, including marijuana, amphetamines and heroin. B/Mo had substantially addressed her substance abuse while separated from B/Fa, and was working part time. B/Fa remained on social security benefits.

B/Mo, a former State Ward, grew up in foster placements and residential facilities and was subjected to serious physical and sexual abuse. She began drinking heavily and attempted suicide at the age of 16.

Parents met when B/Mo was 17 and B/Fa was 15. They had their first child when B/Mo was 21. The parental relationship was turbulent with many separations and B/Mo attempted to suicide by overdose numerous times.

B/Fa's family background was dominated by alcohol and domestic violence in which he routinely intervened to protect his mother. He had a history of juvenile crime, including street violence and assault. He did not complete school and struggled with literacy and numeracy.

During the Montrose assessment week, both parents were observed to be drug affected at times. In their budgeting session with Montrose team, they estimated spending $50 a week on marijuana. There was minimal interaction between parents, and B/Mo said that it was not necessary for B/Fa to be a regular part of the family, as she did not rely on him. However, she also hated being alone.

Children's behaviour demonstrated the traumatic effects of their earlier life with their parents. Five year old girl wet herself frequently and was not distressed by this, three year old boy soiled, and two year old boy was not yet talking. All the children displayed aggressive behaviour - biting, kicking, hitting and spitting. …./Cont'd

Birth Father of the children * Birth Mother of the children *Apprehended Violence Order

Case Number: 11036 (Cont'd)

B/Mo had a flat affect and was focused on her own emotional needs, and little interaction was observed between her and the children. She admitted having difficulty when the children demanded her attention or she needed to meet their needs. Hygiene and adequate supervision were ongoing problems.

The bonding and attachment between B/Mo and children was undermined by their time in out of home care and her ongoing depression related to unresolved issues from her past. B/Fa was noted to be more warm and spontaneous in his interactions with the children.

After the assessment week, the children were required by the previous Court Order to return to their out of home care placement, pending implementation of a restoration caseplan. Access with the parents would increase in line with parents' demonstrated readiness to resume the children's care.

The Montrose team recommended that B/Mo continue to have drug and alcohol counselling and be referred for counselling for depression related to her childhood experiences. B/Fa was referred to anger management counselling. Both parents were referred to parenting groups associated with the children's child care centre. Six-weekly reviews of progress were to be held, to determine the progress of the parents towards the restoration goal.

Outcome:

Despite B/Mo making some progress with D&A counselling, the parental relationship remained volatile and B/Fa was jailed for 6 months for domestic violence. B/Mo subsequently died after a heroin overdose. B/Fa resumed custody of children when Wardship order expired, but there were 10 notifications in the three years after the Montrose assessment, and the children were removed from his care because of physical abuse, then returned with Undertakings, then removed again after one of the children sustained a fractured arm and the father was charged.

At the end of the three year follow-up period, paternal grandmother was being assessed as a potential carer.

Case Number: 23008 (Comparison Group)

FAMILY OUTCOME: Worse
CHILDREN'S OUTCOME: Worse

Family: Four boys (aged 13, 12, 11 and 9) and B/Fa, plus stepmother and a female child of both parents (10mnths). B/Mo of boys left B/Fa 5 years earlier initially taking boys. She moved in with a known sexual perpetrator, so the boys were returned to B/Fa's care and B/Mo had no further contact.

Eight notifications on boys for physical abuse/excessive discipline. B/Fa was sole parent for a number of years and provided adequate physical care but he (and then stepmother also) used harsh and excessive discipline. B/Fa was one of 14 children, many of whom were state wards (parental neglect).

Eldest boy had moderate intellectual disability, and generally presented as quiet, timid and withdrawn, but was excluded from school for inappropriate sexual behaviour, and a number of violent outbursts (often after mild rebuke). He frequently ran away from home overnight, presented himself to Police, and had threatened suicide. He was notified for bruising a number of times and had been in Temporary Foster Care where he presented no problems and did not wish to return home. One other child had significant intellectual delay. All the boys demonstrated fear of the parents' anger.

Outcome:

Eldest boy refused to return home and was subsequently made a Ward to age 18, living initially with paternal grandmother, who rejected him after he behaved inappropriately with a 10 year old girl. Boy disclosed child sexual abuse by a female relative while previously in grandmother's care. He was subsequently excluded from a residential placement for sexual incident with male resident. Eventually progressed to independent living with multiple community supports.

Remaining three boys had 19 notifications in three years after referral - physical abuse by both parents, welts and bruising, hits, punches, kicks and strangling. B/Fa was described as "brutal" and boys continually ran away. Both parents denied or minimised physical and emotional abuse.

Boy #2 self-placed with family friends and refused to return home.

Boy #3 was placed with B/Mo 2 years after referral, after irretrievable breakdown with B/Fa and stepmother. Placement broke down after he sexually assaulted B/Mo's 5 year old son. He was made a Ward, and placed in foster care, but this broke down after he threatened foster mother, subsequent placement broke down after next foster mother threatened boy with a belt and he retaliated. Boy stated that the placement was like living with his father.

Case Number: 11009 (Assessed Group)

FAMILY OUTCOME: No Different
CHILDREN'S OUTCOME: No Different

Family: married parents, B/Fa (38 years) and B/Mo (28 years) and four children: boy 8, girl 7, girl 4, and boy 20 months. B/Fa was employed full time, but finances were chaotic. B/Mo was depressed with possible mild intellectual delay.

Seventeen confirmed notifications for neglect, unhygienic, chaotic conditions in the home, children's unkempt presentation and lice infestation. Four dogs lived inside the house. B/Fa was verbally and physically abusive to B/Mo. There were no routines in the home. Two of the children had at least mild intellectual delay and B/Mo was unable to address any of the children's physical or emotional needs.

Family was referred to Montrose after numerous interventions by support agencies (including total cleaning of the house, and purchase of all new bedding) had failed to produce change, and all support agencies refused to continue involvement.

During the Montrose assessment, B/Mo described herself as "useless" unsupported and depressed. She was dependent on B/Fa and extended family for assistance in all aspects of parenting. B/Fa was involved in a variety of hobbies and sports and did not regard housekeeping or childcare as his role. However, the children all presented as strongly attached to both parents. Neither parent acknowledged the degree of risk to the children.

Because of the level of parent-child attachment, the Montrose team recommended multiple interventions (family support, mediation, respite care) aimed at helping the parents to work together and maintain minimum standards of hygiene and routines in the home, so that the children could safely remain.

Outcome:

Parents steadfastly refused to cooperate with caseplan and home situation remained unchanged. Physical violence from B/Fa to B/Mo ceased after an AVO*, but verbal abuse and lack of support continued. Two more children were born in the next three years.

20 further notifications concerning neglect, malnutrition, failure to thrive and physical abuse. Children continued to be underfed (approaching neighbours for food), and unclean and home remained unhygienic - floors covered with food scraps, animal faeces and dirty nappies.

Two of the children were taken into Departmental care briefly, but restored with a 2 year Supervision Order. Family situation unchanged at the end of the three year follow-up period. Children continued to be subjected to ongoing neglect and hygiene issues but were emotionally bonded to parents.

* Apprehended Violence Order

Case Number: 22022 (Comparison Group)

FAMILY OUTCOME: No Different
CHILD'S OUTCOME: No Different

Family consisted of a 10 year old boy living with a female carer, who was the girlfriend of the boy's B/Fa. B/Fa lived nearby and had frequent contact, but they never lived together. The boy had a chromosomal abnormality and mild intellectual disability. B/Fa gained custody of the boy when he was 6 years old, after paying B/Mo $500, at her request, to relinquish custody.

B/Fa's girlfriend was the primary carer for the child. She had placed her own biological child with her mother, who lived nearby, so that she could devote sufficient time to the subject child's needs. Carer continued to have unrealistic expectations about the boy's future, believing he would outgrow his condition or be "cured".

The boy progressed in her care but as he got older, he became more difficult to handle, despite respite and support services. He became violent and displayed inappropriate sexualised behaviour.

Carer became rejecting of the child when his sexualised behaviour targeted younger children and the placement was on the point of breaking down, but B/Fa insisted that she continue to care for the child and not place him in care. He did not assist her in any way with the boy's care.

Outcome:

The carer was licensed as a foster carer for the child. She continued to provide good physical care for the boy, but there was a very strained emotional relationship between them. A shared care situation was established with other foster carers to give the boy and carer respite.

Situation remained very difficult but placement remained intact. B/Fa continued to be unsupportive.

Case Number 11065 (Assessed Group)

FAMILY OUTCOME: Improved
CHILDREN'S OUTCOME: Worse*

Family - B/Mo, (44) single mother of 8 children; five aged 13 - 3½ yrs in her care. Three older children living independently, but experiencing difficulties (substance abuse and one had a child at 15 yrs). Family known to DoCS for 15 years. Younger 5 children had 11 notifications - bruising, burns, sexual abuse, exposure to DV and B/Mo's threats to harm self and children. B/Mo - long history of alcohol abuse, with periods of rehabilitation. Serious depression and self-harming and serious gambling habit.

Referred to Montrose because numerous interventions and services made very little change in family circumstances. B/Mo sober for some months before referral but not managing children's behaviour. Physical and verbal aggression, violence from 13 year old boy to siblings and from B/Mo to boy. Children often in respite care, family situation deteriorating.

B/Mo - history of sexual assault from age 3-12 years. Significant losses in childhood and adult years. Began drinking at age 12, described self as an alcoholic. History of violent, alcohol affected relationships. Her drinking, "suicidal and homicidal" behaviour led to periods in detox centres and psychiatric hospitals, with treatment including electro-convulsive therapy.

During Montrose assessment, B/Mo initially very anxious and raged if she felt threatened: "You're not taking my f*** kids away". However, engaged with Montrose team, was honest, open and demonstrated insight into effect of her behaviour on the children. Apologised to team for outbursts. Aware of her capacity to physically harm the children and wanted change in her life, but knew she could not do this with them in her care.

B/Mo and Montrose team negotiated an agreed caseplan. Children went into foster care, 6 months Wardship Order with a restoration caseplan. B/Mo undertook therapy, parenting and self esteem groups. Children had family therapy and some in individual counselling. Family Support Services remained involved. The CSC# held case reviews every 6 weeks.

Outcome:

B/Mo successful in therapy and parenting groups. Children were restored ahead of the scheduled time, and support services stayed involved. In Montrose evaluation survey, B/Mo wrote: "Since we have all been reunited it has been up and down, but nowhere near where it was 12 months ago…I am starting to change slowly, but I am. The little ones are starting to settle, maybe because I have changed." In response to the Montrose assessment process, she wrote: "At first I was negative, but now I can see the positive of it, thanks."

No further notifications in the three years after referral.

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* In this family, Children's Outcome was rated 'Worse' because of the need for removal and the 6 month out of home placement, which would be emotionally upsetting for the children. Their life situation after return home was greatly enhanced by the changes B/Mo made in their absence, hence Family Outcome was rated 'Improved'.

DoCS Community Services Centre.

Case Number : 11090 (Assessed Group)

FAMILY SITUATION: Improved
CHILDREN'S OUTCOME: Improved

Family: B/Mo, (24 years) and her 27 year old partner, boy aged 4½ from B/Mo's previous relationship and girl 18 months, from current relationship.

Six notifications on the boy - continual rejection by B/Mo, physical abuse, sexual abuse (outside family) and B/Mo's emotional state threatening child's safety. One notification on girl, B/Mo's threats to physically harm.

Family referred to Montrose for concerns regarding the B/Mo 's parenting skills, child management abilities and problems with anger control. Her physical attacks on the 4½ year old boy included hitting, kicking and holding him up against a wall by his throat. B/Mo stated she was fearful she would kill him. Boy having nightmares and not wanting B/Mo to come near him. Displaying aggression to other children at preschool, and the 18 month old girl was biting and kicking the boy. Concerns that B/Mo's partner was favouring his daughter over his step-son.

B/Mo's partner worked long hours, leaving her with children for extended periods. Significant financial problems, exacerbated by pre-existing debts and B/Mo's reliance on take-away meals, videos and paid babysitting.

During Montrose assessment, B/Mo was reluctant to engage in the process and displayed some anger if challenged or if asked to discuss topics she did not wish to. However, she revealed a difficult childhood, being raised between her grandmother and her mother who led a transient lifestyle and had numerous partners.

B/Mo disclosed to the Montrose team that she was sexually assaulted as a child by a step-brother and was the victim of a gang rape at age of 14. She left school in Year 10, having missed a large amount of time. She was involved in a number of relationships, most of them violent, and had three terminations before age 16. She surrendered a child for adoption at 16 because the child was the product of a domestic violence rape and B/Mo felt that she was incapable of being a parent because she was "too screwed up". She had several more relationships, and after the birth of her son when she was 19, she returned to live with her mother, who virtually raised the boy for the first two years, while B/Mo continued to have transient relationships. After the birth of daughter, she requested and underwent a tubal ligation.

B/Mo complained of depression and mood swings and had mild epilepsy. Stated that she did not like herself, and felt like a failure. She had not resolved her grief over death of her grandmother and had an ambivalent relationship with her own mother.

B/Mo's current partner moved in with her after the birth of their child. His parents had separated when he was 9 years old, after verbal arguments, and alcohol abuse. He lived with his father, and visited his mother. He completed Year 10 and gained an apprenticeship.

When asked about his family during the assessment, the boy stated that he did not have one. He said "Daddy gets angry with me", "Mummy makes me cry. I cry a lot" and his sister "hurts me -like everyone."

The 18 month old baby presented as happy and outgoing, but called all females "Mum". B/Mo claimed that girl "plans" to hurt the boy - "I can see it in her eyes - she's not happy till she hurts him".

…/Cont'd

Case Number : 11090 (Cont'd)

Recommendations of Montrose assessment were for an Intensive in-home Family Based Service to work with family, initially for a period of 6 weeks, reviewed at three weeks. If children continue to be at risk at that time, long term placement options would need to be determined by Children's Court action.

If signs of improvement in family situation within 6 weeks, DoCS to apply for a 12 Month Supervision Order, parents required to sign Undertakings not to physically discipline children, B/Mo to be referred for a psychiatric assessment and individual counselling, parents attend relationship counselling and boy's needs be assessed by a psychologist. DoCS to fund some day care for children and supervise regular reviews.

Outcome:

Caseplan accepted. Review after 2 months indicated that B/Mo had engaged well with Intensive Family Based Service, and Children's Court action regarding placement was not required.

Case closed one year later - risk factors to children had decreased, parents had engaged well with Family Support service and counselling, and there had been no notifications on the children.

Three years later, no further notifications on either child.

Case Number: 22020 (Comparison Group)
FAMILY OUTCOME: Improved
CHILDREN'S OUTCOME: Improved

Family: married couple (ages unknown), boy 2½ years and girl 4 months.

Previous history with DoCS - 1 notification regarding B/Mo's inability to deal with over-active, destructive and aggressive behaviour of 2½ year old boy, who had been a problem "since birth", but his behaviour had escalated since the birth of the baby. The boy had been admitted to hospital for observation regarding his behaviour, but no medical findings.

B/Mo reported that he was highly energetic, hit and spat, threw tantrums and slept only 4 hours a night, going to sleep at 10pm, then waking at 2am, and did not sleep during the day. He was very possessive of B/Mo, reluctant to let her out of his sight, even to go to the toilet.

B/Mo stated that she was at her wits' end, and felt like kicking and belting him (although she never had done so) and was fearful she would harm him. B/Mo stated that she felt no bonding with the boy, and this was worse since the birth of the baby, and the boy's presence in the home was increasing her negative feelings towards him.

Maternal grandparents minded the boy one day a week and he attended preschool 5 days a week 9am-4pm. B/Mo went for drives at night to avoid being with the child.

B/Fa was supportive of B/Mo but worked long hours. Parent's relationship was suffering because of the situation with the child, who B/Mo said was ruling their lives.

B/Mo made contact with DoCS requesting Temporary Foster Care for the boy. He was deemed to be at risk of harm and the case was registered due to the safety risk and B/Mo's level of stress.

Outcome:

Multiple support services were put in place by the local DoCS caseworker. These included referral of the boy for psychological assessment and payment for extended hours of day care for him. B/Mo was referred to a Social Worker at Community Health, and was supported by the DoCS caseworker with regular home visits. B/Mo accessed a number of community supports, including a short term residential parenting service with the baby.

There were no further notifications on either of the children in the three years after referral.

7.4 Results: Family Outcome Three Years after Referral.

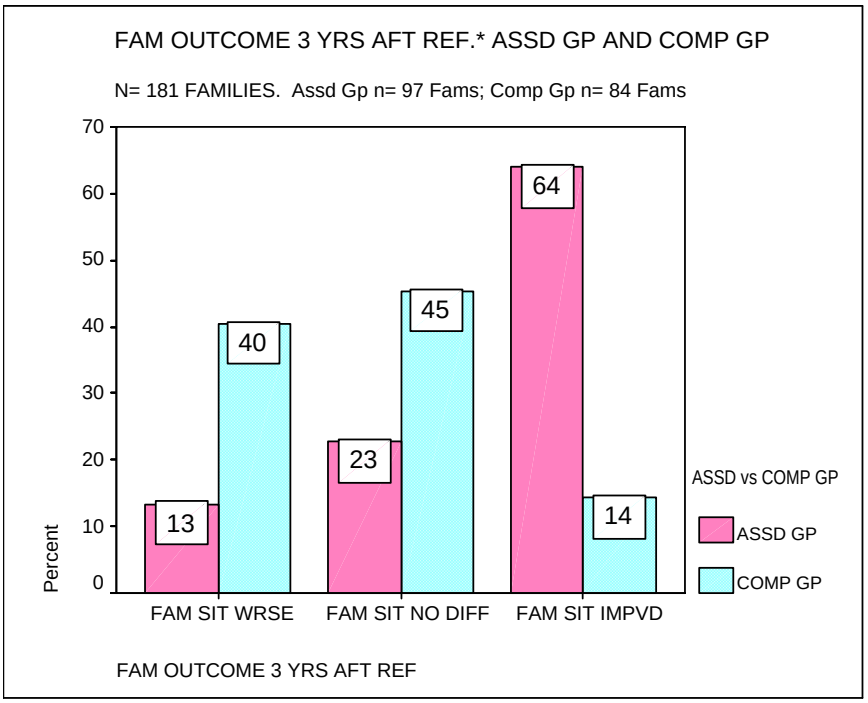
Family Outcome three years after referral was rated for 181 of the 200 families in the total study group - 97 Assessed Group families and 84 Comparison Group families. No information or insufficient information was available to determine Family Outcome for the other 19 families.

Overall, 37% of the 181 families were rated as Improved three years after referral, and 30% as No Different, while 23% were rated Worse. Although the rate of improvement may appear modest, it is important to bear in mind that all families in the study met the Montrose referral criteria that child protection risk was at a sufficient level to place the children's ongoing placement in their families in jeopardy. Under these circumstances, a rate of improvement of nearly 40% is substantial.

The Family Outcome results demonstrate that the Assessed Group families are significantly more likely to be in the Improved category of Family Outcome three years after referral than the Comparison Group families (Appendix 7.1). Sixty-four percent of Assessed Group families are rated as Improved, compared with only 14% of the Comparison Group families (Fig.7.3). By contrast, over three times as many of the Comparison Group families as Assessed Group families are rated Worse and nearly twice as many Comparison Group families as Assessed Group families are rated No Different.

These results clearly demonstrate that, even taking into account the effect of individual family characteristics and intervening events in the family's life in the follow-up period, having participated in a Montrose assessment is significantly associated with Improved life situation for the family three years after referral.

Fig. 7.3: Family Outcome. (N=181 Families).
Assessed Group n=97; Comparison Group n=84.



7.4.1 Family Outcome: Main Effects Models

In this section of the study, the main area of interest is the ability of certain independent variables to predict the likelihood (odds ratio) that families will be in a specific Family Outcome category - *Improved, No Different* or *Worse* - three years after referral. Using the Multinomial Logistic Regression model building process described in Chapter 5, two models emerge with a statistically significant overall relationship between a combination of independent variables and the dependent variable Family Outcome. These two models satisfy all the statistical requirements for demonstrating a robust relationship between the combination of the independent variables and the dependent variable.

Three variables are common to both models:

- Montrose Assessed Group vs Comparison Group*
- Number of Male Children per Family, and
- Number of Confirmed Notifications per family at time of referral.

* Significant at the level of $p<0.001$ in both models.

The fourth independent variable contributing to each model is either:

- Current Domestic Violence at time of Referral or
- Diagnosis of ADD/HD[#] in one or more children per family.

7.4.2 Family Outcome: Main Effects Model 1

The SPSS Output for Family Outcome Main Effects Model 1 is reproduced in Appendix 7.2. The following section describes each of the independent variables' relationship with Family Outcome.

FAMILY OUTCOME: MAIN EFFECTS MODEL 1
Independent Variables and their Likelihood Ratio Test Chi-Square Significance

a. Montrose Assessed Group vs Comparison Group (p=0.000)
b. No. of Male Children per Family (p=0.018)
c. No. of Confirmed Notifications per Family at time of Referral (p=0.026)
d. Domestic Violence Current in Family at time of Referral (p=0.035)

The independent variables in Model 1 represent a combination of child related variables (Male Children per family), family related variables (Domestic Violence current at time of referral), and variables related to an interaction between the family and the child protection service (DoCS), i.e. Montrose Assessed Group vs Comparison Group, and Number of Confirmed Notifications.

7.4.2 a. Montrose Assessed Group vs Comparison Group

The results indicate that participation in a Montrose assessment significantly increases the likelihood[*] of families being in the Improved category of Family Outcome rather than No Different or Worse, relative to Comparison Group families ($p<0.001$). Specifically, Assessed Group families are 18.1 times more likely to be Improved rather than Worse, three years after referral,

[#] Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder
[*] Odds ratio

compared with Comparison Group families (p<0.001). *

Assessed Group families are also 11.2 times more likely to be Improved rather than No Different, relative to Comparison Group families (p<0.001).

7.4.2 b. Number of Male Children per Family.

For the purpose of analysis, the continuous variable Number of Male Children per Family was grouped into two categories around the median value for the total study group (2 male children per family). The two categories comprise families with 0-2 male children and those with three or more male children. These figures relate to the family size three years after referral and do not specify whether or not the male children are living in the family.

The number of male children per family has a significant relationship with the Family Outcome three years after referral. Families with three or more male children are 2.8 times more likely to be in the Worse category of Family Outcome rather than Improved, relative to families with one, two or no male children (p=0.045). Families with three or more male children are also 3.5 times more likely to be No Different than Improved (p=0.006).

7.4.2 c. Number of Confirmed Notifications per Family at Referral.

Child protection notifications to the NSW Department of Community Services (DoCS) are deemed to be Confirmed when allegations of child abuse and/or neglect are substantiated following a DoCS investigation, usually involving interviews with the alleged perpetrator, the child (where age appropriate) and frequently staff of other services, e.g. school or child care, GP etc.

The variable Number of Confirmed Notifications per Family at time of referral for a Montrose Assessment is divided into two groups around the median point for Confirmed Notifications for the 200 families in the study, i.e. Four or

* Significance of the Wald statistic (SPSS Output - MNLR Parameter Estimates Table).

less vs Five or more Confirmed Notifications. The resulting variable is predictive for Family Outcomes categories, those families with five or more Confirmed Notifications at referral being associated with negative Family outcomes.

The Assessed Group and Comparison Group are comparable on this variable at time of referral, the Assessed Group having 53% of families with five or more Confirmed Notifications (Comparison Group 55%).

Families with five or more Confirmed Notifications at referral are 3 times more likely to have a Worse Family Outcome three years after referral than to be Improved, relative to families with 0-4 Confirmed Notifications (p=0.014).

In addition, families with five or more Confirmed Notifications are 2.5 times more likely to be No Different rather than Improved three years later (p=0.031).

7.4.2 d. Current Domestic Violence in Family at Referral.

Current Domestic Violence in the family of time of referral (with or without a history of previous domestic violence), is predictive of less favourable Family Outcome three years later.

Families who are experiencing Current Domestic Violence at the time of referral are 3 times more likely to be in the Worse category of Family Outcome rather than Improved, relative to families with no Current Domestic Violence at time of referral (p=0.016).

Further, families with Current Domestic Violence at referral are twice as likely to have Worse than No Different Family Outcome, relative to families with no Current Domestic Violence (p=0.046).

7.4.3 Family Outcome: Main Effects Model 2

The second of the Family Outcome Main Effects Models contains three of the independent variables in Model 1, i.e. Montrose Assessed Group and Comparison Group; Number of Confirmed Notifications/Family at time of Referral and Number of Male Children per Family - with the additional independent variable of Diagnosis of one or more children in the family with ADD or ADHD.

FAMILY OUTCOME MAIN EFFECTS MODEL 2
Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. **Montrose Assessed Group vs Comparison Group (p=0.000)**
b. **Number of Children Diagnosed with ADD/HD per Family (p=0.009)**
c. **Number of Confirmed Notifications / Family at time of Referral (p=0.010)**
d. **Number of Male Children per Family (p=0.023)**

7.4.3 a. Montrose Assessed Group vs Comparison Group.

In Main Effects Model 2, Assessed Group families are 19.5 times more likely to have Improved rather than Worse Family Outcome three years after referral, relative to Comparison Group families ($p<0.001$). In addition, Assessed Group families are 12 times more likely than to be rated Improved rather than No Different ($p<0.001$). These results are consistent with those for Model 1.

7.4.3 b. Number of Children per Family Diagnosed with ADD/HD.

There were 56 families in the 200 study group families (28%) where one or more of the children was diagnosed with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder*. This rate of diagnosis is up to 11 times greater than the estimated incidence of diagnosed ADD/HD in the general population of children and youth in New South Wales (NSW Dept Health Report 1996). The number of families with one child or more

* Jointly referred to in this study as ADD/HD.

diagnosed ADD/HD is almost exactly the same in the Assessed Group (n=27) and Comparison Group (n=29) (Appendix 7.4). In most families in this study, the diagnosis of ADD/HD also meant the use of prescribed medication, sometimes of more than one type, even in children as young as 3 years old. This medication is usually prescribed to aid concentration in the child or young person, but is sometimes also used by parents/carers to control difficult behaviour, and in some instances is used more frequently and above the prescribed dosage, according to the needs of the parent rather than the child. Hence this group of children and young people are at a particular type of risk.

For purposes of analysis, the Variable was divided into two groups:

- families where one child or more has been diagnosed by a qualified medical practitioner as having either Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder
- families where none of the children has a formal diagnosis of ADD/HD.

In this study, Family Outcome for families with a child or children diagnosed with ADD/HD is significantly less favourable than for families with no ADD/HD diagnosis. Families with one or more child diagnosed with ADD/HD, are 4.6 times more likely to be Worse rather than Improved three years after referral, compared with families with no children diagnosed ADD/HD ($p=0.003$). In addition, at a less significant level ($p<0.10$), but still demonstrating a trend, these families are 2.5 times more likely to be No Different, rather than Improved ($p=0.054$).

7.4.3 c. Number of Confirmed Notifications per Family at Time of Referral.

As for Family Outcome Main Effects Model 1, the variable Number of Confirmed Notifications per Family at Referral is divided into 2 groups (Four or less vs Five or more Confirmed Notifications). Consistent with Model 1, a

higher number of Confirmed Notifications at referral is predictive of more negative Family Outcome three years later.

In Family Outcome Main Effects Model 2, families with Five or More Confirmed Notifications at referral are 3.9 times more likely to be Worse rather than Improved three years after referral, relative to families with 0-4 Confirmed Notifications (p=0.005). In addition, families with Five or More Confirmed Notifications are 2.6 times more likely to be rated No Different than Improved (p=0.026).

7.4.3 d. Number of Male Children per Family.

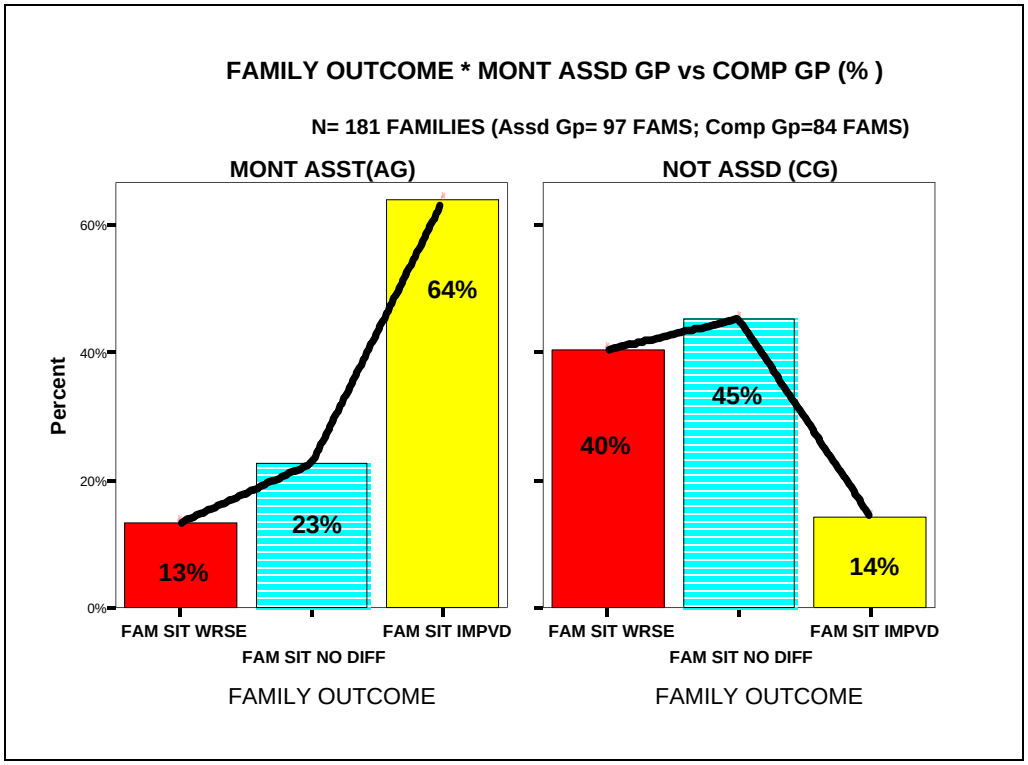
As in Model 1, the variable Numbers of Male Children per Family is divided into two categories - 0-2 male children and three or more male children. Three or more male children in families (regardless of ages and whether or not they are living with the family) is a significant factor for Family Outcome in both Main Effects models.

In Model 2, families with Three or More Male Children are 3.5 times more likely to be in the No Different Family Outcome category than in the Improved category, relative to families with 0-2 male children (p=0.007). At a less significant level, (p<0.10), but indicating a directional trend, families with Three or More Male Children are 2.6 times more likely to be Worse than Improved (p=0.062).

7.4.4 Summary of Family Outcome Results.

In terms of Family Outcome three years after referral, Assessed Group families are significantly more likely than Comparison Group families to be rated as Improved rather than Worse or No Different. ($p<0.001$) Fig. 7.4 demonstrates the clear directional trend of Family Outcomes for the Assessed Group and the Comparison Group.

Fig. 7.4: Family Outcome Trends Three Years after Referral (N=181 Families). Assessed Group n=97; Comparison Group n=84.



Family Outcome: Main Effects Models.

Two robust models emerged with a statistically significant overall relationship between the combination of four independent variables and the dependent variable Family Outcome.[#]

FAMILY OUTCOME: MAIN EFFECTS MODEL 1

a. Montrose Assessed Group vs Comparison Group (p=0.000)[*]
b. No. Male Children per Family (p=0.018)
c. No. Confirmed Notifications / family at time of referral (p=0.026)
d. Domestic Violence Current in Family at time of referral (p =0.035)

The combination of independent variables in Main Effects Model 1 provides the following information concerning Family Outcome three years after referral for a Montrose assessment:

1. Families who participate in a Montrose assessment are 18 times more likely to be Improved rather than Worse, and 11 times more likely to be Improved rather than No Different, relative to non-assessed Comparison Group families (p<0.001).

2. Families with three or more male children are 2.8 times more likely to be Worse rather than Improved (p=0.045) and 3.5 times more likely to be No Different rather than Improved (p=0.006), relative to families with two or less male children.

3. Families with five or more Confirmed Notifications at time of referral are 3 times more likely to be rated Worse rather than Improved (p=0.014) and 2.5 times more likely to be No Different rather than Improved (p=0.031), relative to families with 0-4 Confirmed Notifications.

4. Families experiencing current Domestic Violence at the time of referral are 3 times more likely to be Worse (p=0.016) rather than Improved and

[#] Model fitting chi-square p< 0.001.
[*] Likelihood Ratio Test chi-square significance.

twice as likely to be Worse than No Different (p=0.046) relative to families with no Current Domestic Violence at time of referral.

FAMILY OUTCOME: MAIN EFFECTS MODEL 2

a. Montrose Assessed Group vs Comparison Group (p =0.000)
b. No. Children Diagnosed with ADD/HD per Family (p =0.009)
c. No. Confirmed Notifications / Family at time of Referral (p =0.010)
d. No. of Male Children per Family (p =0.023)

The combination of independent variables in Main Effects Model 2 provides the following information concerning Family Outcome three years after referral for a Montrose assessment:

1. Families who participated in a Montrose assessment are 19 times more likely to be Improved rather than Worse, and 12 times more likely to be Improved rather than No Different, relative to Comparison Group families (p<0.001).

2. Families with three or more male children are 3.5 times more likely to be No Different rather than Improved, relative to families with 0-2 male children (p=0.007). At a less significant level, but indicating some directional trend, families with three or more male children are 2.6 times more likely to be Worse rather than Improved (p=0.062).

3. Families with five or more Confirmed Notifications per family at referral are 3.9 times more likely to be Worse rather than Improved (p=0.005) and 2.6 times more likely to be No Different than Improved (p=0.026) relative to families with 0-4 Confirmed Notifications.

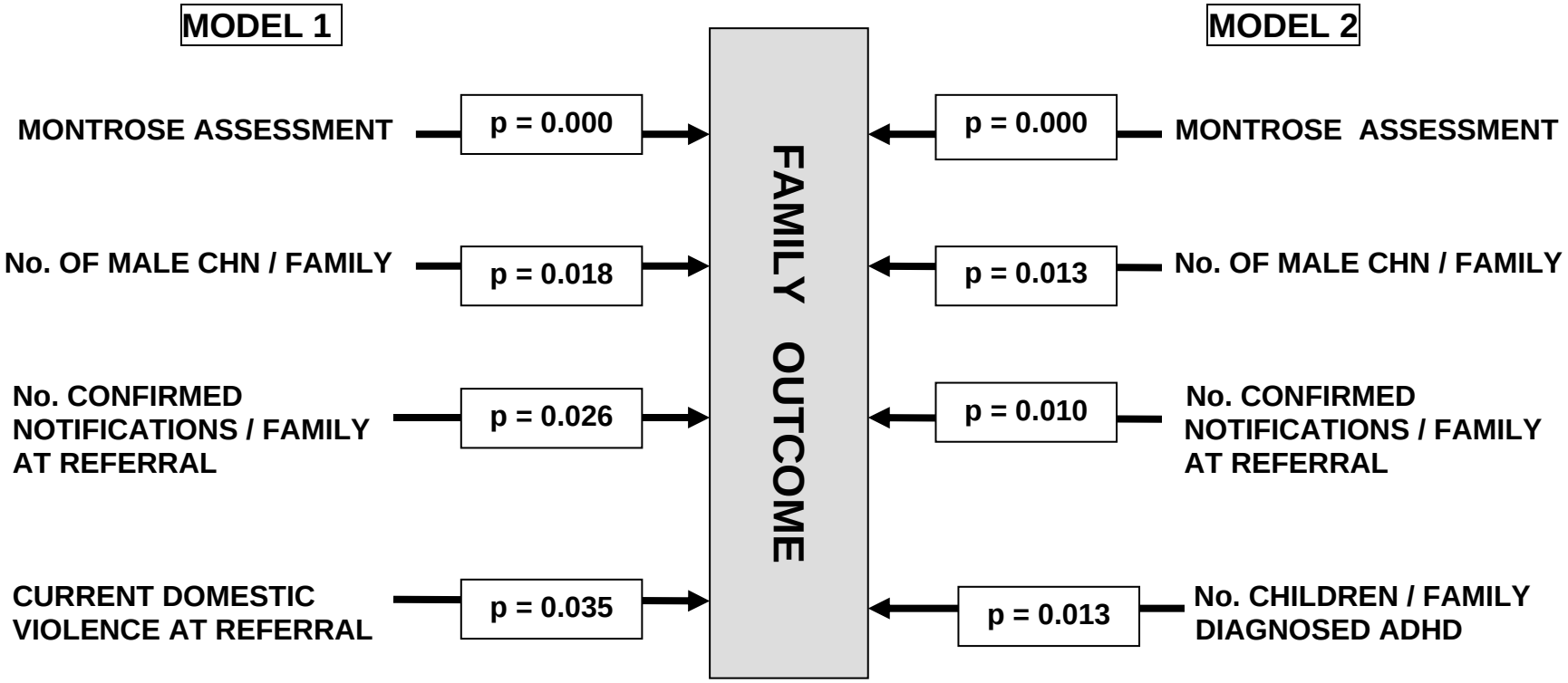
4. Families with one or more child diagnosed with ADD/HD, are 4.6 times more likely to be Worse rather than Improved three years after referral, compared with families with no children diagnosed ADD/HD (p=0.003). At a less significant level, but indicating some directional trend, families with diagnosed ADD/HD in one or more children, are 2.5 times more likely to be No Different, rather than Improved (p=0.054).

In summary, both Main Effects Models 1 and 2 indicate that a Montrose assessment is associated with more positive Family Outcomes three years after referral. Having three or more male children per family and having more than five confirmed notifications at referral are factors associated with Worse or No Different family Outcomes.

In addition to these three variables, domestic violence at time of referral (Model 1) or diagnosis of ADD/HD in one or more children in the family (Model 2) are associated with Worse Family Outcomes.

The Main Effects Models for Family Outcome are depicted in Fig. 7.5

Fig 7.5. MAIN EFFECTS MODELS: FAMILY OUTCOME
IMPROVED / NO DIFFERENT / WORSE



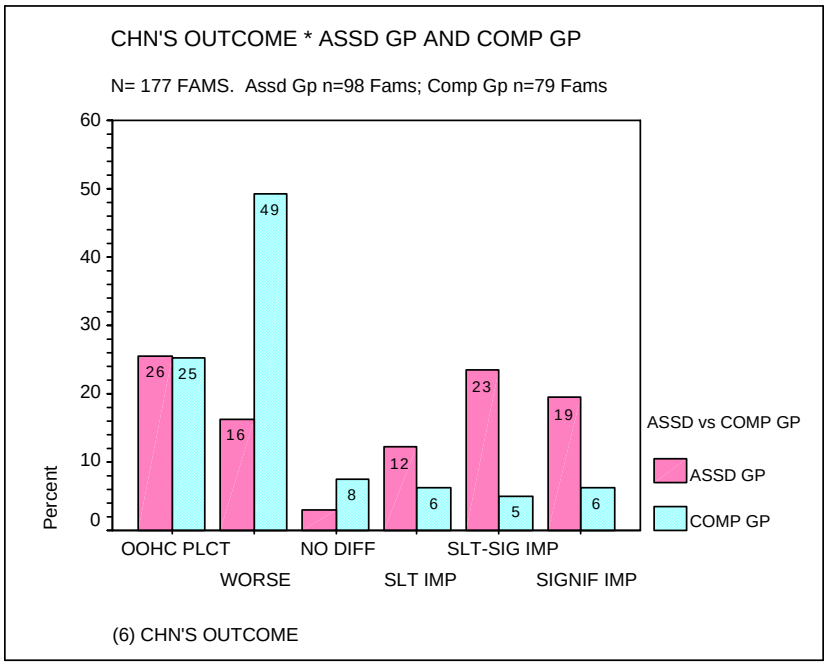
7.5 Results: Children's Outcome Three Years after Referral.

7.5.1 Introduction.

Sufficient file information was available to rate Children's Outcome in 177 of the 200 study group families - 98 Assessed Group families and 79 Comparison Group families. Even applying the conservative approach to rating Children's Outcome described earlier in this chapter (i.e. the life situation of all children in the family must be improved for the family to be rated Improved, family is rated Worse if one child or more have a worse outcome), the results demonstrate a significant difference in favour of improved outcomes for children from families who participate in a Montrose assessment (Assessed Group) ($p<0.001$).

Children's Outcome was initially rated on a 5 point scale, Worse / No Different / Slightly Improved / Slightly-Significantly Improved / Significantly Improved, plus a sixth category for families where one child or more required short term or long term placement in the three year follow-up period. (Fig. 7.6)

Fig. 7.6: Children's Outcome (6 Categories) (N =177 families). Assessed Group n=98; Comparison Group n=79.



Within these six categories, the Assessed Group has more than twice the proportion of families as the Comparison Group in all three categories of Improved Children's Outcome. Children's Outcome is rated as No Different in only 11% of families - 8% Comparison Group (n=6 families) and 3% Assessed Group (n=3 families).

Where all the children remained in the family in the three years after referral, Children's Outcome is rated as Worse in three times as many Comparison Group as Assessed Group families ($p<0.001$). In fact, the Children's Outcome in nearly half (49%) of the Comparison Group families is rated as Worse, as opposed to only 16% of the Assessed Group.

For the purposes of analysis, the rating of Children's Outcome was reduced to three major categories, by combining the three sub-categories of Improved Children's Outcome and merging the category "Children Require Placement Short/Long Term" with the category Worse because it reflects a serious child protection risk level in the family. The three Children's Outcome categories are:

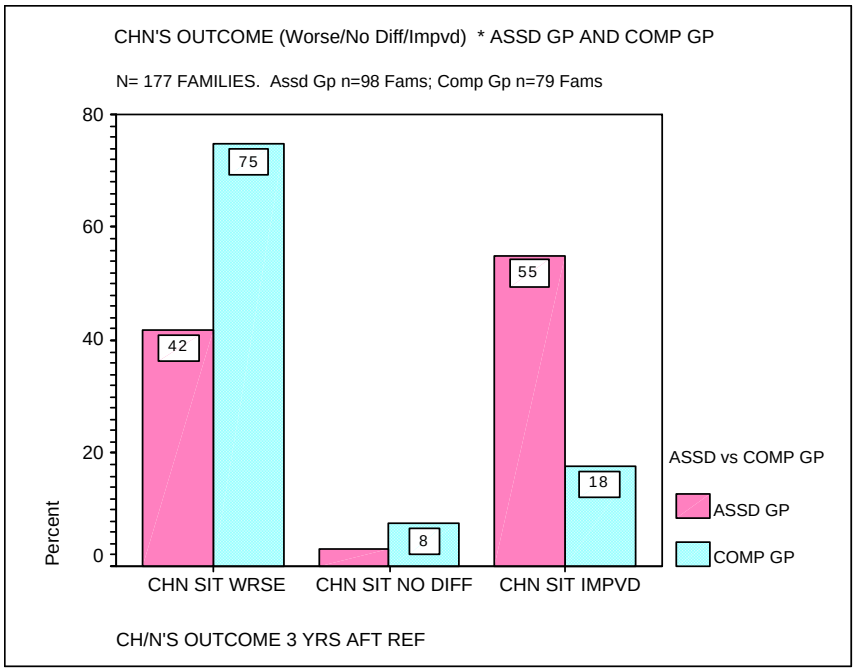
1. Child/ren's Situation Worse.
2. Child/ren's Situation No Different.
3. Child/ren's Situation Improved.

Combining the category for Out Of Home Care Placement with the Worse Children's Outcome category acknowledges the traumatic emotional impact on children who are involuntarily removed from parents, even for a short period of time, and even as part of a caseplan for which restoration is the goal. Positive results of children's short term removal, while the parents address issues that impact negatively on the children, will be reflected in an Improved rating of Family Outcome.

Fig. 7.7 compares the Children's Outcome results - Improved, No Different, and Worse - by Assessed Group and Comparison Group. A rating of Improved means that *all* children in the family had improved life situations in

the three years after referral. The category Worse includes any families where one or more child required short or long term placement in the three years after referral and also families where *any* of the Children's Outcomes was rated as Worse.

Fig. 7.7: Child/ren's Outcome (Worse/No Different/Improved) (N=177 Families). Assessed Group n=98; Comparison Group n=79.



Three years after referral, there are significantly more families from the Assessed Group in the Improved category and more Comparison Group families in the Worse category ($p<0.001$).

The category No Different is clearly under-represented compared with the other two categories of Children's Outcome. This is in contrast to the Family Outcome variable, where 34% of families are rated as No Different three years after referral. A crosstabulation of Family Outcome and Children's Outcome (Table 7.2) reveals that all 9 families where the Children's Outcome is rated No Different also have Family Outcome rated as No Different. The other families with Family Outcome rated No Different are predominantly associated with a Worse Children's Outcome (77%), with only 7% of families with a Worse Family Outcome having an Improved Children's Outcome.

Table 7.2: Children's Outcome * Family Outcome (N=173 families).

FAM OUTCOME 3 YRS AFT REF * CH/N'S OUTCOME 3 YRS AFT REF Crosstabulation

			CH/N'S OUTCOME 3 YRS AFT REF			
			CHN SIT WRSE	CHN SIT NO DIFF	CHN SIT IMPVD	Total
FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	45	0	0	45
		% within FAM OUTCOME 3 YRS AFT REF	100.0%	.0%	.0%	100.0%
	FAM SIT NO DIFF	Count	43	9	4	56
		% within FAM OUTCOME 3 YRS AFT REF	76.8%	16.1%	7.1%	100.0%
	FAM SIT IMPVD	Count	9	0	63	72
		% within FAM OUTCOME 3 YRS AFT REF	12.5%	.0%	87.5%	100.0%
Total		Count	97	9	67	173
		% within FAM OUTCOME 3 YRS AFT REF	56.1%	5.2%	38.7%	100.0%

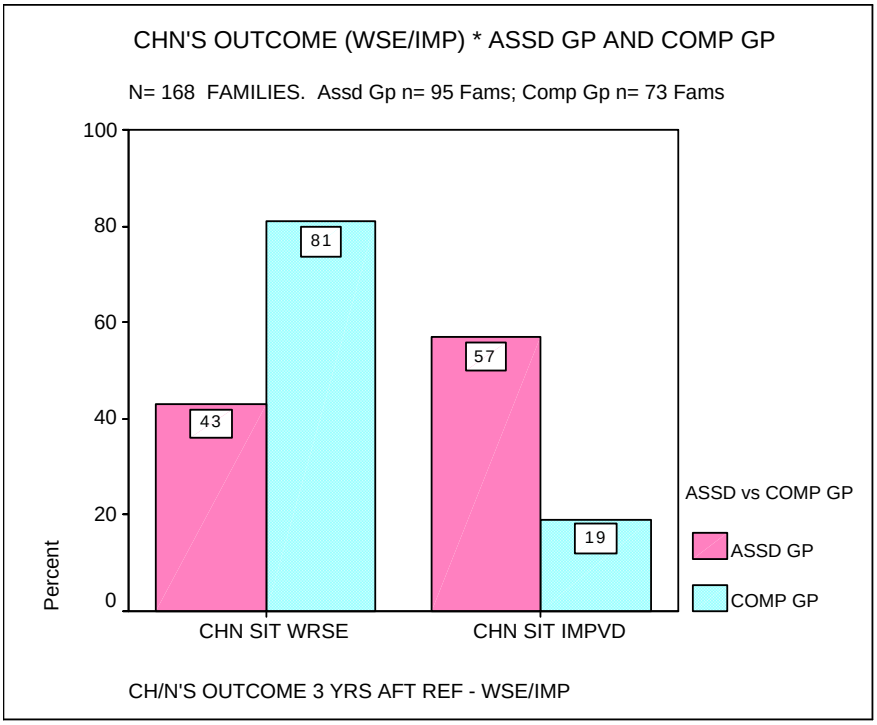
The strong message associated with this finding is that while families or their circumstances may not be different three years after referral, the quality of life for children who live in those families does not remain static, but is most likely to deteriorate. The relationship between Family Outcome and Children's Outcome is discussed in more detail later in this chapter.

7.5.2 Children's Outcome: Improved / Worse.

Because of the low number of families in the Children's Outcome category 'No Different', Children's Outcome was crosstabulated with the Assessed Group and Comparison Group, excluding the 9 "No Different" families, listing the results only for families where the children's situation is rated Improved or Worse.

The results for the 168 families (Assessed Group n=95; Comparison Group n=73) in the Improved and Worse categories highlight the significant difference between the Assessed Group and Comparison Group in terms of Children's Outcome ($p<0.001$) (Fig. 7.8). Children from 81% of the Comparison Group families are rated as having Worse Children's Outcomes, compared with only 43% of Assessed Group families. Conversely, children from 57% of the Assessed Group families are rated as having an Improved situation, compared to only 19% of the Comparison Group.

Fig. 7.8: Children's Outcome (Improved / Worse) N=168 Families. Assessed Group n=95; Comparison Group n=73.



An obviously concerning fact is the high number of families in both groups for whom the Child/ren's Outcome is rated Worse three years after referral. The reasons for this are complex, and may be related to family structure and relationships, or to the types of family changes that impact on the family in the three years after referral (See Table 7.1 and Fig. 7.1 in Section 7.2 of this chapter). Overall, the largest proportion of individual family changes reported in both the Assessed Group and Comparison Group families are ones which would have a negative effect on the children's life situation. However, the proportion of negative family changes represents 78% of the Comparison Group, compared with only 53% of the Assessed Group.

The number of families rated as Worse is also impacted by the researcher's decision, described earlier in this chapter, to rate all families with children who went into out of home care in the three years after referral as having Worse outcomes, because of the emotional effect of removal on the children, and to use the Family Outcome variable to describe the longer term positive or negative results of the removal and, if relevant, restoration to the family.

7.5.3 Children's Outcome: Main Effects Model.

Using multinomial logistic regression, it is possible to look at other independent variables which also impact on Children's Outcome. Because the model-building process would be affected by the small numbers in the No Different category, this category was retained for the model building process, but excluded from analysis.

The Main Effects Model for Children's Outcome (Appendix 7.5) demonstrates a statistically significant overall relationship between the dependent variable Children's Outcome and three independent variables - Montrose assessment; Number of Confirmed Notifications per Family at Referral; and Substance Abuse (current of past) by a Male Caregiver in the Family (Model Fitting Chi-Square significance $p<0.001$).

CHILDREN'S OUTCOME: MAIN EFFECTS MODEL.
Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Montrose Assessment vs Comparison Group (p=0.000)*
b. Number of Confirmed Notifications per Family Before Referral (p=0.006)
c. Male Carer's Substance Abuse (p=0.034)

7.5.3 a. Montrose Assessment vs Comparison Group.

Three years after referral, Children's Outcome in Assessed Group families is 7.3 times more likely to be rated as Improved rather than Worse, relative to Comparison Group families who did not have the Montrose assessment ($p<0.001$).*

7.5.3 b. Number of Confirmed Notifications per Family before Referral.

For the purposes of analysis, the continuous independent variable Number of Confirmed Notifications per Family at Referral was divided around the median point for the 200 families in the study into two groups, 0-4 Confirmed

* Significance of the Wald statistic (SPSS Output - MNLR Parameter Estimates Table).

Notifications and 5 or more Confirmed Notifications. Higher numbers (5+) of confirmed notifications per family at referral are predictive of worse outcomes for children in those families three years after referral.

Crosstabulation of Number of Confirmed Notifications at referral and Children's Outcome (Appendix 7.6) (N=168 families) demonstrates that 63% of families with five or more Confirmed Notifications had Worse Children's Outcomes, compared with 37% of families with 0-4 confirmed notifications (p=0.005).

The main effects model for Children's Outcome indicates that the life situation of children from families with five or more Confirmed Notifications at referral is 2.7 times more likely to be rated as Worse rather than Improved three years after referral, relative to families with four or less Confirmed Notifications (p=0.006).

7.5.3 c. Male Carer's* Substance Abuse

This variable applies to all families where the male caregiver has abused drugs and/or alcohol, currently or in the past, while he is/was a member of the referred family with some level of responsibility for the children's safety, welfare and wellbeing. The relevant factor here is the *substance abuse*, whether *present* <u>*or*</u> *past*. A previous substance abusing partner of the mother may have left the family, but the impact may still be associated with Children's Outcome years later.

Families where the male caregiver has current or past substance abuse are twice as likely to be in the Worse, rather than in the Improved, category for Children's Outcome three years after referral, relative to families where there is no reported substance abuse by the male carer (p=0.026).

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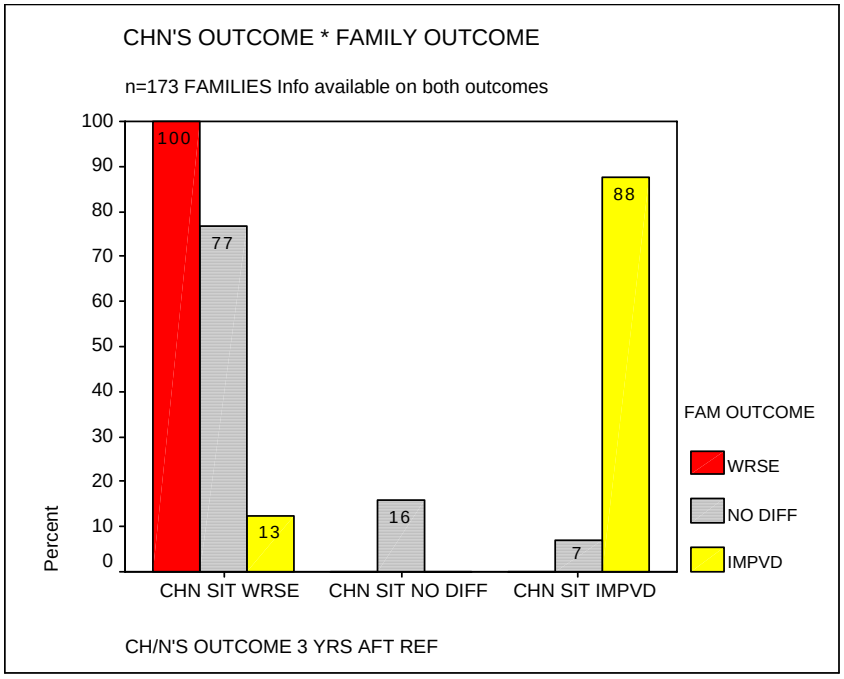
* The terms *male carer* and *male caregiver* are used interchangeably and refer to:
- the biological father of some or all of the children, or
- the mother's past or current partner who has been/is a member of the family and had some level of responsibility for the children.

7.5.4 Relationship Between Family Outcome and Children's Outcome.

Along with the other outcome variables in this results chapter, Children's Outcome is one of the factors used to rate Family Outcome. The relationship between Family Outcome and Children's Outcome three years after referral is interrelated in a number of significant ways (Fig. 7.9).

Fig. 7.9: Children's Outcome x Family Outcome (N=173 Families.)



1. For 100% of families with a *Worse* Family Outcome, the Children's Outcome is also rated Worse.

2. Where Family Outcome is rated *No Different*, Children's Outcomes are primarily also Worse (77% of families). They are No Different for 16% of families and Improved for only 7%.

3. Where Family Outcome is rated *Improved*, Children's Outcome is also rated Improved in 87.5% of families but is rated Worse in the remaining 12.5% (n=9) of the families. In eight of these families where the children's situation is rated Worse but the Family Outcome is rated Improved, this result is likely to be due to the Montrose team recommending short term placement while the parent/s attempted to develop their parenting skills,

prior to the children being restored. In these cases, the researcher's rating method means that the out of home care placement itself attracts a Children's Outcome rating of Worse (because of the emotional impact on children of separation from their parent/s). However, the Family Outcome after placement and subsequent restoration is rated Improved, reflecting the improved situation for the parents and children after the intervention.

Practice Implications.

The key information here is that if the family situation is worse in the three years after referral, the effect on the overall life situation for the children in those families is totally negative - their circumstances do not remain unchanged or improve. Where the family situation is unchanged, the Children's Outcome is significantly more likely to also be worse, rather than no different or improved.

On the other hand, if the family situation improves, in the majority of cases, the children's situation also improves. In this study, there are no cases where the children's situation remained No Different if the Family Outcome was Improved.

The implication of this direct relationship between Children's Outcome and Family Outcome is that interventions working solely with the children (e.g. preschool placement or individual counselling for the child with no parental involvement) are not likely to produce a positive outcome for the children. Interventions aimed at increasing the positive life circumstances for children must target the whole family situation, in particular the parent/s or primary caregivers.

7.5.5 Summary of Children's Outcome Results.

Improved Children's Outcome is significantly associated with the family having participated in a Montrose assessment. Of 177 families measured using the categories Improved, No Different and worse, all children from 55% of Assessed Group families had an Improved life situation three years after referral, compared with only 18% of Comparison Group families ($p<0.001$).

Where all children remained in the family in the three years after referral, the Comparison Group has significantly more families (49%) with Worse Children's Outcome, compared with the Assessed Group (16%). When the category for children's short-term or long-term placement outside the family is combined with the Worse category of Children's Outcome (because of the negative emotional effect of removal on the child), the Comparison Group has 75% of families rated Worse compared with 42% of Assessed Group families.

Children's Outcome was rated as No Different in only 11% of families (8% Comparison Group, 3% Assessed Group), demonstrating that although families may not change, children's situations in these families tend to polarise between improved or worse, in this study the majority (77%) being rated as Worse.

When Children's Outcome is divided into only two categories - Improved or Worse (N=168 Families), there is a significant difference between the Assessed Group and Comparison Group, with the Comparison Group having 81% of families rated Worse, compared with 43% of the Assessed Group, or conversely, the Assessed Group having 57% of families rated Improved, compared with only 19% of the Comparison Group ($p<0.001$).

The Main Effects Model for Children's Outcome indicates that children from families who participate in a Montrose assessment are 7.3 times more likely to be Improved than to be Worse three years after referral, relative to Comparison Group families who did not have an assessment ($p<0.001$).

The Children's Outcome in families with Five or more Confirmed Notifications at referral is 2.7 times more likely to be rated as Worse rather than Improved, relative to families with four or less Confirmed Notifications (p=0.006).

Children's Outcome in families with Past or Current Substance Abuse by a Male Caregiver is twice as likely to be Worse, rather than Improved, relative to families with no reported substance abuse by the male carer (p=0.026).

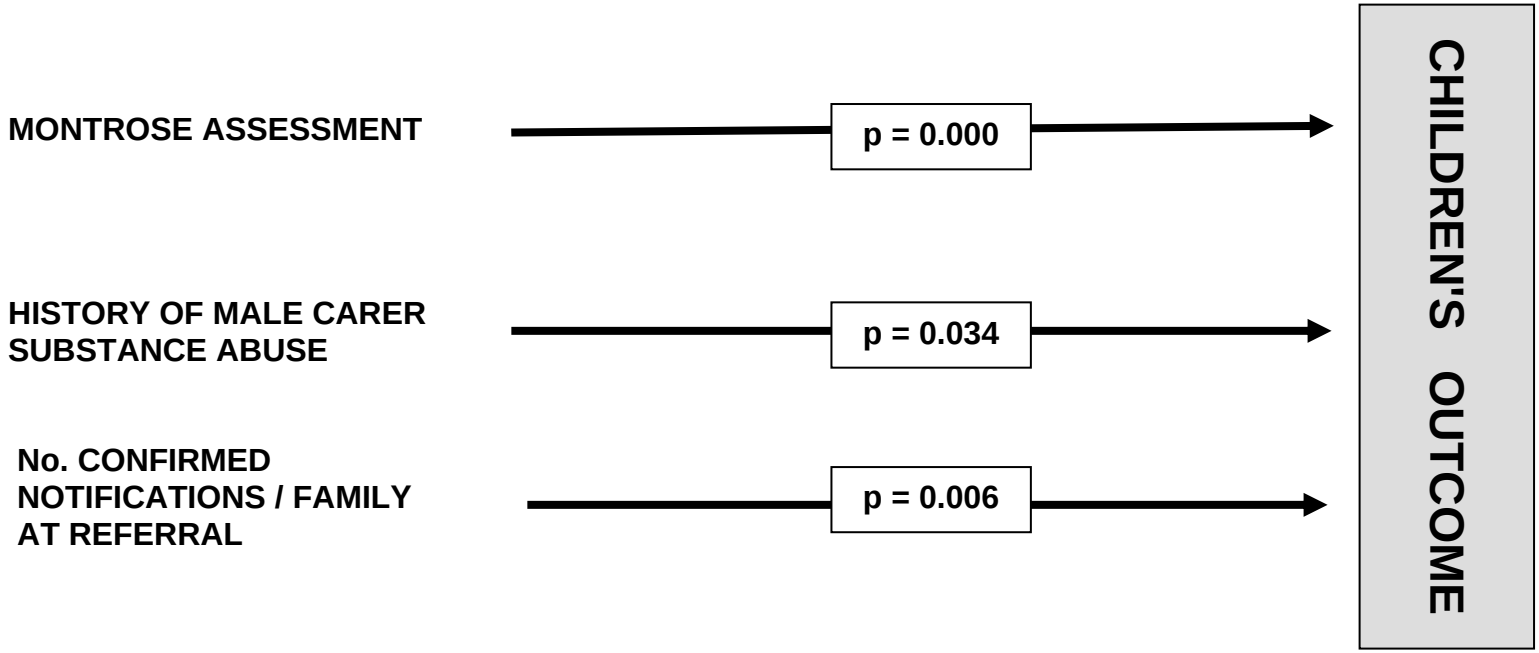
There is a clear relationship between Family Outcome and Children's Outcome. All families with a Worse Family Outcome, also had a Worse Children's Outcome rating. Where Family Outcome is rated Improved, Children's Outcome is also rated Improved in 87.5% of families.

However, where Family Outcome is rated *No Different*, Children's Outcomes are primarily Worse (77% of families), indicating that in families that are not responsive to interventions, the children's situation is substantially more likely to deteriorate rather than remain the same or improve. This result indicates the need to review interventions regularly, to ensure that positive change is taking place. If this is not the case, the children's placement in the family must be reconsidered.

The practice implications suggested by these results are that interventions that only involve the child/ren (e.g. preschool or individual counselling) are less likely to produce a long-term positive outcome for the children than interventions involving the parents/caregivers as well as the children.

The Main Effects Model for Children's Outcome is depicted in Figure 7.10.

Fig. 7.10: MAIN EFFECTS MODEL: CHILDREN'S OUTCOME
WORSE / IMPROVED



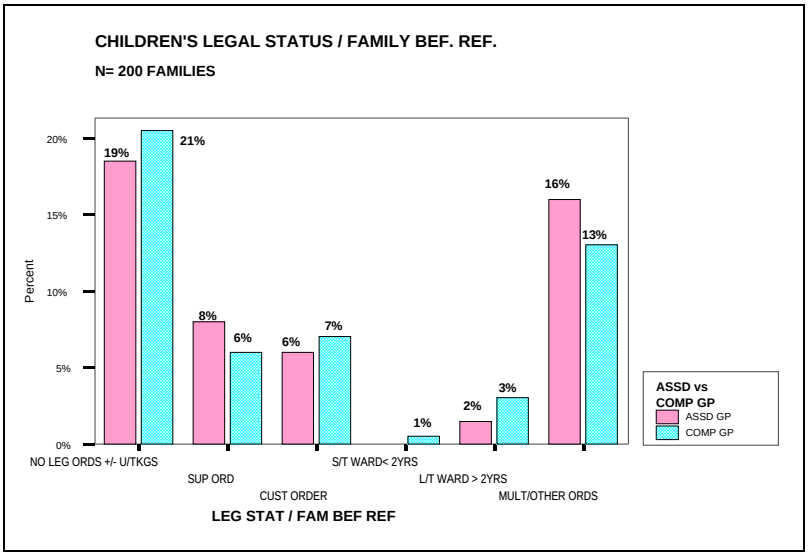
7.6 Results: Children's Legal Status Three Years After Referral.

Data for the outcome category *Children's Legal Status*[*] *per Family, Three Years After Referral* was collated using DoCS computerised child protection files (CIS) for each child under 18 years of age living in the family home at time of referral to Montrose, or who returned to the family home or were born in the three years after referral. Six categories of legal status (Children's Court Orders only) were initially utilised to describe the legal orders applicable to each family:

- No Legal Orders[#]
- Supervision Order[*]
- Custody Order
- Short Term Wardship
- Long Term Wardship
- Multiple Legal Order Types[◊]

There is no significant difference between the Assessed Group and Comparison Group in Legal Order types at time of referral to Montrose (Fig. 7.11). *No Legal Orders* and *Multiple Order Types* are the most frequent categories for both Groups.

Fig. 7.11: Legal Status per Family at Referral (6 Categories). (N = 200 families). Assessed Group n=100; Comparison Group n=100.



[*] Children's Court Orders
[#] May include informal Undertakings with the Department, but no Children's Court Order.
[*] Supervision Order, Custody Order, Wardship Order: Children's Court Order for one or more child/ren.
[◊] Multiple Order Types: in this study refers to Children's Court Orders for removal of at least one child.

When the six types of Legal Status per Family are compared three years after referral, there is a significant difference between the Assessed Group and Comparison Group (p=0.002). The Assessed Group has 58% of families with No Legal Orders, compared with 49% of Comparison Group families, and the Assessed Group has significantly more Supervision Orders (17% vs Comparison Group 6%), while the Comparison Group has more Custody Orders (20% vs Assessed Group 6%) (Appendix 7.9).

To prevent the small numbers in some Legal Status categories affecting analysis, the variable was divided into three main categories, reflecting different degrees of state intervention into the lives of the children and families:

a. *No Legal Orders*
   - may include informal undertakings by the parent/carer with the Department of Community Services, but involves no Children's Court action.

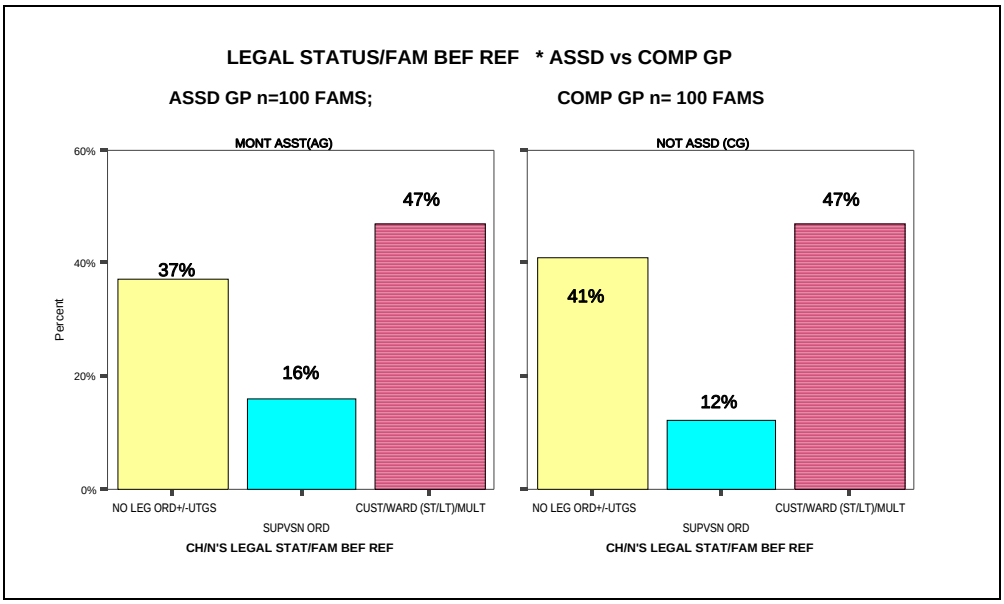
b. *Supervision Order*
   - mainly range from 6 months to 2 years (up to 5 years in rare cases) and may refer to one child or more per family. The Order requires Children's Court action, and DoCS supervision of the family, but does not involve removal of the children from the family.

c. *Custody / Wardship / Multiple Order Types.*
   - *Custody Orders*, made through the Children's Court, signify removal of one or more child/ren from the home to the care of another person, for the period of the order. Placement options include foster care, residential care or placement with an extended family member or other relative. Guardianship of the child may also be transferred to a family member in a long term order, but this is not always the case.
   - *Wardship Orders*, made through the Children's Court, mean that the guardianship of the child is transferred from the parent/s to the Minister for Community Services, for the period of the Order, ranging from 6 months to the time the child reaches 18 years (under the 1987 Act).

- For the purposes of this study, *Multiple Order Types* per Family represents a combination of legal status orders, which includes at least one Custody or Wardship Order, involving removal of at least one child from the family.

Using these three categories, there is no significant difference between Assessed and Comparison Group families at time of referral to the Montrose Program (Fig. 7.12).

Fig. 7.12: Legal Status per Family at Referral (3 Categories) (N=200 Families). Assessed Group n=100; Comparison Group n=100.

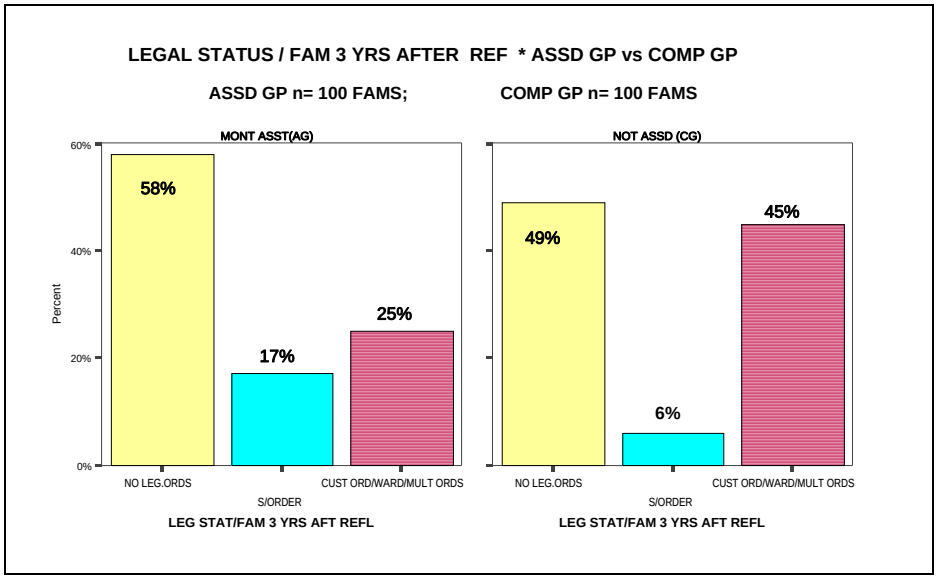


Families with some type of Children's Court Legal Order account for 63% of the Assessed Group and 59% of the Comparison Group. The proportion of families with Orders in the most serious legal status category (Custody Order / Wardship / Multiple Order Types), represents nearly half (47%) of both groups, indicating the serious nature of the child protection concerns for both groups at time of referral.

7.6.1 Legal Status Outcome: Results

Three years after referral to Montrose, there is a significant difference between the Assessed Group and Comparison Groups in terms of Legal Status Outcome (p=0.003) (Fig. 7.13).

Fig. 7.13: Legal Status per Family in Three Years after Referral (3 Categories). (N = 200 families). Assessed Group n=100; Comparison Group n=100.



The category Custody/Wardship/Multiple Order Types has decreased from time of referral by 22% in the Assessed Group, compared with only a 2% decrease in the Comparison Group. This means that Legal Orders associated with out of home placement for one child or more now account for only 25% of the Assessed Group, compared with 45% of the Comparison Group.

This decrease in the most serious types of legal orders occurs in spite of the fact that the Montrose team actually recommended long-term Wardship or Custody Orders in 9% of families and short term Wardship orders (less than two years and usually with a goal of restoration) in 12% of families. (Table 7.3).

Another difference between the Assessed Group and Comparison Group is the significantly higher proportion of Supervision Orders in Assessed Group families (17% vs Comparison Group 6%) (p=0.003). This difference may be explained in part by the number of families for whom a Supervision Order was a recommendation of the Montrose Team. A Supervision Order allows time for parents to acquire parenting strategies, or for intervention with a mental health or a substance abuse issue, while the children remain in the

family home under the supervision of a DoCS Caseworker, who also monitors the parents' progress. This Order also facilitates access to resources and services to assist the family.

A Supervision Order was recommended by Montrose in 27% of Assessed families (Table 7.3), although the recommendation may not always be put into action by the referring Caseworker or by the Children's Court, who may decide on a less intrusive action or more a serious legal response. Some families that had completed Supervision Orders would be counted in the *No Legal Orders Three Years after Referral* category.

Table 7.3: Legal Orders Recommended by Montrose Team. (Assessed Group n = 100 Families).

Recommended Action / Legal Order*	% of Families
Parent: Undertakings (Informal; or Formal as part of a S/Order)	30.0
SUPERVISION ORDER	**27.0**
SHORT TERM WARDSHIP ORDER (< 2 yrs)	12.0
LONG TERM WARDSHIP ORDER (2 - 18 yrs)	5.0
CUSTODY ORDER (usually to family member)	4.0
DoCS review current legal order if no change in X# (1/3/6) mnths	23.0
Alternate placement if no change in X# (1 / 3 / 6) months	7.0

In summary, three years after referral to Montrose, 75% of Assessed Group families were subject to either no Legal Orders, or to a time-limited Supervision Order that allows the children to remain in the family home under DoCS supervision. This result is considerably better than the 55% of Comparison Group families in the same two categories and demonstrates that the Montrose program was successful in achieving its goal of avoiding removal of children from their family, while maintaining their safety, welfare and wellbeing.

* Different orders may be made for different children in same family.

7.6.2 Children's Legal Status Outcome: Main Effects Model

The MNLR model-building process yielded a model which meets all the requirements for demonstrating a significant overall relationship between Children's Legal Status Outcome and a combination of three independent variables (Appendix 7.11).

The independent variables in the model include two variables which relate to an interaction between the family and the child protection service (Montrose Assessed Group vs Comparison Group, and No Legal Orders vs Legal Orders at Referral), and a parent-related variable (Mother/female caregiver's current or past Substance Abuse).

LEGAL STATUS PER FAMILY THREE YEARS AFTER REFERRAL: MAIN EFFECTS MODEL

Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Montrose Assessed Group vs Comparison Group. (p=0.001)
b. No Legal Orders per Family before Referral. (p=0.001)
c. Past/Current Substance Abuse by Mother/Female Caregiver. (p=0.034)

7.6.2 a. Montrose Assessed Group vs Comparison Group.

Participation in a Montrose assessment increases the likelihood of a family having either No Legal Orders or a Supervision Order three years after referral, rather than having serious Legal Orders involving placement of one child or more (Custody Order/ Wardship / Multiple Order Types).

Assessed Group families are 2.3 times more likely to have No Legal Orders rather than Custody Order / Wardship or Multiple Order Types three years after referral, relative to Comparison Group families (p=0.013). Further, Assessed Group families are 5.8 times more likely to be subject to a Supervision Order rather than the more serious Custody Order / Wardship / Multiple Order Types, compared with Comparison Group families (p=0.001). This last factor is undoubtedly influenced by Supervision Orders

recommended by the Montrose assessing team in 27% of Assessed families (Table 7.3).

A Supervision Order may in fact indicate a positive outcome, because the Custody Order / Wardship / Multiple Order Types category is associated with children's placement outside the family, while the Supervision Order means that the children remain in the family, under DoCS supervision, and often with additional resources, while the family addresses the issues that are jeopardising the children's safety, welfare and wellbeing.

7.6.2 b. No Legal Orders per Family before Referral.

Families with no legal orders before referral did significantly better three years after referral, compared with families who already have Children's Court Legal Orders related to one or more child at the time of referral to Montrose.

Families with no history of legal orders at referral are 2.5 times more likely to have No Legal Orders three years after referral, rather than be in the Custody Order / Wardship / Multiple Legal Order Types category, relative to families who have one or more Children's Court Orders at referral ($p<0.005$).

In addition, families that have had no legal orders before referral are 4.2 times more likely to have No Legal Orders, rather than a Supervision Order, three years after referral ($p<0.004$).

7.6.2 c. Past / Current Substance Abuse by Mother / Female Caregiver.

Past or current substance abuse by the mother / female caregiver* at time of referral is associated with poorer child protection outcomes in terms of the type of Children's Court Legal Orders three years after referral.

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* In most cases, the female caregiver in the family is the mother of some or all of the children. In this study, the terms mother and female caregiver are used interchangeably, except where biological relationship to the child/ren is a relevant factor.

Families where the mother/female caregiver has a history of alcohol and/or drug abuse, or is currently substance abusing at time of referral, are 3.8 times more likely to be in the Custody Order / Wardship / Multiple Legal Order Types category three years after referral than in the Supervision Order category, relative to families with no reported substance abuse by the mother/female caregiver at referral ($p<0.016$).

The implication of this finding is important in terms of the disruption to the children's lives, because the Custody Order / Wardship / Multiple Legal Order Types category is associated with placement outside the family of one child or more, whereas a Supervision Order allows the child/ren to remain in the family, under the supervision of a DoCS caseworker, while the mother addresses the parenting issues associated with her substance abuse.

7.6.3 Summary Of Children's Legal Status Outcome Results.

The Main Effects Model for Legal Status per Family Three Years after Referral indicates that three variables are associated with Children's Legal Status three years after referral - Montrose Assessment, Previous Legal Orders and Mother's Past or Current Substance Abuse.

There are more Assessed Group families in the No Legal Orders category three years after referral (58% vs 49% Comparison Group). On the other hand, Comparison Group families are over-represented in the Custody Order / Wardship / Multiple Order Types category (45% vs 25% Assessed Group families).

Assessed Group families have more Supervision Orders (17% vs 6% Comparison Group), but this is partly explained by the number of families for whom Supervision Orders were part of the recommended caseplan after the Montrose assessment. A Supervision Order means that the children are able to be left in the family home while the parent/s addressed parenting issues, rather than the children being removed to an alternative placement.

In the Main Effects Model for Legal Status Three Years after Referral, Assessed Group families are 2.3 times as likely to have No Legal Orders (p=0.003), and 5.8 times more likely to have a Supervision Order (p=0.001), rather than be subjects of a Custody Order / Wardship or Multiple Order Types.

Relative to families with Children's Court orders at referral, families with no legal orders are 2.5 times more likely to also have No Legal Orders three years after referral, rather than be in the Custody Order / Wardship / Multiple Legal Order Types category (p=0.005), and 4.2 times more likely to have no legal orders than a Supervision Order (p=0.004).

Families where the mother/female caregiver has past or current substance abuse issues are 3.8 times more likely to be in the Custody Order / Wardship / Multiple Legal Order Types category rather than to have a Supervision Order three years after referral, relative to families with no history of maternal substance abuse (p=0.016). This means that the likelihood of one or more children being removed from the parental home is significantly greater in families where the mother/female caregiver has abused, or is currently abusing, drugs and/or alcohol.

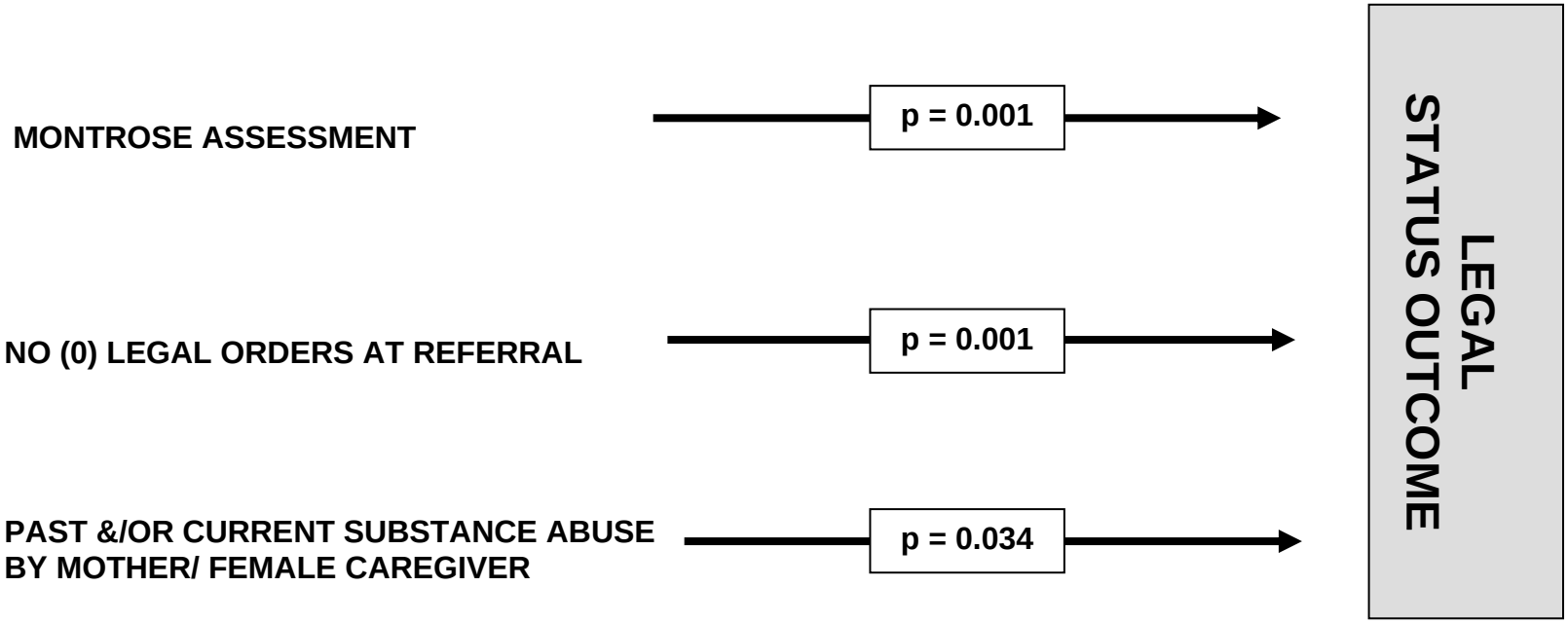
In summary, the Main Effects Model for Legal Status Outcome indicates that families who participate in a Montrose assessment are significantly less likely to be the subject of the most serious category of Legal Orders three years after referral, compared with Comparison Group families. Families with no legal orders at referral are more likely than those with legal orders to still have no legal orders three years later, and families where there is no past or current substance abuse by the female caregiver at referral are less likely to be subject to the type of Children's Court legal orders that affect the children's ongoing placement in the family.

The practice implications of these results indicate that conducting a comprehensive family assessment *before* Children's Court action (i.e.

application for Legal Orders) may significantly decrease the need for more stringent legal intervention at a later time. The concept of "early intervention" has in recent years been associated with interventions into families with young children, typically below the age of three years (Davis 1996; Scott and O'Neill 1996; Perry 1998). Results of this study expand the concept of early intervention to include intervening *early in the child protection careers* of high risk families, regardless of the age of the children, with a view to providing supports and services which will divert families away from the need for more stringent statutory or legal interventions at a later date.

The Main Effects Model for Legal Status Outcome three years after referral is demonstrated in Figure 7.14.

Fig 7.14: MAIN EFFECTS MODEL: LEGAL STATUS OUTCOME.
NO LEGAL ORDERS / SUPERVISION ORDER / CUSTODY; WARDSHIP; MULTIPLE ORDER TYPES.



7.7 Results: Children's Placement Three Years after Referral.

7.7.1 Children's Placement Options.

Children's Placement Three Years After Referral, is related to Legal Status per Family Three Years After Referral. The numbers differ slightly between the two variables because children may be placed informally with relatives or others, without a Children's Court Order changing their Legal Status and while remaining the legal responsibility of their parents.

The hierarchy of children's placement options favoured by the Montrose program, is consistent with the philosophy of applying the least interventionist child protection approach that will still improve the child's situation in terms of safety, welfare and wellbeing. The hierarchy is as follows.

1. All children remain in their family home, with adequate supports to improve the level of parental care and minimise risk to the children's safety, welfare and wellbeing.
2. Where risk factors require removal of children from the home following the Montrose assessment, the goal is that placement is short term, preferably with extended family, and that the child returns to the parents' care if the issues causing risk can be satisfactorily resolved.
3. Failing this outcome, longer term placement with extended family is seen as a preferable option to Substitute Care, in order to preserve the child’s sense of security, attachment and identity.
4. Substitute Care is a last option for long term placement, necessary in cases where neither the parents nor the extended family can provide the necessary level of safety and nurturing to the child.

In line with this hierarchy of most favoured placement options for children, the children's placement categories of interest in this study are:

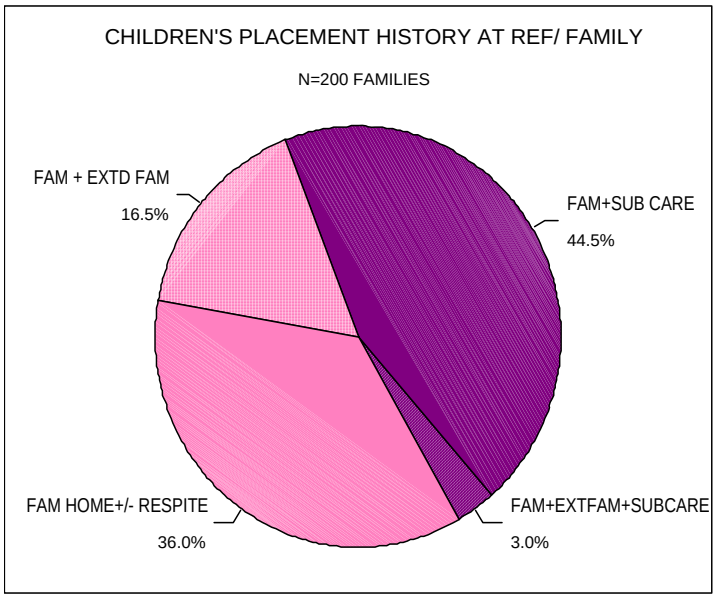
a. *The Family Home* (in some cases with the support of informal respite care with relatives, or formal respite or voluntary Temporary Foster Care arranged via DoCS, e.g. for a few nights a month or for time in the school holidays),

b. *The Extended Family* (which, because of their small numbers in this study also includes non-custodial parents), and

c. *Substitute Care* (government or non-government foster care with non-relative carers, or residential care or independent living programs.)

At time of referral to Montrose, children from 36% of the study group families had never experienced any significant out of home placement, although 33% of families (n=66) had used respite care or voluntary Temporary Foster Care at least once to support the placement at home. Children from just over half the families (52.5%) had only lived with parents or with extended family (with or without respite or Temporary Foster Care). One or more children from 44.5% families had been placed in substitute care at some time and in a further 3% of families, children had been placed with extended family as well as in substitute care (Fig. 7.15).

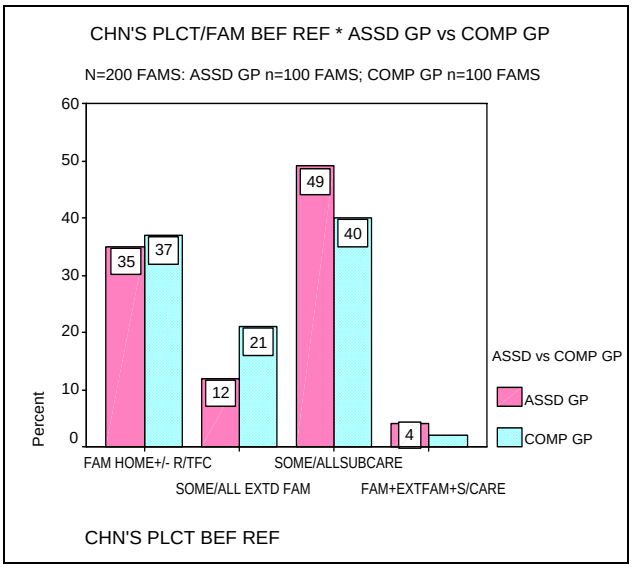
Fig. 7.15: Study Group: Children's Placement History per Family, at Referral. (N=200 Families).



In total, at least one child from 64% of the 200 study group families (i.e. 128 families) had experienced short or long term out of home care at time of referral to Montrose. This is a measure of the child protection concerns and family functioning of the families referred to Montrose, and the challenge that faces the Montrose team trying to develop caseplans that will lower the level of risk to the children's safety, welfare and wellbeing sufficiently to enable them to remain in the family.

There is no significant difference between the Assessed Group and the Comparison Group with regard to the history of children's placement types at time of referral to Montrose. (Fig. 7.16).

Fig. 7.16: Children's Placement History per Family at Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



In 35% of the Assessed Group families and 37% of the Comparison Group families, all the children had always lived within the family home before referral to Montrose, although some had used respite care or Temporary Foster Care to assist the parents to cope. In 12% of the Assessed Group families and 21% of the Comparison Group families, at least one child had lived or was living with extended family[*]. In 49% of the Assessed Group and

[*] For the purposes of this section, the small number of families where children were living with the non-custodial parent at time of referral, are included in the *Extended Family* subcategory.

40% of the Comparison Group families, one or more child had a history of placement in Substitute Care, while a very small number of families had children who had lived in a combination of extended family care and substitute care, as well as in the family home.

7.7.2 Children's Placement Outcome.

The major unit of measurement for this study is the *family*, rather than the individual child, and it is possible for families to have some children in the family home and other children in other placements. The placement types measured three years after referral were initially collated into 5 categories:

- All children in the family home (51.3%);
- All children with extended family (7.6%);
- All children in substitute care (7.6%);
- Some children with family, some with extended family (10.7%); and
- Some children with family, some in substitute care (22.8%).

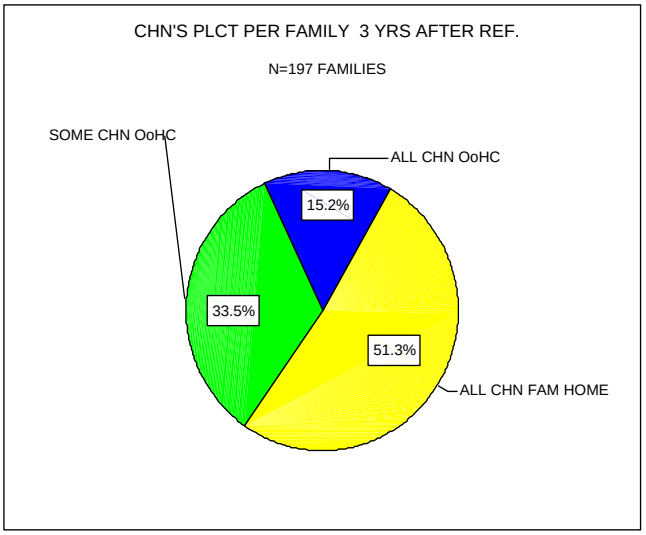
The small numbers in the categories *All Children in Extended Family* and *All Children in Substitute Care* posed difficulties for analysis. Given that there was no significant difference between the Assessed Group and Comparison Group on the variable Children's Placement Three Years after Referral, the five placement options were reduced to three categories as follows, for the purpose of analysis of relationships with other variables:

1. *All* Children in the Family Home.
2. *Some* Children in Out of Home Care (Extended Family or Substitute Care).
3. *All* children in Out of Home Care (Extended Family or Substitute Care).

Using these three Children's Placement Outcome categories, just over half the families in the study (51.3%) had All Children Living in the Family Home three years after referral; 33.5% of families had Some Children in Out of Home Care and others within the family; and 15.2 % of families had All Children in Out of Home Care (Fig. 7.17). Three Comparison Group families

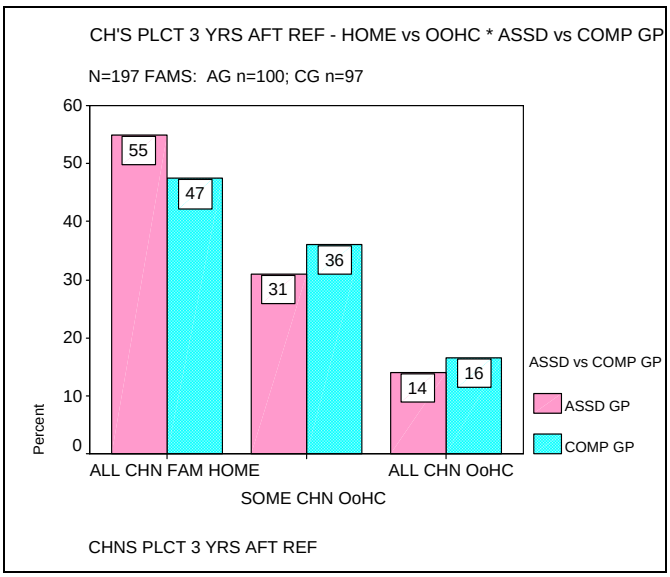
had insufficient information available to determine the placement of all children and are not included in the analysis.

Fig. 7.17: Children's Placement per Family Three Years after Referral. (N=197 Families).



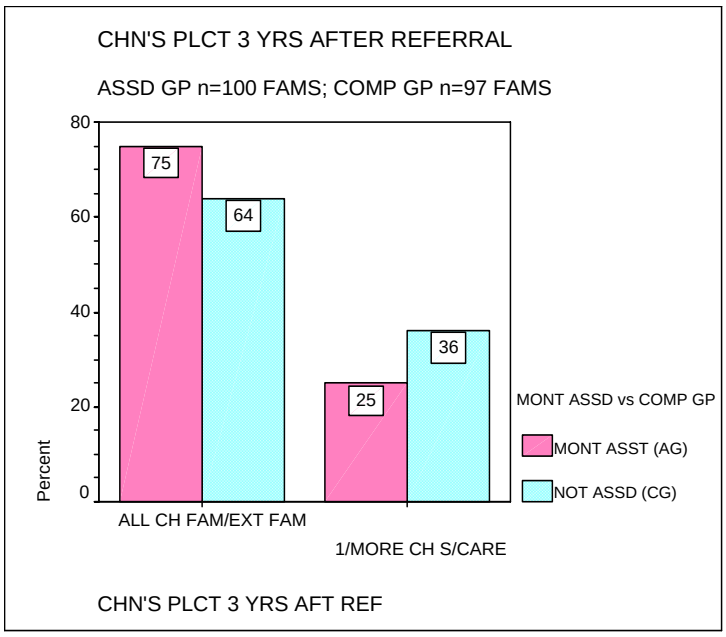
When the three Outcome categories for the variable Children's Placement Three Years After Referral are compared by Assessed Group and Comparison Group, the Assessed Group has more families with All Children in the Family Home and fewer with either Some or All Children in Out of Home Care (Fig 7.18), but the difference between the Assessed Group and Comparison Group is not statistically significant.

Fig 7.18: Children's Placement Three Years After Referral. (N= 197 Families). Assessed Group n=100; Comparison Group n=97.



One of the primary goals of the Montrose program is to keep children within the family, *or extended family*, wherever possible. This was achieved in 75% of Assessed Group families, where all children were placed in either their birth family or extended family three years after referral, rather than in non-relative Substitute Care, compared with 64% of the Comparison Group (p=0.062); (Appendix 7.15); (Fig. 7.19).

Fig. 7.19: Children's Placement Three Years after Referral (Family or Extended Family vs Substitute Care). (N=197 Families). Assessed Group n=100; Comparison Group n= 97.



7.7.3 Children's Placement Three Years After Referral: Main Effects Models.

Multinomial Logistic Regression was used to determine what factors may influence outcome in terms of children's placement within the family or in out of home care, three years after referral.

The MNLR model-building process yielded two valid models which indicated significant relationships between independent variables and the dependent variable Children's Placement Three Years After Referral (Appendix 7.17 and Appendix 7.18). The models indicate that the three variables most strongly associated with children’s placement three years after referral are a history of

previous placement/s of one or more children, younger age group of the primary caregiver, and substance abuse by a parent or caregiver, with substance abuse by the father/male caregiver* being the stronger determinant. The two Main Effects Models are a combination of the first two variables and either past/current substance abuse by the father/male caregiver (Model 1) or the mother/ female caregiver (Model 2).

7.7.4 Children's Placement Three Years After Referral: Main Effects Model 1.

CHILDREN'S PLACEMENT THREE YEARS AFTER REFERRAL: MAIN EFFECTS MODEL 1

Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Children's Placement History Before Referral (p=0.008)
b. Age Group of Primary Carer at Referral (p=0.011)
c. Past / Current Substance Abuse by Male Caregiver (p=0.037)

7.7.4 a. Children's Placement History before Referral.

In Main Effects Model 1, families where all children had only lived in the family home prior to referral to the Montrose program are 5.8 times more likely to have All Children in the Family Home three years after referral, rather than All Children in Out of Home Care,* relative to families where some or all of the children had been in Substitute Care before referral (p=0.006).

Families where some or all children have been placed with extended family, rather than in Substitute Care, before referral are 9.2 times more likely to have All Children in the Family Home three years after referral (p=0.041).

This indicates that avoiding family breakdown in the first instance is a significant factor in preventing long term out of home placement of all the children in the family. Where placement is necessary, kinship placements are more likely than substitute care placements to result in restoration of the

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* Male Carer/Caregiver = Biological Father or Mother's past or current partner - not necessarily living with family at referral, but having / had a significant caregiving role with the children

* Out of Home Care = with Extended family or in Substitute care.

children to the birth family. The findings may also indicate that those families who have the practical support of extended family members in caring for the children have an increased possibility of maintaining the longer term care of their children.

7.7.4 b. Age Group of Primary Carer at Referral.

In this study, the Primary Caregiver is defined as the person who has the major responsibility for the day to day care of the children. The variable Age of Primary Caregiver is divided into two groups, around the median age for the total study group, i.e. 15 to 34 years old and 35 years and over.

In Main Effects Model 1, families with a Primary Caregiver aged between 15 and 34 years of age are 4.9 times more likely to have All Children in Out of Home Care three years after referral rather than have All Children in the Family Home, relative to families where the Primary Carer is 35 years or older (p=0.009).

7.7.4 c. Past / Current Substance Abuse by Male Caregiver.

A history of, or current, drug and/or alcohol abuse by the Father/Male Caregiver in a family has significant long-term effects on Children's Placement. Families with current or past substance abuse by a Male Carer are 3.2 times more likely to have All Children in Out of Home Care, rather than All Children in the Family Home three years after referral, relative to families where there is no reported substance abuse by the Male Carers (p=0.021).

The important point to be drawn from this finding is that any past *or* current Substance Abuse by a Father/Male Caregiver in a family has a long-term impact on the life situations for children in that family, often continuing many years after the substance abusing male carer has left the family. The impact may be due to the effects of the substance abuse on the economic and/or emotional life of the family, or as a result of domestic violence or abuse or neglect associated with the substance abuse.

The effect on the children may also be seen in the types of behaviours that they perceive as normal or acceptable in families. Relationships between the children and the female carer can be affected by the relationship between the female carer and her partner. Some children may take on a role of protecting their mother if the partner is violent when substance affected, or adopting a quasi-adult role and compensating for her if she is also substance abusing. Alternatively, the children may identify with the substance abusing male and treat their mother with disrespect and/or aggression.

All of these behaviours can have an impact on the ability of the family to adequately care for and manage the children, and which in turn has implications for the child's increased potential to enter the Out of Home Care system.

7.7.5 Children's Placement Three Years After Referral: Main Effects Model 2

A second valid model produced using MNLR describes the relationship between Children's Placement Three Years After Referral and two of the same independent variables as Model 1, with the additional variable Past/Current Substance Abuse by Mother/Female Caregiver (rather than Father/ Male Carer's Substance Abuse in Model 1).

CHILDREN'S PLACEMENT THREE YEARS AFTER REFERRAL: MAIN EFFECTS MODEL 2:
Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Children's Placement History Before Referral (p=0.012)
b. Age Group of Primary Carer at Referral (p=0.041)
c. Past/Current Substance Abuse by Mother/ Female Caregiver (p=0.049)

7.7.5 a. Children's Placement History before Referral.

In Main Effects Model 2, families where all children had only lived in the family home prior to referral to the Montrose program are 4.9 times more likely to also have All Children Living in the Family Home, rather than have

All Children in Out of Home Care three years after referral, relative to families where some or all of the children had been in Substitute Care before referral (p=0.010).

Families where some or all children were living with Extended Family at referral are 8.7 times more likely to have All Children Living in the Family Home at follow-up, rather than have All Children in Out of Home Care, relative to families where some or all of the children had been in Substitute Care before referral (p=0.045).

7.7.5 b. Age Group of Primary Carer at Referral.

In this model, families where the Primary Caregiver is in the age group 15 to 34 years at referral are 3.5 times more likely to have All Children in Out of Home Care at follow-up rather than All Children in the Family Home, relative to families where the primary caregiver is aged 35 years or above at referral (p=0.041).

7.7.5 c. Past/Current Substance Abuse by Mother/ Female Caregiver.

Families where the Mother/Female Caregiver has past or current substance abuse are 3 times more likely to have All Children in Out of Home Care three years after referral, rather than All Children in the Family Home, relative to families with no reported past or current maternal substance abuse (p=0.042).

Further, families with Substance Abuse by Mother/Female Carer are 3.7 times more likely to have *All* rather than only *Some* Children in Out of Home Care three years after referral, relative to families where there is no history of substance abuse by the Mother/Female Caregiver (p=0.021).

7.7.6 Summary Of Children's Placement Outcome Results.

The variable Children's Placement Three Years after Referral is measured in three categories - *All* Children Living in the Family Home; S*ome* Children placed in Out of Home Care* and *All* Children placed in Out of Home Care - reflecting increasing degrees of state intervention into the family structure and the lives of the children. Based on the findings of this study, Children's Placement Outcome appears to be most strongly related to:

1. A history of out of home care placement for any children in the family.
2. The younger age group of the parent/primary caregiver.
3. Past or current substance abuse by the parent/caregiver.

Two robust models emerged with a statistically significant overall relationship between the combination of three independent variables and the dependent variable Children's Placement Three Years After Referral.

Main Effects Model 1.

a. Children's Placement History Before Referral (p=0.008)
b. Age Group of Primary Carer at Referral (p=0.011)
c. Past/current Substance Abuse by Male Caregiver (p=0.037)

In Main Effects Model 1, families where the children have had no out of home care placements prior to referral are 5.8 times more likely to have All Children Living in the Family Home three years after referral, rather than All Children in Out of Home Care, relative to families where some/all children have been in Substitute Care before referral (p=0.006). If placement is necessary, placement with extended family is clearly preferable to placement in Substitute Care, in terms of children's restoration to the birth family. Families where children are or have been placed in relative care at referral are 9.2 times more likely to have All Children living in the Family Home three years after referral (p=0.041), compared with families where one child or more has been in non-relative Substitute Care.

* Out of Home Care includes placements with Extended family or in Substitute care.

Families with a younger primary caregiver age group (15 to 34 years) are 4.9 times more likely to have All Children in Out of Home Care rather than All Children in the Family Home three years after referral, relative to families where the primary carer is 35 years or older at referral (p=0.009).

Families with past or current substance abuse by a father/male carer are 3.2 times more likely to have All Children in Out of Home Care, rather than All Children in the Family Home three years after referral, relative to families where there is no reported substance abuse history for the male caregiver/s (p=0.021).

Main Effects Model 2.

a. Children's Placement History Before Referral (p=0.012)
b. Age Group of Primary Carer at Referral (p=0.041)
c. Past/Current Substance Abuse by Mother/Female Carer (p=0.049)

Similar to Main Effects Model 1, families where there has been no previous out of home placement are less likely to have later placements of the children. In Main Effects Model 2, families with no placements prior to referral to are 4.9 times more likely to have All Children Living in the Family Home, rather than All Children in Out of Home Care three years after referral, relative to families where some or all of the children have been in Substitute Care before referral (p=0.010).

Families with previous Extended Family placement for some or all children are 8.7 times more likely to have All Children Living in the Family Home rather than All Children in Out of Home Care at follow-up, relative to families where some or all of the children had been in Substitute Care before referral (p=0.045).

Where the Primary Caregiver is aged 15 to 34 years at referral, families are 3.5 times more likely to have All Children in Out of Home Care rather than All Children in the Family Home three years after referral, relative to families where the Primary Caregiver is aged 35 years or above at referral (p=0.041).

Where the Mother/Female Caregiver has engaged in past or current substance abuse, families are 3 times more likely to have All Children in Out of Home Care rather than All Children in the Family Home three years after referral, relative to families with no reported past or current maternal substance abuse (p=0.042).

Further, families with Mother/Female Caregiver substance abuse are 3.7 times more likely to have *All* Children in Out of Home Care rather than *Some* Children in Out of Home Care three years after referral, relative to families with no reported substance abuse by the Mother/Female Caregiver (p=0.021).

Conclusion:

The results of this study indicate a need for early intervention in families to try to prevent the initial placement of children in any form of out of home care. Previous out of home care placements are significantly associated with future placements. It is therefore important to try to maintain children within the family while actively addressing child protection concerns, if this can be achieved without jeopardising the safety, welfare and wellbeing of the children.

If children's placement is unavoidable due to child protection concerns, kinship or extended family placements are more likely than Substitute Care placements to result in successful restoration of the children to their birth family. Families who have the practical support of extended family members in caring for the children have an increased possibility of achieving and maintaining the longer term care of their children.

These results have implications for the range of options that Departmental officers need to consider *before* removing children from their parent’s care, especially if there is no previous history of out of home care. If safety risks are managed, maintaining the child in the family with supports may be a

better option for children's longer term placement outcome for some families. If out of home care placement is unavoidable, placement with extended family appears to be a preferable option to placement in Substitute Care.

Children with Parents/Primary Caregivers under 35 years of age are at higher risk for out of home placements, so early supportive intervention with younger parents, aimed at avoiding the children's initial placement outside the family, is likely to have a more positive long term outcome for the children than removal of the child/ren from the family.

Past or current substance abuse by the Father/Male Caregiver has significant effects on children's placement three years after referral, being significantly associated with placement of *all* children outside the family home. This link highlights the importance of taking a complete family history in child protection cases, including fathers or ex-partners who are no longer in the family. Before intervening with families, it is essential to identify the precipitating problem, which may at times be masked by the current presenting economic or child protection concerns.

Similar to the pattern for families with substance abuse by a male carer, families where the mother/primary caregiver has past or current substance abuse are more likely to have all children in out of home care three years after referral, rather than in the family home.

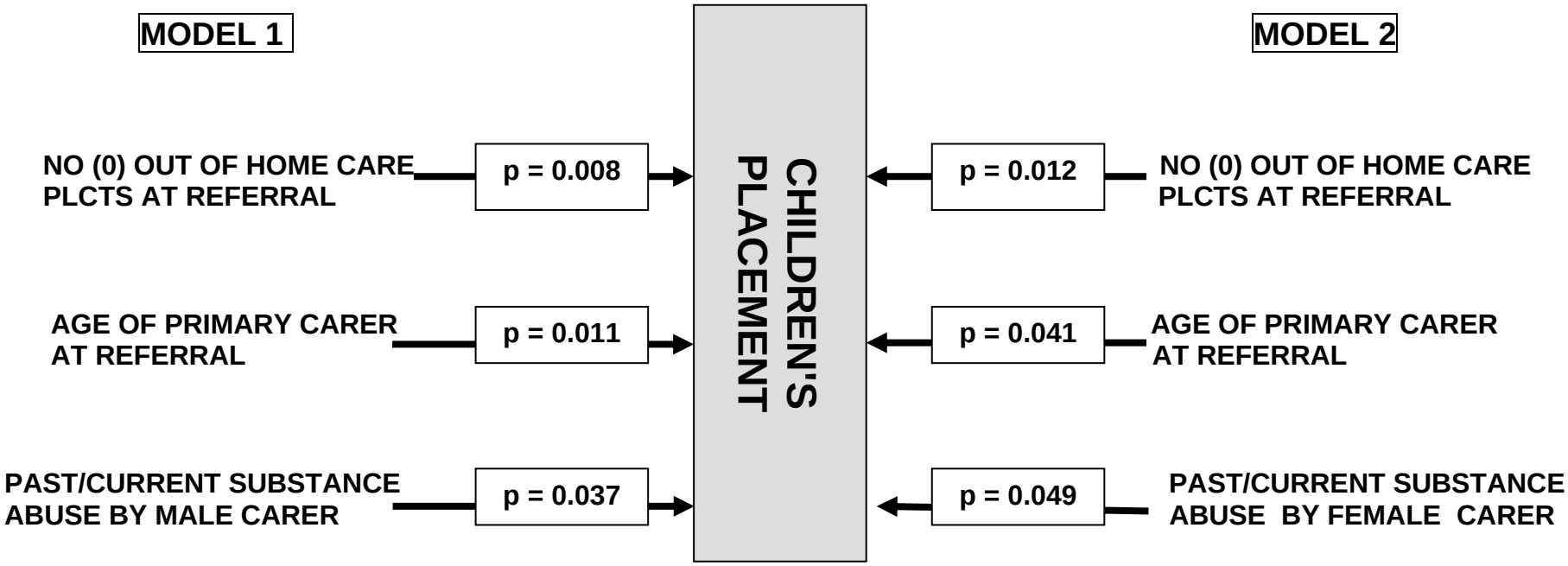
Importantly, maternal substance abuse is associated with placement of *all* children, rather than only *some* children in out of home care. Clearly, there is a need to actively address current substance abuse, or the effects of past substance abuse by female carers, in order to reduce the risk of long term placement for all the children in these families.

Children should not remain in the family if there are serious safety or wellbeing concerns, but there is a need for caseworkers to consider a wide range of Departmental and non-government interventions to assist parents

and protect children in the early stages of their contact with the child protection/child welfare system, with children's removal from home being the last option of choice, to be used only after other less intrusive options have been tried.

Figure 7.20 describes the two Main Effects Models for Children's Placement Outcome.

Fig. 7.20 MAIN EFFECTS MODELS: CHILDREN'S PLACEMENT THREE YEARS AFTER REFERRAL
ALL CHN in FAMILY HOME / SOME CHN in OUT OF HOME CARE / ALL CHN in OUT OF HOME CARE



7.8 Results: Number of Notifications per Family, Three Years after Referral.

The Department of Community Services' computerised client database (CIS) holds records of all notifications of alleged risk or harm to children and young people in the state of NSW for over two decades. One common method of measuring outcome is the comparison of notification rates of the same family, before and after assessment. This may be seen to be an indication of the level of child protection concerns held about that family by the community.

In the 200 study group families referred to Montrose, there were 2303 notifications on all children under 18 years that had ever been part of the family up to the time of referral. There is no significant difference between the total notification rate of the Assessed Group and Comparison Group, the Assessed Group having 1196 notifications and the Comparison Group 1107.

In the three years before referral to Montrose the 200 study group families were the subject of 1490 notifications, with no significant difference between the Assessed Group and Comparison Group. The Assessed Group families had a total of 773 notifications, with a mean of 7.73 and a range between 0 and 53 notifications per family. The Comparison Group had a total of 717 notifications, with a mean of 7.17 and a range from 0 to 32 notifications per family. (Appendix 7.27)

Families who have come to the notice of the Department, referred by or referred on to support services, are likely to remain open to increased scrutiny from those services for some time after a notification is made. The number of notifications made to DoCS following referral for a Montrose assessment is therefore one method of tracking the families' progress.

The number of notifications per family three years after referral to Montrose was compared with the number of notifications per family in the three years

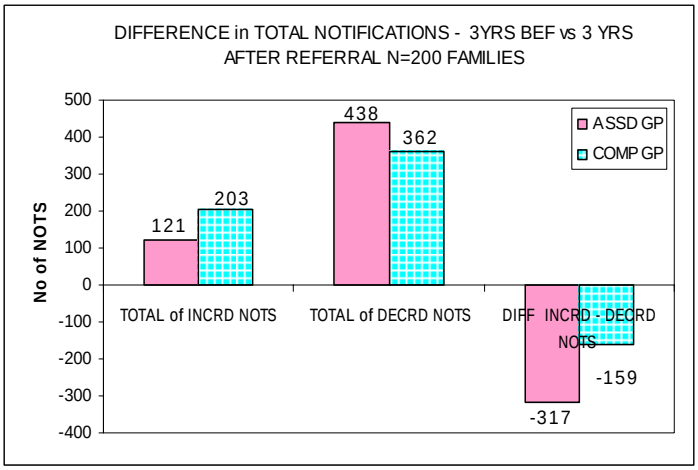
before referral, to determine if the notification rate diminished for the Assessed Group families after the Montrose intervention.

7.8.1 Number of Notifications per Family Three Years after Referral.

In the three years after referral to Montrose, the Assessed Group families had 456 notifications, with a range from 0-40 notifications per family. The Comparison Group had just over 100 more notifications (n=558 notifications), with a range from 0-28 notifications per family. The difference between the Assessed Group and Comparison Group is significant at the level of p=0.088 (Appendix 7.27).

When the total number of *decreased* notifications is deducted from the number of *increased* notifications for the Assessed and Comparison Groups, the difference in notifications for each group demonstrates an important fact in terms of both human and financial cost - i.e. that children in the Assessed Group families were the subject of 317 fewer notifications in the three years after referral than in the three years before, compared with a decrease of only 159 notifications in the Comparison Group. (Fig. 7.21)

Fig. 7.21: Difference in Number of Notifications per Family in Three Years Before Referral vs Three Years After Referral (N=200 Families). Assessed Group n=100; Comparison Group n=100.



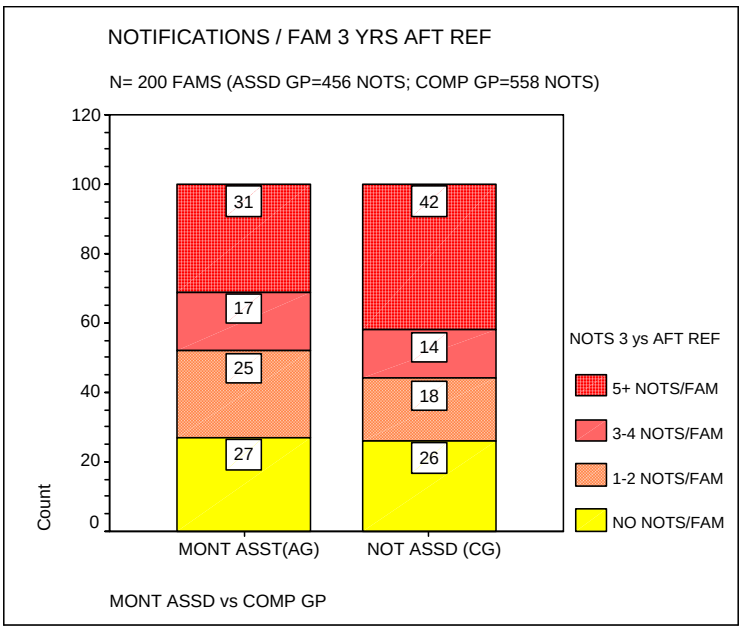
The Assessed Group therefore has an average decrease of 3.17 notifications per family (Anova: p<0.001), while the Comparison Group notifications decreased by an average of 1.59 per family (Anova: p=0.007).

The number of notifications per family three years after referral is measured using four categories:

- No notifications
- 1-2 notifications
- 3-4 notifications
- 5+ notifications.

The proportion of families with no notifications in three years following referral is equivalent for the two groups. However, the Assessed Group has more families with 1-2 and 3-4 notifications and the Comparison Group has substantially more families (12%) with 5 or more notifications. (Fig. 7.22)

Fig. 7.22: Notifications per Family Three Years after Referral. (4 Categories). (N=200 Families). Assessed Group n=100; Comparison Group n=100.



The Assessed Group has the largest individual decreases in number of notifications per family from three years before to after referral, i.e. two families with 33 and 32 fewer notifications respectively. In the Comparison Group, the greatest decrease is a family with 22 fewer notifications. At the other extreme, the greatest increase in number of notifications per family is shared by the Assessed Group and Comparison Group, with one family in

each having 22 more notifications in the three years after, compared with the three years before, referral.

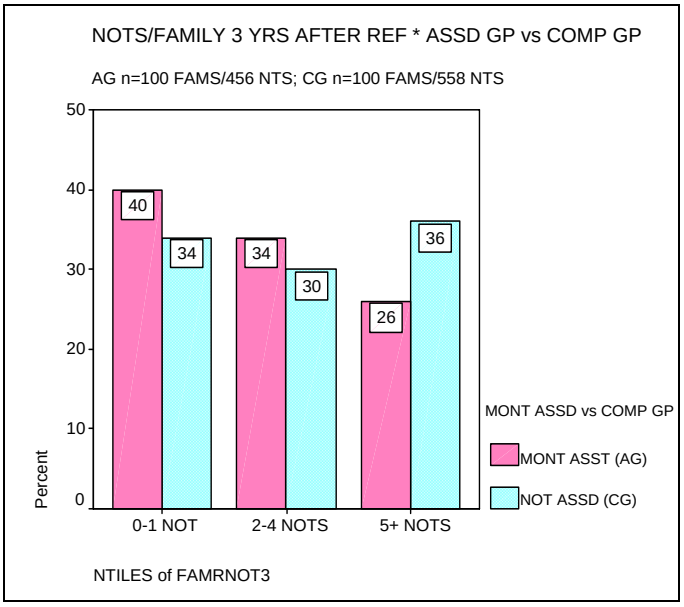
7.8.2 Number of Notifications per Family Three Years After Referral: Main Effects Model.

There is a large range (from 0-40) in the number of notifications per family three years after referral. When applying nominal regression model building to the data, it was necessary to deal with the two issues of a very small number of high end outliers and a substantial number of families with no further notifications. To facilitate the process of analysis, the results within the Outcome variable Number of Notifications per Family, Three Years after Referral are divided into three equal groups:

1. 0-1 notification
2. 2- 4 notifications
3. 5 or more notifications.

Using these Outcome categories, the Assessed Group has more families than the Comparison Group with 0-1 and 2-4 notifications three years after referral, but 10% fewer families with 5 or more notifications. Although the difference between the two groups is not statistically significant, there is a clear trend line in the Assessed Group, in contrast to the Comparison Group (Fig.7.23).

Fig. 7.23: Notifications Per Family Three Years After Referral (3 Categories). (N=200 Families). Assessed Group n=100; Comparison Group n=100.



The number of Assessed Group families with 1-4 notifications in the three years after referral is not entirely surprising given the serious associated with families referred to Montrose. The finding is also consistent with other research which indicates that families involved with support services after a child protection notification may attract additional child protection reports because of an increased level of surveillance when the support services have regular contact with the family (DePanfilis and Zuravin 1999). Another reason may be that more of the Assessed Group families were the subject of a Supervision Order, recommended by Montrose, which also increases the level of child protection monitoring on the family.

Multinomial Logistic Regression produces a single Main Effects Model, containing the strongest combination of factors associated with the Outcome variable Number of Notifications per Family three years after referral ($p<0.001$; Appendix 7.28).

NUMBER OF NOTIFICATIONS PER FAMILY
3 YEARS AFTER REFERRAL: MAIN EFFECTS MODEL
Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Number of Notifications per Family at Referral. (p=0.003)
b. Age of Primary Caregiver. (p=0.007)
c. Number of Children Diagnosed with ADD/HD per Family. (p=0.038)

7.8.2 a. Number of Notifications per Family at Referral. (0-2; 3+)

The independent variable Number of Notifications per Family *at Referral* is broader than just the three years before referral, and covers all children under 18 in the designated family in all the years before referral. The number of notifications per family has a wide range from 0-63, with a very small number of families at the higher end. For the purpose of analysis, and in order to avoid numerical problems in the analysis of data, the variable was divided into two categories: 0-2 notifications and three or more notifications.

This independent variable should not be confused with the dependent (Outcome) variable Number of Notifications per Family 3 Years *after* Referral, which has *three* categories: 0-1 notifications, 2-4 notifications and five or more notifications.

There was no significant difference between the Assessed Group and Comparison Group in Number of Notifications per Family at Referral divided into these two categories. (Appendix 7.27).

In the MNLR Main Effects Model, families with two or less notifications before referral are 9.2 times more likely to have 0-1 notifications, rather than five or more notifications, per family three years after referral, compared with families with three or more notifications before referral (p=0.005).

These results support the theme that has emerged throughout this study, i.e. that intervention *before* a family develops a pattern of contact with the child

protection system increases the likelihood of more positive longer term outcomes for children.

7.8.2 b. Age of Primary Caregiver.

Younger age group in the primary caregiver is associated with a higher number of notifications per family three years after referral. Families with a primary caregiver in the 15 - 34 years age group are 3.5 times more likely to have five or more notifications rather than 0-1 notifications three years after referral, relative to families with primary caregivers aged 35 years and over (p=0.006).

Further, families with primary caregivers in the 15 - 34 year age group are 3.4 times more likely to have five or more notifications than to have 2-4 notifications three years after referral, relative to families with primary caregivers in the 35 years and over age group (p=0.008).

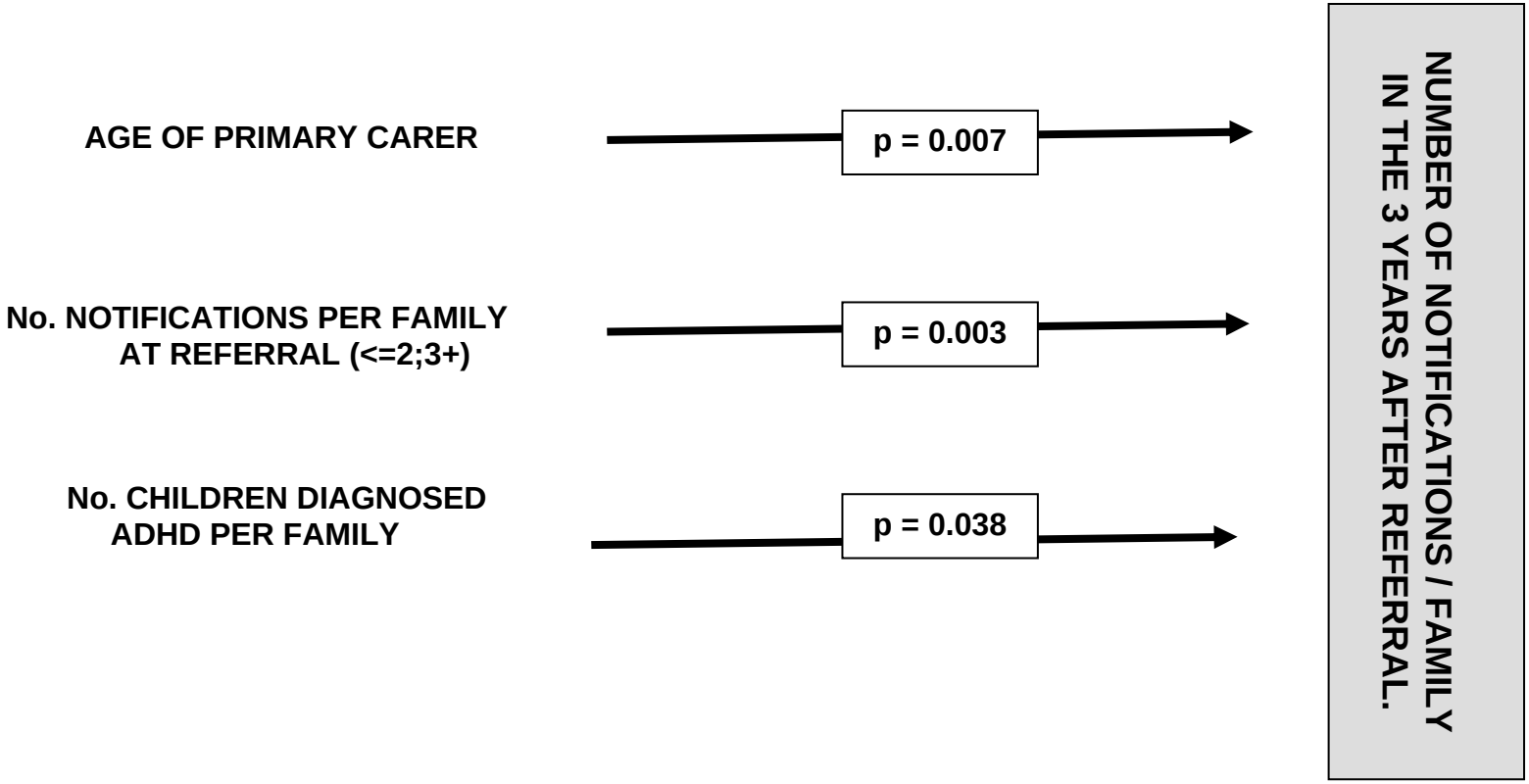
7.8.2 c. Number of Children Diagnosed with ADD/HD per Family.

A diagnosis of ADD/HD in one child or more per family is associated with higher numbers of notifications three years after referral. Families with no children diagnosed ADD/HD are 2.8 times more likely to have 0-1 notifications per family, rather than five or more notifications, three years after referral, relative to families with one or more child diagnosed ADD/HD (p=0.022).

Further, families with no children diagnosed ADD/HD are 2.6 times more likely to have 2-4 notifications per family, rather than five or more notifications per family, three years after referral, relative to families with one or more child diagnosed ADD/HD (p= 0.032).

The Main Effects Model for Number of Notifications per Family three years after Referral is depicted in Figure 7.24.

Fig 7.24: MAIN EFFECTS MODEL: NO. of NOTIFICATIONS PER FAMILY IN THE THREE YEARS AFTER REFERRAL (0-1; 2-4; 5+).



7.9 Results: Number of Confirmed Notifications per Family, Three Years after Referral.

In accordance with NSW DoCS procedure, and where staff resources are available, confirmation (substantiation) of abuse or neglect is determined following an investigation by a Departmental caseworker. The decision is based on physical evidence of maltreatment, or by a third party witnessing the abuse or neglect, or admission by the person causing the harm, or confirmation of the abuse by the child. Notifications are deemed to be either Confirmed (substantiated) or Not Confirmed. If none of these substantiating factors is present, the notification would be deemed "Not Confirmed". The family may be offered referral for assistance, but the investigation is closed.

However, due to the exponential rise in the number of notifications of child abuse and neglect in NSW since the early 1990s and the subsequent strain on finite DoCS staffing resources, a standardised process for prioritising responses to reports was in place during the years of this study (1990-1999). The priority for child protection response was dependent on the *severity* of the reported risk to the child and the *vulnerability* of the child because of tender age or level of dependence on adult carers. Therefore, a "low risk" notification - where the level or probability of harm is deemed to be low or the child is older - could be closed without investigation because it was prioritised behind cases deemed to be of higher risk. In this case, the report could be classified "not confirmed", even though there was no investigation. Similarly, where a notification was deemed to be trivial or malicious, or where the family could not be located, the notification may also be closed, "not confirmed".

Hence, although there are instances of notifications being made on scant evidence or maliciously, the classification "not confirmed" is not always an indication that the maltreatment *did not occur*, but rather that it was not substantiated through investigation.

Comparing the number of Confirmed Notifications per family in the three years *after* referral with the number in the three years *before* referral provides an outcome measure in the study group families, since confirmed notifications document the incidence of *known* maltreatment. However, because of the factors highlighted above, the numbers are likely to be a baseline rather than a definitive measure of the actual incidence of abuse and neglect in individual families.

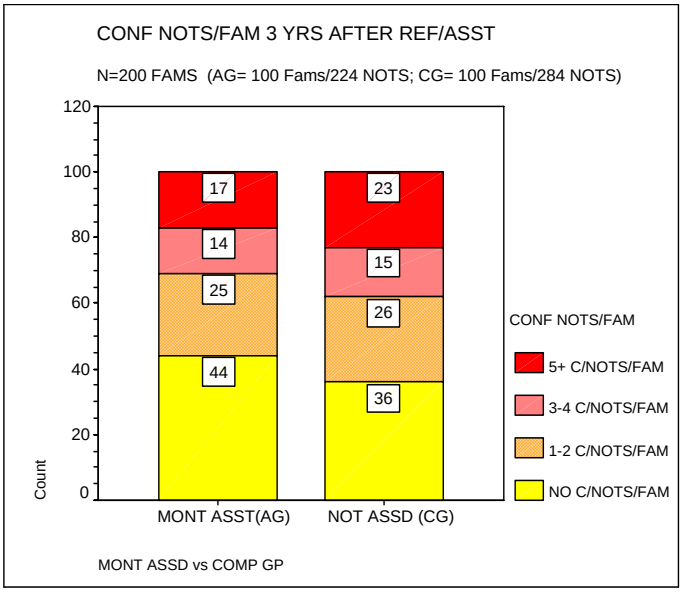
In all the years on CIS records before referral, the 200 study group families had a total of 1522 confirmed notifications on all children under 18 years who had ever lived or were living in the families. There was no significant difference between the Assessed Group (53%; n=809 confirmed notifications) and Comparison Group (47%; n=713 confirmed notifications). The Assessed Group had a mean of 8.09 confirmed notifications per family and the Comparison Group 7.13.

There was also no significant difference between the Assessed Group and Comparison Group in terms of numbers of confirmed notifications in the three years immediately preceding the referral for a Montrose assessment. There were a total of 1007 for the whole study group. The 100 Assessed Group families had 524 confirmed notifications (52%), ranging from 0-35 per family, and with a mean of 5.24 confirmed notifications per family. The Comparison Group had 483 confirmed notifications with a range of 0-25 per family, and a mean of 4.83 confirmed notifications per family.

7.9.1 Number of Confirmed Notifications per Family Three Years after Referral.

Three years *after* referral, the Assessed Group has 8% more families with No Confirmed Notifications than the Comparison Group, and 5% fewer families in the category Five or more Confirmed Notifications. The numbers of families with 1-2 and 3-4 confirmed notifications are similar for both groups. (Fig. 7.25). Overall, there is no statistically significant difference between the two groups.

Fig. 7.25: No. Confirmed Notifications per Family in Three Years after Referral. (N=200 families.) Assessed Group n=100; Comparison Group n=100.

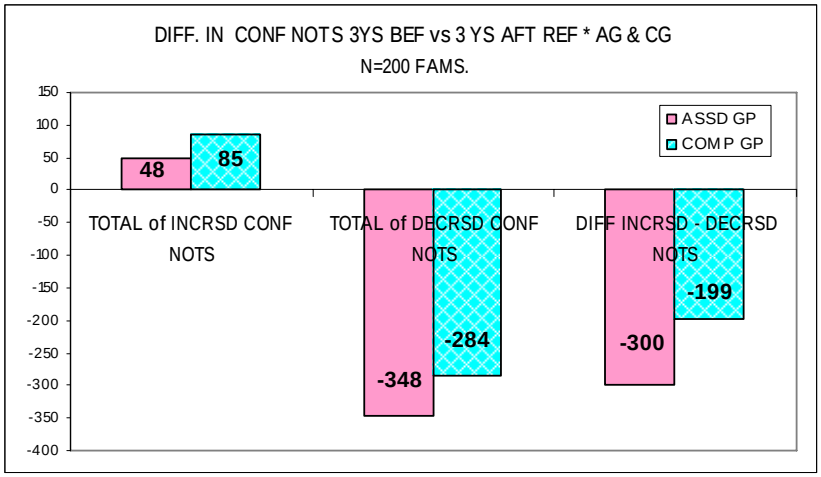


In terms of the relative change in the number of confirmed notifications between three years before and three years after referral, the Assessed Group has fewer families where the number of confirmed notifications increased and more families where the number declined.

The Assessed Group has 72 families with *fewer c*onfirmed notifications (Comparison Group = 65), including one family with 25 and one with 24 fewer confirmed notifications (Comparison Group = one family with 20 and one with 16 less). At the other extreme, the Comparison Group has 24 families with *more* confirmed notifications (Assessed Group =13) including families with 12, 11 and 10 more (Assessed Group = one family with 9 and one with 6 more).

The total number of *decreased* confirmed notifications deducted from the number of *increased* notifications for the Assessed and Comparison Groups (Fig.7.26) demonstrates that children in the 100 Assessed Group families were the subject of 300 fewer confirmed notifications in the three years after referral than in the three years before, compared with a decrease of only 199 confirmed notifications in the 100 Comparison Group families.

Fig. 7.26: Difference in No. Confirmed Notifications per Family in Three Years Before Referral vs Three years After Referral. (N=200 families). Assessed Group n =100; Comparison Group n =100.



Overall, the mean number of confirmed notifications per family in the three years *after* referral compared with the three years *before* referral decreased by 3.00 in the Assessed Group, while the Comparison Group has an average decrease of 1.99 confirmed notifications per family (Appendix 7.29).

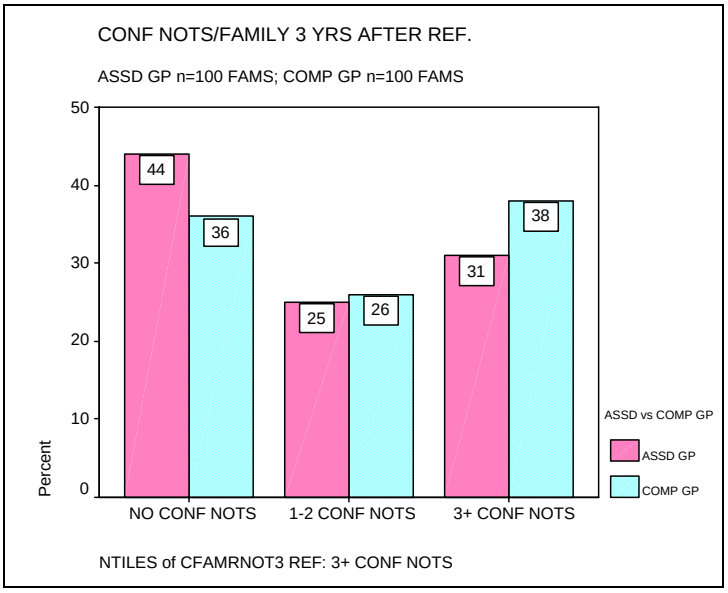
7.9.2 Number of Confirmed Notifications / Family Three Years After Referral: Main Effects Model

In order to deal with the issue of a small number of outliers at the high end of Confirmed Notifications, for the purposes of analysis, the Outcome variable Number of Confirmed Notifications per Family Three Years After Referral has been divided into three categories:

1. No Confirmed Notifications
2. 1-2 Confirmed Notifications
3. 3 or More Confirmed Notifications.

Using these three categories, the Assessed Group has 8% more families than the Comparison Group with No Confirmed Notifications, and 7% fewer families with 3 or More Confirmed Notifications three years after referral (Fig. 7.27), but the overall difference between the groups is not statistically significant.

Fig. 7.27: Confirmed Notifications per Family Three Years After Referral. (3 Categories). (N=200 Families). Assessed Group n =100; Comparison Group n =100.



Multinomial Logistic Regression produces a single Main Effects Model containing the strongest combination of factors associated with the dependent variable Number Of Confirmed Notifications per Family Three Years After Referral (p<0.001; Appendix 7.30).

NUMBER OF CONFIRMED NOTIFICATIONS PER FAMILY IN THE THREE YEARS AFTER REFERRAL: MAIN EFFECTS MODEL

Independent Variables and their Likelihood Ratio Test Chi-Square Significance

a. **Number of Notifications per Family at Referral (p=0.003)**
b. **Past/Current Substance Abuse by Mother/Female Caregiver (p=0.012)**
c. **Number of Male Children per Family (p=0.025)**

7.9.2 a. Number of Notifications per Family at time of Referral.

Fewer notifications per family before referral (i.e. for all children under 18 in the family for all years before referral) is significantly associated with fewer Confirmed Notifications per Family the Three Years after Referral. Specifically, families with only 0-2 notifications before referral are 7.5 times more likely to have No Confirmed Notifications, rather than Three or More

Confirmed Notifications, three years after referral, relative to families with three or more notifications before referral (p= 0.009).

In addition, families with 0-2 notifications before referral are 7.4 times more likely to have only 1-2 Confirmed Notifications, rather than Three or More Confirmed Notifications, at follow-up, relative to families with three or more notifications before referral (p= 0.013).

These results support previous findings regarding the importance of intervening with families when the number of notifications/confirmed notifications is low, or preferably picking up "at risk" families via community support services *before* child protection issues are serious enough to warrant a notification.

7.9.2 b. Past/Current Substance Abuse by Mother/Female Caregiver.

Past or current alcohol or other drug abuse by the Mother/Female Caregiver in the family is associated with higher numbers of confirmed notifications three years after referral. Families with reported substance abuse by Mother/Female Carer are 3.2 times more likely to have Three or More Confirmed Notifications, rather than 1-2 Confirmed Notifications, three years after referral, relative to families with no reported substance abuse history in the female carer (p = 0.004).

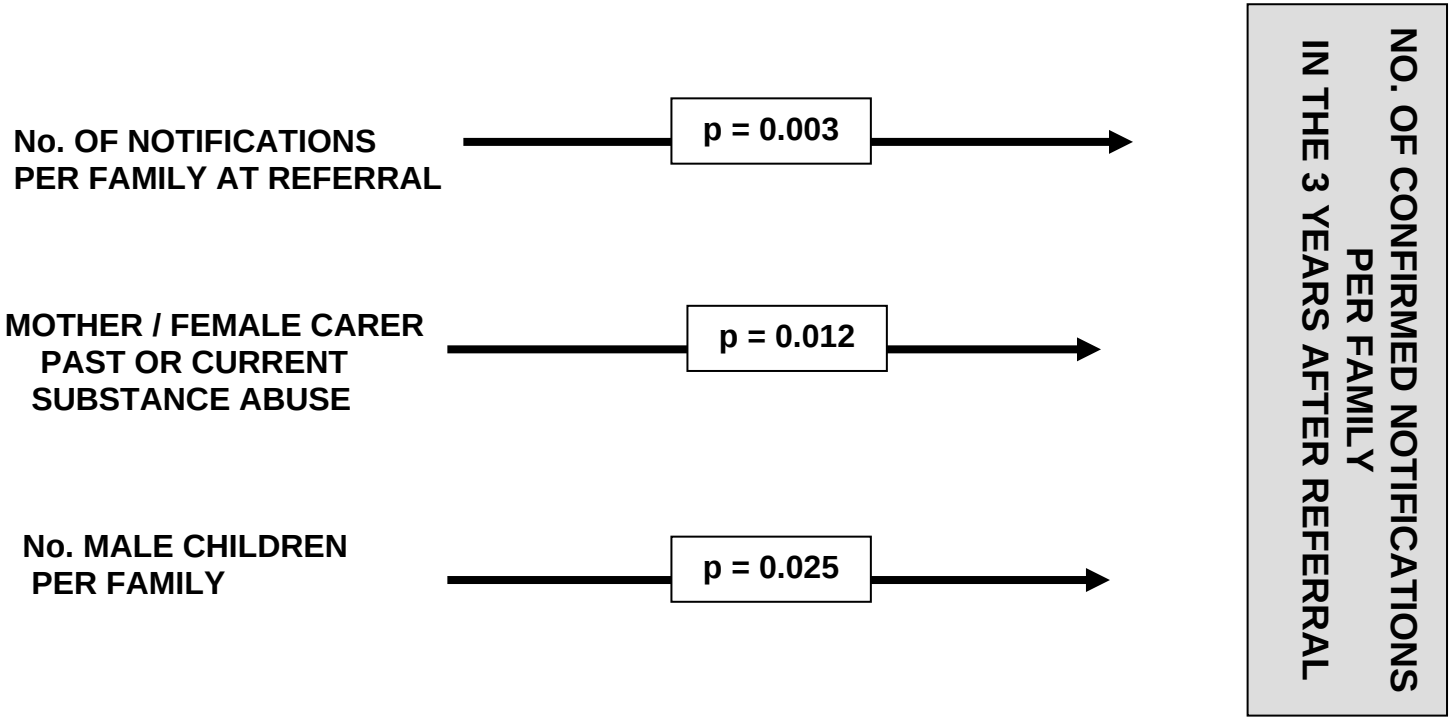
7.9.2 c. Number of Male Children per Family.

Having two or less male children per family is associated with more positive outcome in terms of numbers of confirmed notifications three years after referral. Families with two or less male children are 2.6 times more likely to have No Confirmed Notifications, rather than three or more Confirmed Notifications, three years after referral, relative to families with three or more male children (p=0.011).

In addition, families with 0-2 male children are 2.3 times more likely to have only 1-2, rather than three or more, Confirmed Notifications at follow-up, relative to families with three or more male children (p=0.054).

Figure 7.28 demonstrates the Main Effects Model for Number of Confirmed Notifications Three Years after Referral.

Fig 7.28 MAIN EFFECTS MODEL: NO. of CONFIRMED NOTIFICATIONS PER FAMILY IN THE THREE YEARS AFTER REFERRAL



7.9.3 Summary Of Results: Number of Notifications and Number of Confirmed Notifications Per Family, Three Years After Referral.

- **Number of Notifications Per Family, Three Years After Referral.**

In the three years after referral to Montrose, the Assessed Group families had 456 notifications, while the Comparison Group families had over 100 more notifications (n=558). The difference between the Assessed Group and Comparison Group is significant at the level of p=0.088.

From the three years before to three years after referral to Montrose, children in Assessed Group families were the subject of 317 less notifications (mean= 3.17 per family), where the decrease in the Comparison Group was half that number (n=159; mean = 1.59 per family).

The Main Effects Model for Notifications per Family in the Three Years after Referral highlights three variables significantly associated with positive outcome:

a. Two or less notifications per family at time of referral,
b. The primary caregiver being aged 35 years or older, and
c. No (0) children in the family being diagnosed with ADD/HD.

The results indicate that families with two or less notifications before referral are 9.2 times more likely to have no notifications or only one notification, rather than five or more notifications, three years after referral, relative to families with three or more notifications before referral (p=0.005).

Primary caregivers in the younger age group (15 - 34 years) are associated with higher numbers of notifications three years after referral. Families with younger primary caregivers are 3.5 times more likely to have five or more, rather than 0-1, notifications (p=0.006) and 3.4 times more likely to have five or more, rather than 2-4, notifications (p=0.008), relative to families with primary caregivers over 35 years at referral.

Families with children diagnosed with ADD/HD are associated with higher numbers of notifications three years after referral. Families with no children diagnosed ADD/HD are 2.8 times more likely to have 0-1 notifications (p=0.022) and 2.6 times more likely to have 2-4 notifications (p= 0.032) than to have five or more notifications, relative to families with one or more child diagnosed with ADD/HD.

- **Number of Confirmed Notifications Per Family, Three Years After Referral.**

Three years after referral there are more Comparison Group families with three or more confirmed notifications and more Assessed Group families with no confirmed notifications, although the difference is not statistically significant. The difference between the mean number of confirmed notifications per family from three years before to three years after referral declines at a greater rate for Assessed Group (-3.00) than Comparison Group (-1.99) families.

In the Main Effects Model for Confirmed Notifications per Family Three Years after Referral, factors most strongly associated with a lower number of Confirmed Notifications three years after referral are:

1. Two or less notifications per family at time of referral.
2. No history of Substance Abuse in mother / female carer.
3. Two or less male children per family.

Having fewer notifications before referral is significantly associated with fewer confirmed notifications per family three years after referral. Relative to families with three or more notifications before referral, families with 0-2 notifications before referral are 7.5 times more likely to have no Confirmed Notifications (p= 0.009) and 7.4 times more likely to have only 1-2 Confirmed Notifications (p= 0.013), rather than three or more, three years later.

Families where the Mother/Female Carer has past or current substance abuse at referral are 3.2 times more likely to have three or more Confirmed Notifications rather than 1-2 Confirmed Notifications three years after referral, relative to families with no substance abuse history in the female carer (p=0.004).

Relative to families with three or more male children, families with two or less male children are 2.6 times more likely to have no Confirmed Notifications (p=0.011), and 2.3 times more likely to have only 1-2 Confirmed Notifications (p=0.054), rather than three or more Confirmed Notifications, three years after referral.

Conclusion.

Having fewer notifications per family at referral is significantly associated with both fewer notifications and fewer confirmed notifications three years later. The clear message to be drawn from this finding is that early intervention with "at risk" families is a positive preventative measure for reducing child protection risk over time. If vulnerable families can be assisted by community support services before child protection issues are serious enough to warrant a notification, it may be possible to avoid a long term pattern of negative contact with the child protection system, and to achieve more positive longer term outcomes.

The significant finding here is that it is the *number* of notifications that is related to ongoing child maltreatment, not the *reason* for the notification. This has relevance for the way child protection services tend to prioritise urgency for response to notifications, because it implies that the practice of responding less quickly or frequently to "low risk" matters such as neglect or emotional abuse is not an effective way of dealing with burgeoning numbers of reports. Research indicates that "low risk" families are as likely, or more likely to continue to be notified as families with more "serious" child protection issues (English et al 1999).

In addition, it would appear that factors associated with both the *carer* (primary caregiver's age; substance abuse by mother/female caregiver) and the *children* (diagnosis of ADD/HD and number of male children) play an important role in the future number of Notifications (and subsequently Confirmed Notifications) for families.

Children with ADD/HD in a family increase the level of child protection notifications for that family, but the link is not entirely clear and requires further research, particularly into whether the risk is higher if there are also more than two male children in the family, which has been demonstrated to be a risk factor for increased confirmed notifications at follow-up.

Similarly, the connection between number of male children and poorer child protection outcomes requires further investigation, for instance to test whether it is related to single female caregivers trying to manage male children as they get older, especially if the male children have been exposed to domestic violence.

Given the association between number of notifications three years after referral and diagnosis of ADD/HD demonstrated in this chapter, the link between the number of male children per family and increased numbers of confirmed notifications could be associated with higher rates of diagnosis of ADD/HD in boys than girls. Alternatively, the association may be due to oppositional, aggressive or impulsive behaviour, which is sometimes mistaken for ADD/HD in boys, but has also been linked with exposure to child maltreatment and domestic violence. The knowledge that a higher number of male children in a family is a risk factor associated with a number of outcome variables in this study indicates that Caseworkers should bear it in mind when assessing child protection risks in a family.

Early intervention services usually target younger aged primary caregivers, but often this applies to very young parents (under 20 years). The results of this study demonstrate that parents under 35 are still at increased risk for

ongoing child protection notification. This may be related to the number of children that they may have by the age of 35 compared with when they are in their early 20's, particularly if they have multiple relationships.

Past or current substance abuse by the mother/female caregiver is strongly associated with increased child protection risk and worse outcomes for the children in a number of the other outcome variables in this study. It is clearly also associated with higher numbers of notifications per family.

An important practice message here is that the substance abuse does not have to be *current* to increase the child protection risk. Prior periods of maternal substance abuse can continue to have effects on children for some time after the substance abuse ends. It is therefore important for caseworkers to take a full drug and alcohol history from parents, and to continue to be vigilant with these families, even if the mother/female caregiver is engaged in or has completed a rehabilitation program and is no longer using substances. Caseworkers also need to be diligent in securing interventions to address the *covert* as well as the *overt* effects of past and current substance abuse in both the parent and the children.

7.10 Results: Abuse Type per Family Three Years after Referral.

7.10.1 Definition of Abuse Types.

During the period of this study (1993-1999), notifications of alleged abuse and neglect were recorded on the DoCS* computerised child protection data base, the Client Information System (CIS). Each CIS record of a notification includes the type of abuse or neglect reported.

The four major categories of abuse listed on the CIS are *Physical, Sexual, Emotional* and *Neglect*, with additional categories for *No Abuse* and *Parent Request for Assistance*. Each of the maltreatment categories contains subcategories of specific types of abuse as follows: *Physical* (20 categories), *Sexual* (13 categories), *Emotional* (12 categories*) and *Neglect* (10 categories).

In this study, 38 different varieties of abuse type were reported in notifications related to the 744 children and young people. In collating the abuse history for each child, it became obvious to the researcher that as the number of notifications increased, so did the variety of types of abuse per child. For the majority of the children in the study, no single abuse type is consistent over the course of the child's history of notifications. This finding is supported in the literature (English et al 1999; Higgins and McCabe2000).

In this study, the *family,* rather than the individual child, is the unit for comparison. Consequently, when the abuse types for each child are collated into a family measure, it is more likely that there will be more than one type of abuse per family. In fact, only 25% of the 200 study group families have a single abuse type, the remaining 75% of families having multiple abuse types. (Table7.4)

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* NSW Dept of Community Services

* Emotional Abuse at this time included Child Exposed to Domestic Violence, Parent's Mental Health Issues and Parent Drug and Alcohol Issues.

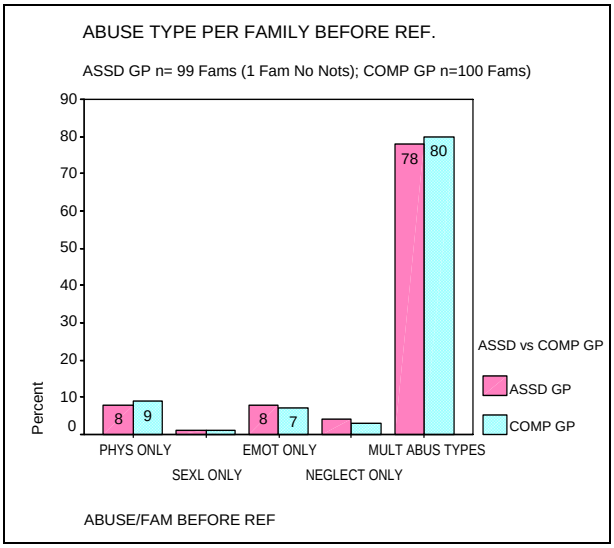
Table 7.4: Abuse Types per Family before Referral (N=200 families)

ABUSE TYPE / FAM BEFORE REFERRAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	PHYS	19	9.5	9.6	9.6
	SEXL	2	1.0	1.0	10.7
	EMOT	18	9.0	9.1	19.8
	NEGLCT	9	4.5	4.6	24.4
	PHYS+SEXL	5	2.5	2.5	26.9
	PHYS+EMOT/NEG	58	29.0	29.4	56.3
	SEXL+EMOT/NEG	24	12.0	12.2	68.5
	EMOT+NEG	6	3.0	3.0	71.6
	PHYS+SEX+EMOT/NEG	56	28.0	28.4	100.0
	Total	197	98.5	100.0	
Missing	NO NOTS/NO ABUSE	3	1.5		
Total		200	100.0		

There is no significant difference between the Assessed Group and Comparison Group in terms of distribution of primary reported abuse types per family before referral. By far the largest proportion of both groups fall into the Multiple Abuse Type category. (Fig. 7.29).

Fig. 7.29: Abuse Types per Family before Referral. (N=199 Families). Assessed Group n=99[#]; Comparison Group n=100.

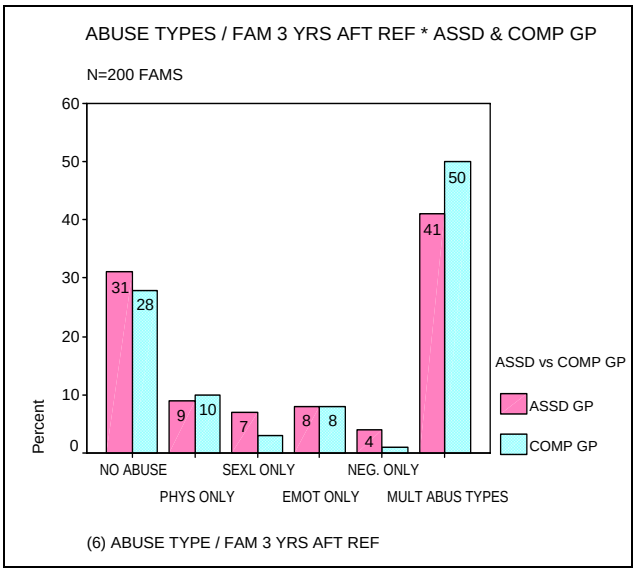


Three years after referral, there is a marked increase in the number of families with no notifications and therefore no reported abuse and slightly more families with a single type of reported abuse, but still no significant

[#] One Assessed Group family had no notifications before referral. The family was a client of DoCS Disability Services, who made the referral due to child protection concerns due to the level of family stress associated with the child's intellectual disability and behaviour.

difference between the Assessed Group and Comparison Group in terms of the proportion of families in each category of abuse type (Fig. 7.30).

Fig. 7.30: Abuse Types per Family Three Years after Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



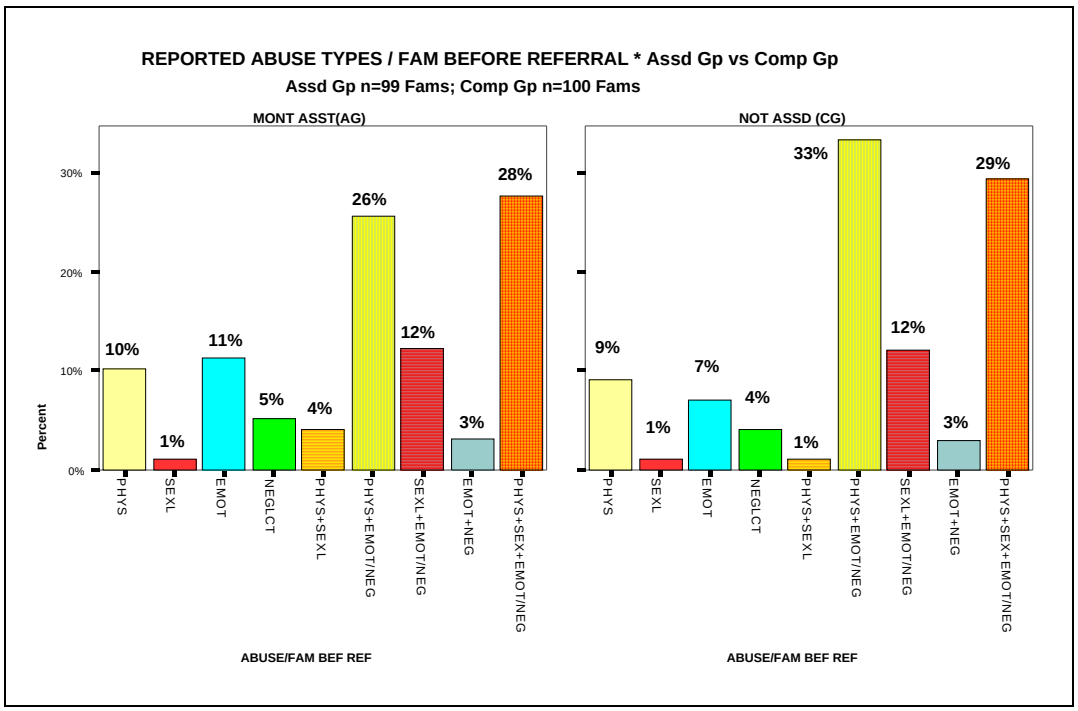
7.10.2 Multiple Abuse Types category.

The category *Multiple Abuse Types* can be separated into the combinations of abuse types it comprises. At the time of referral, both the Assessed Group and Comparison Group were dominated (66% Assd Gp; 74% Comp Gp) by three categories of combinations of abuse types:

- Physical + Emotional/Neglect
- Sexual + Emotional/Neglect
- Physical + Sexual + Emotional/Neglect

This distribution of abuse types before referral to the Montrose program is almost the same in the Assessed Group and Comparison Group and demonstrates that many of the children in the study group had been exposed to various combinations of both abuse and neglect (Fig. 7.31).

Fig. 7.31: Abuse Types per Family before Referral (9 Categories). (N=199 Families). Assessed Group n=99[#]; Comparison Group n=100.



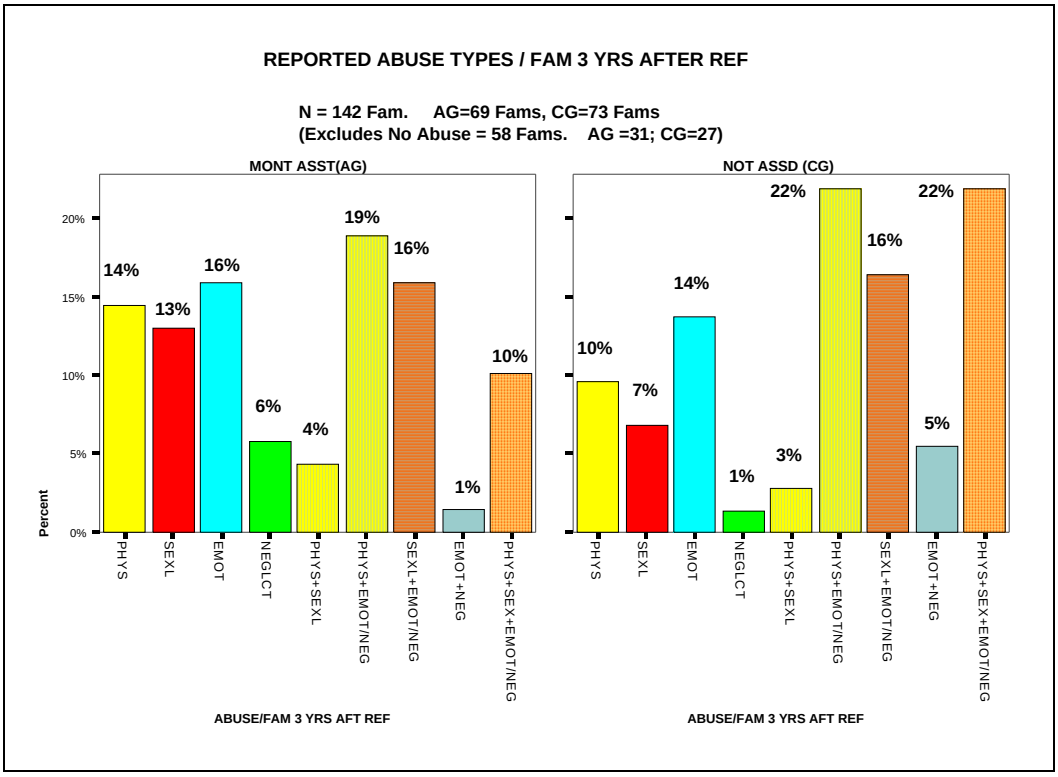
In the three years after referral, the proportion of families with a single abuse type is larger for both groups, however, the pattern of abuse types is still dominated (45% Assd Gp; 60% Comp Gp) by the categories:

- Physical + Emotional /Neglect
- Sexual + Emotional/Neglect and
- Physical + Sexual + Emotional/ Neglect (Fig. 7.32).

The Assessed Group has less than half as many families as the Comparison Group in the most serious abuse category, which contains *all* abuse types: Physical + Sexual + Emotional/Neglect, although the difference is not statistically significant.

[#] Disability Services case referred to on previous page.

Fig. 7.32: Abuse Types per Family Three Years after Referral (9 Categories). (N=200 Families). Assessed Group n=100; Comparison Group n=100.

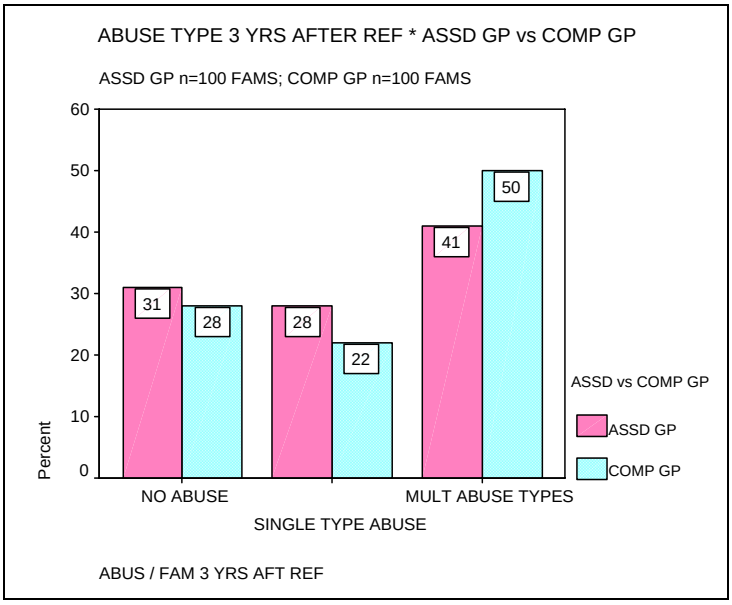


Because of the low numbers in some of the individual abuse types, the Outcome variable *Abuse Type per Family Three Years after Referral* was divided into three categories for the purpose of data analysis:

1. No Notifications / No Abuse
2. Single Abuse Type
3. Multiple Abuse Types

Three years after referral, the Assessed Group has slightly more families with No Abuse and Single Abuse Type, and 9% fewer families in the Multiple Abuse Type category (Fig. 7.33), although the difference between the Assessed and Comparison Groups is not statistically significant.

Fig. 7.33: Abuse Types per Family Three Years after Referral (3 Categories). (N=200 Families). Assessed Group n=100; Comparison Group n=100.



7.10.3. Abuse Type Per Family Three Years After Referral: Main Effects Model

Multinomial Logistic Regression produced a single model, with only two variables significantly associated with the Outcome variable Abuse Type per Family Three Years after Referral (p=0.002). These are Number of Notifications per Family at Referral and Age of Primary Caregiver.

ABUSE TYPE PER FAMILY THREE YEARS AFTER REFERRAL: MAIN EFFECTS MODEL

Independent Variables and Their Likelihood Ratio Test Chi-Square Significance

a. Number of Notifications per Family at Referral (p=0.003)
b. Age of Primary Caregiver. (p=0.028)

7.10.3 a. Number of Notifications per Family at Referral.

The independent variable Number of Notifications per Family at Referral has a wide range, from 0-53, with a very small number of families at the higher end. To assist with data analysis, the variable was divided into two categories: 0-2 Notifications and three or more Notifications per Family at referral. There was no significant difference between the Assessed Group and Comparison Group on this variable before referral to Montrose.

Families with less notifications at referral are associated with fewer notifications three years after referral. Number of Notifications per Family at Referral is significantly associated with Abuse Type Three Years after Referral ($p < 0.001$). Of the 91 families in the Multiple Abuse Types category three years after referral, 95% had three or more notifications at referral (Appendix 7.35).

In the Main Effects Model, families with 0-2 notifications at referral are 6.2 times more likely to be in the No Abuse category three years after referral rather than in the Multiple Abuse Types category, relative to families with three or more notifications at referral ($p=0.003$).

In addition, families with 0-2 notifications at referral are 4.6 times more likely to be in the Single Type Abuse category than the Multiple Abuse Types category, relative to families with three or more notifications ($p=0.022$).

7.10.3. b. Age of Primary Carer at Referral.

The variable *Age of Primary Carer at Referral* was divided into two categories around the median age, i.e. 15 to 34 years and 35 or more years. In the MNLR Main Effects Model, families with Primary Carers aged 15-34 years are 2.9 times more likely to be in the Multiple Abuse Types category than in the Single Abuse Type category three years after referral, relative to families where the Primary Carer is aged 35 years or over at referral ($p=0.008$).

Primary caregivers in the younger age group are significantly associated with the Multiple Abuse Types category three years after referral, with 71% of the category being comprised of families with primary caregivers aged 15-34 years ($p=0.047$; Appendix 7.36). The single abuse type category is comparable for both age groups.

Interestingly, the No Notifications/No Abuse category also contains 65% of families with younger age primary caregivers, possibly indicating that early

intervention with some parents in this age group may produce positive change and reduce child protection risk.

7.10.4 Abuse Type Three Years after Referral, Compared with Other Outcome Categories.

When measured against the other Outcome variables for this study, it is not surprising to find that families with Multiple Abuse Types three years after referral are associated with significantly worse Outcomes than those with No Abuse and many of those with a Single Abuse Type (Appendix 7.37).

In terms of *Family Outcome*, families with Multiple Abuse Types three years after referral account for 75% of the Worse and 70% of the No Different categories ($p<0.001$). For *Children's Outcome***,** families with Multiple Abuse Types made up 68% of the Worse and 56% of the No Different Categories ($p<0.001$).

In terms of *Legal Status*, families with Multiple Abuse Types three years after referral accounted for 60% of the most interventionist category - Custody Order/Wardship/Multiple Orders, and also 57% of Supervision Orders ($p=0.004$). The families with Multiple Abuse Types also accounted for one third of the category No Legal Orders. This may be due to the fact that certain combinations of abuse types are less likely to attract legal intervention than others. For instance, it is difficult to substantiate Multiple Abuse Types that include or combine *Emotional Abuse* and *Neglect* at the evidentiary level required by the Children's Court. Therefore these combinations of abuse are less likely to result in court action than those that include physical or sexual abuse where forensic evidence may be more accessible. The issue of *severity* of the abuse, regardless of type, may also be a factor.

With respect to *Children's Placement Three Years after Referral*, families with Multiple Abuse Types accounted for 60% of the All Children in Out of Home Care category and 52% of the Some Children in Out of Home Care category ($p=0.038$).

Interestingly, 37% of the Children's Placement category All Children in the Family Home is also comprised of families with Multiple Abuse Types. A possible explanation is that, as for the Legal Status Outcomes, the *severity* of the abuse is not assessed as requiring the children's removal from the home, but this lack of intervention leaves children exposed to ongoing abuse, which in turn leads to Multiple Abuse Types over time.

Overall, from the comparisons with the other Outcome variables, it is very apparent that families with Multiple Abuse Types, regardless of what *types* of abuse are involved, are significantly correlated with poorer outcomes for children in terms of both their wellbeing and their continuing placement in the family. There is some evidence in the literature to support this increased negative impact of Multiple Abuse Types (Higgins and McCabe 2000; English et al 1999).

7.10.5 Summary of Results: Abuse Type Three Years After Referral.

As an Outcome variable, Abuse Type per Family, Three Years after Referral presents a number of challenges. The high number of families with Multiple Abuse Types and the low numbers with a Single Abuse Type per family create difficulties for analysing the relationship between any single type of abuse (physical, sexual, emotional, neglect) and the factors associated with it. In order to address this factor, the Outcome variable was divided into families with No Reported Abuse (29%), those with a Single Abuse Type (26%) and those with Multiple Abuse Types (45%).

The Main Effects Model for this outcome category found only two factors significantly associated with Abuse Type Three Years after Referral:

a. Number of Notifications per Family before Referral
b. Age of Primary Carer.

While the model provides some useful information in terms of the relationship between Abuse Type Three Years after Referral and the variables Number of

Notifications per Family before Referral and Age of Primary Carer at Referral, insufficient numbers in any single abuse type make it impossible to determine the outcome associated with a specific abuse type (Physical / sexual / emotional / neglect).

In the Main Effects Model, families with 0-2 notifications at referral are 6.2 times more likely have No Abuse (p=0.003) and 4.6 times more likely to have Single Type Abuse (p=0.022), rather than to be in the Multiple Abuse Types category three years after referral, relative to families with three or more notifications at referral.

Families with Primary Caregivers aged 15-34 years, rather than 35 years or older, are 2.9 times more likely to have Multiple Abuse Types, rather than a Single Abuse Type three years after referral. (p=0.008).

In examining the implications of these Main Effects Model findings, it is important to note that a higher number of notifications does not necessarily reflect the degree of severity of child abuse. Abuse types regarded as more "severe", i.e. serious physical injury or sexual abuse, will usually only have one notification before child protection services intervene. In fact, families with multiple notifications are often those perceived as having "less serious" or "lower risk" problems, i.e. chronic neglect and emotional abuse, including verbal abuse, impact of parental substance abuse, parent's mental health issues or children witnessing domestic violence. In many of these cases, because of resource management issues, such notifications may be prioritised as less serious than other abuse types at intake and may not be investigated at all. Alternatively, an investigation may be precipitated only after a number of similar notifications are received.

Larger numbers of notifications per family are more likely to be equated with chronic child protection issues, often those with less immediately detectable impact on the children, e.g. low level physical neglect or emotional abuse. However, because such problems are less likely to result in child protection

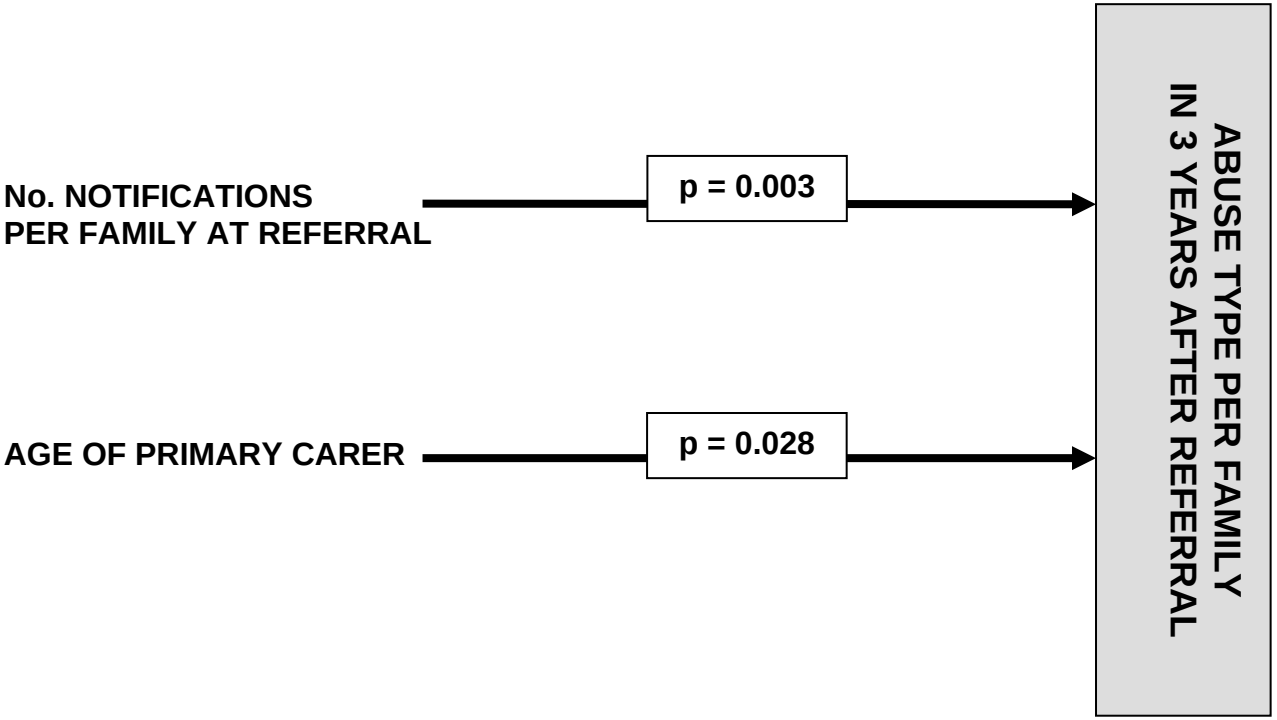
service intervention, the effects on the children can be prolonged, resulting in physical, emotional and/or developmental damage which is not detected until later in the family's child protection/child welfare career. Such abuse can have more serious long term effects on the child and may have effects into the next generation because of the tendency for parenting patterns to be replicated.

The association between younger parental age and Multiple Abuse Types in the three years after referral reinforces the other findings of this study with regard to early intervention with younger age group parents who usually have less childrearing knowledge and capacity. It is important to note however, that it is not only the very youngest parents with one or perhaps two children that need to be targeted. There is a also a need to target parents under 35 years who may by this age have *more* children, and whose difficulties may not emerge until a significant change in their family circumstances – e.g. relationship breakdown, new partner with negative effect on children's welfare, too many children or children too close together, parental mental illness etc. Early intervention in this context relates to intervening early to prevent the family from embarking on a long term relationship with child protection services.

What is clear is that families with Multiple Abuse Types three years after referral are associated with poor outcomes in other Outcome Variables used in this study (Family Outcome, Children's Outcome, Legal Status and Children's Placement), and that children in families with Multiple Abuse Types are likely to have less favourable outcomes, in terms of their general wellbeing, legal status and continuing placement in the family.

Figure 7.34 describes the Main Effects Model for Type of Abuse Three Years after Referral.

7.34 MAIN EFFECTS MODEL: ABUSE TYPE PER FAMILY IN THREE YEARS AFTER REFERRAL.



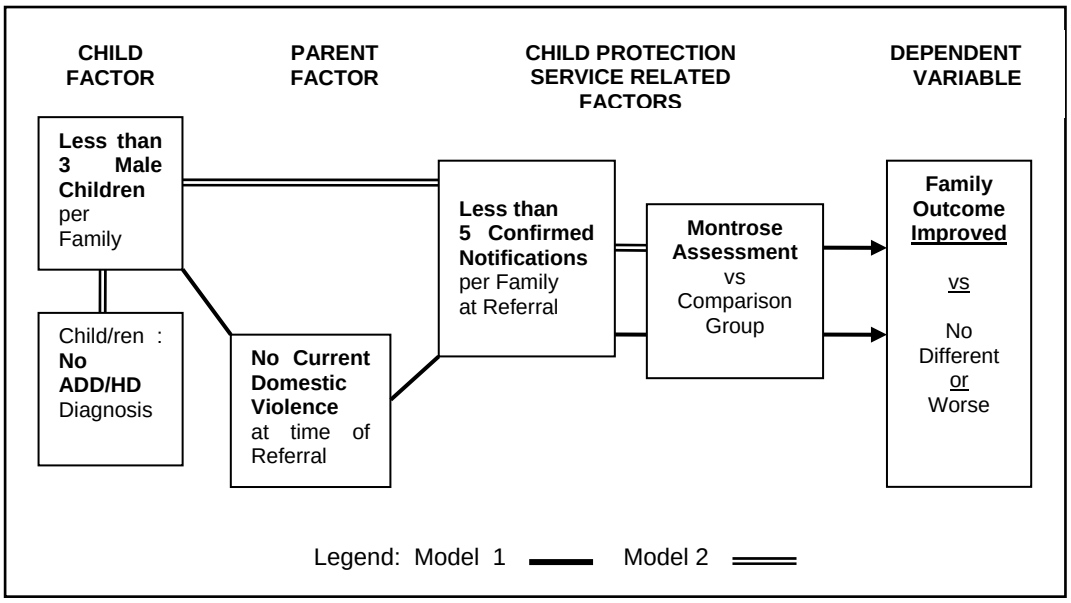
7.11 Summary of Outcome Results, and Predictive Models for Child Protection Outcome.

7.11.1 Family Outcome Results.

Families who participate in a Montrose Home-based Family Assessment (the Assessed Group) are significantly more likely than families who did not have a Montrose assessment (the Comparison Group) to be rated as Improved rather than Worse or No Different Three Years after Referral.

MNLR modelling produces two robust Main Effects Models with a statistically significant relationship between specific independent variables and Family Outcome Three Years after Referral (Fig. 7.35).

Fig 7.35. Predictive Model: Family Outcome.



Three factors are common to both models:

- *Family participation in a Montrose Assessment* - significantly associated with Improved Family Outcome rather than Worse or No Different.
- *Number of Male Children per Family* - families with three or more male children are significantly associated with Worse Family Outcome
- *Number of Confirmed Notifications at Referral* - families with five or more confirmed notifications are associated with Worse or No Different Family Outcome rather than Improved.

Model 1 also contains the variable *Current Domestic Violence at Referral*, and **Model 2** includes the variable *One or More Child in Family Diagnosed with ADD/HD*. Both these factors are associated with Worse Family Outcome three years after referral.

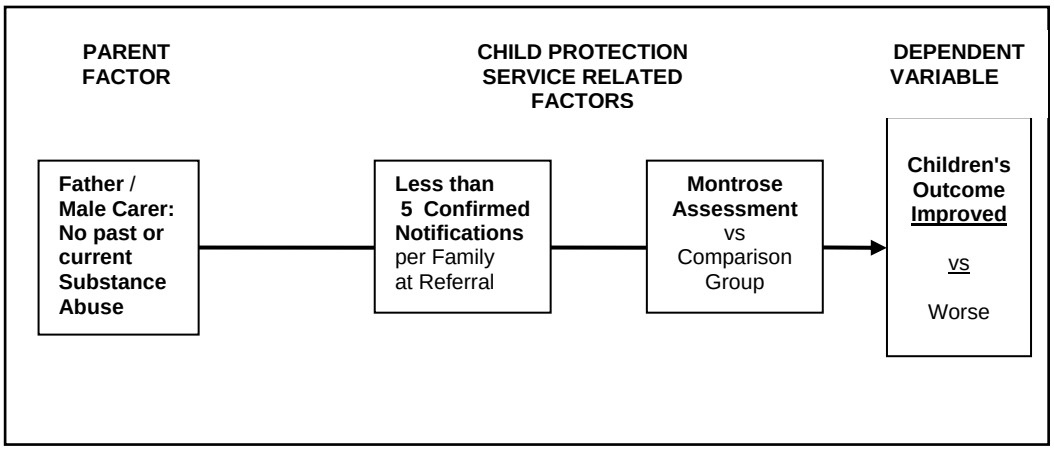
7.11.2 Children's Outcome Results.

Children's Outcome three years after referral is polarised between Improved and Worse, with few instances of Children's Outcome being rated No Different, even where Family Outcome is rated No Different. Improved Children's Outcome is associated with family participation in a Montrose assessment. Significantly more Assessed Group families are rated as having an Improved life situation for the children three years after referral, compared with Comparison Group families.

The Main Effects Model (Fig. 7.36) indicates that Children's Outcome is significantly related to three variables:

1. *Family participation in a Montrose assessment* - significantly associated with Improved Children's Outcome.
2. Families with *Five or More Confirmed Notifications at Referral* - significantly associated with Worse Children's Outcome.
3. *Past/Current Substance Abuse by the Father/Male Caregiver* - significantly associated with Worse Children's Outcome.

Fig 7.36. Predictive Model: Children's Outcome.



7.11.3 Children's Legal Status Outcome Results.

Legal Status Outcome in this study is measured three years after referral in three categories of Children's Court Legal Orders:

1. No Legal Orders
2. Supervision Order - where children remain in the family home under DoCS supervision while parenting issues are addressed, and
3. Custody Order / Wardship / Multiple Order Types, a composite category which involves the most interventionist action into family life and includes at least one child placed in out of home care.

Three years after referral, more Assessed Group families have no Children's Court Legal Orders, while Comparison Group families are over-represented in the Custody Order / Wardship / Multiple Order Types category.

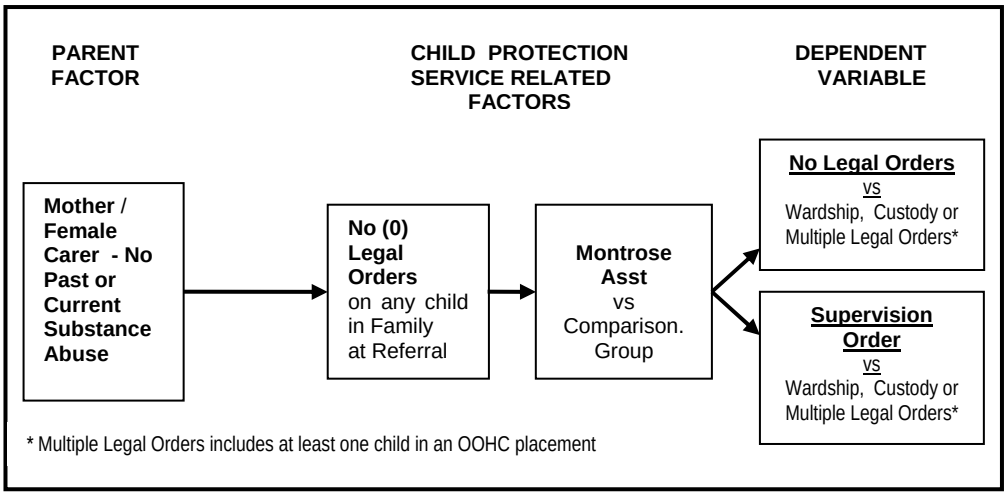
The Main Effects Model for Legal Status Outcome (Fig. 7.37) indicates that three variables are associated with Children's Court Legal Orders in families three years after referral:

1. *Family participation in a Montrose assessment* – significantly associated with No Legal Orders or Supervision Orders rather than Custody/Wardship Orders or Multiple Order Types three years after referral.
2. Families with *no history of Children's Court Legal Orders* - significantly associated with having No Legal Orders three years after referral, rather than a Supervision Order or Custody /Wardship Order or Multiple Legal Order Types.
3. *Past/Current Substance Abuse by Mother/Female Caregiver* - significantly associated with Custody /Wardship Order or Multiple Legal Order Types rather than a Supervision Order.

These results highlight the need for comprehensive family assessment and decisive early intervention with families, to try to prevent the need for initial Children's Court legal orders which appear to be strongly associated with ongoing need for child protection legal intervention including removal of one

or more children. This is especially the case in families with past or current maternal substance abuse.

Fig 7.37. Predictive Model: Legal Status Outcome.



7.11.4 Children's Placement Outcome Results.

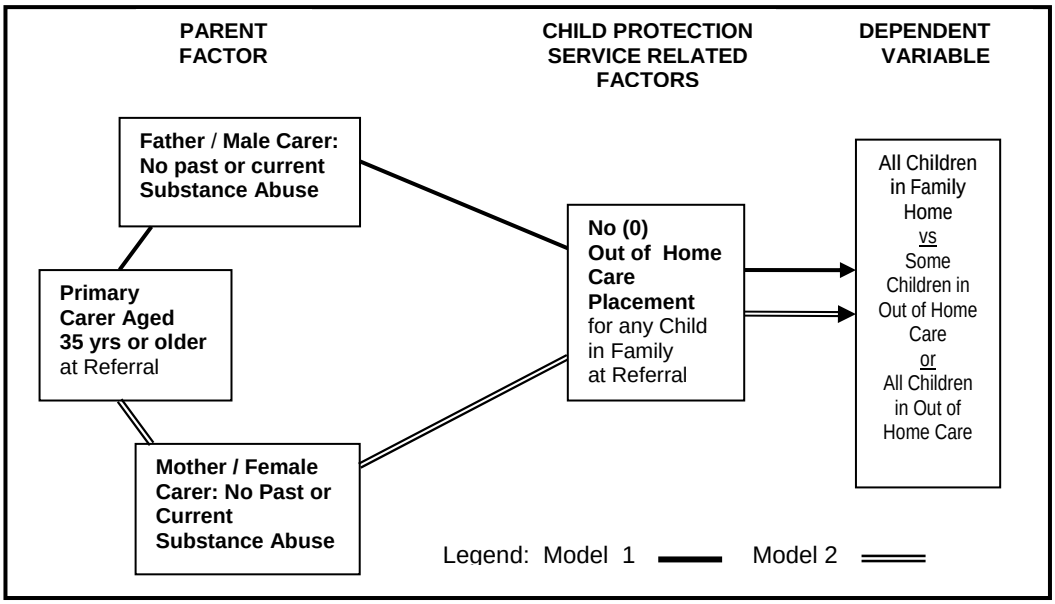
The variable Children's Placement Three Years After Referral is measured in three categories, reflecting an increasing degree of state intervention into the family structure and the lives of the children:

1. All Children Living in the Family Home.
2. Some Children placed in Out of Home Care.*
3. All Children placed in Out of Home Care.

Two robust Main Effects Models (Fig 7.38) demonstrate a statistically significant relationship between the combination of three independent variables and the dependent variable Children's Placement Three Years after Referral. Two factors are common to both models – *Children's Out of Home Care Placement History before Referral,* and *Age of Primary Caregiver*. The third variable in each model relates to Past or Current substance abuse by the parent/caregiver. In Model 1 this relates to the Father/Male Caregiver, in Model 2 to the Mother/ Female Caregiver.

* Out of Home Care includes placements with Extended family or in Substitute care.

Fig 7.38. Predictive Models: Children's Placement Outcome.



1. *Children's Placement History before Referral* – families with no out of home care placements prior to referral (rather than placement in Substitute Care) are significantly more likely to have all children living in the family home three years after referral, rather than all children in out of home care. Families where children have been placed in extended family care rather than Substitute Care prior to referral are also significantly more likely to have all children living in the family home, rather than in out of home care, three years after referral.

2. *Younger Age Group (15-34 years) of Primary Caregiver at Referral* – significantly associated with all children being placed in out of home care rather than in the family home three years after referral, relative to families where the Primary Carer is 35 years or older.

3. *Past or Current Substance Abuse* by either the *Father/Male Caregiver* (Model 1) or *Mother/Female Caregiver* (Model 2) - both significantly associated with all children being in out of home care rather than in the family home three years after referral, relative to families where there is no reported substance abuse by the caregiver/s. Maternal substance abuse is also associated with *all* children rather than only *some* children being in out of home care three years after referral.

7.11.5 Notifications Per Family Three Years After Referral.

From the three years before to three years after referral to Montrose, Assessed Group families were the subject of an average of 3.17 less notifications per family, compared with the Comparison Group average of 1.59 per family.

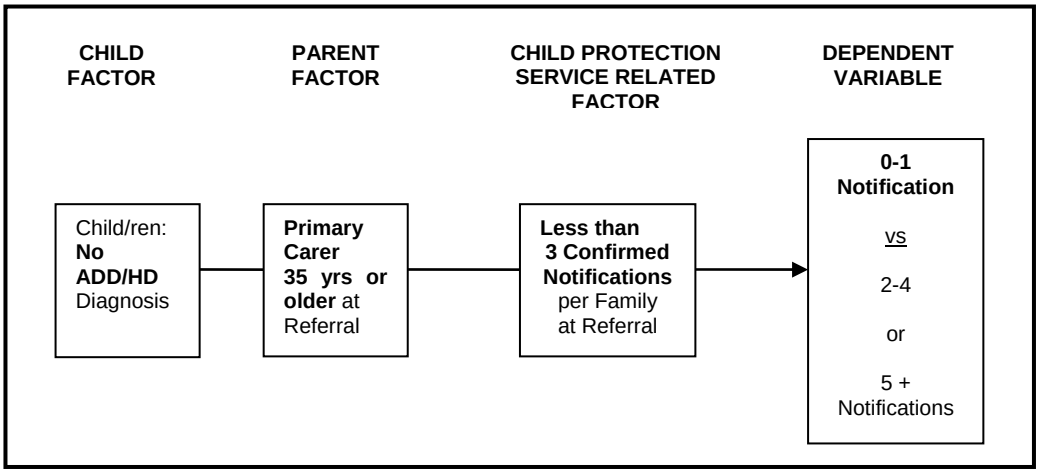
The Main Effects Model for Notifications per Family in the Three Years after Referral (Fig 7.39) highlights three variables significantly associated with number of notifications at follow-up:

1. *Three or More Notifications per Family at Referral* - significantly associated with Five or More Notifications per Family, rather than one or none, three years after referral.

2. *Younger Aged Primary Caregiver (15-34 years)* - significantly associated with Five or More notifications, rather than 0-1 or 2-4, three years after referral.

3. Families with *One or More Children Diagnosed with ADD/HD* - significantly associated with Five or More Notifications, rather than 0-1 or 2-4.

Fig 7.39. Predictive Model: Child Protection Notifications.



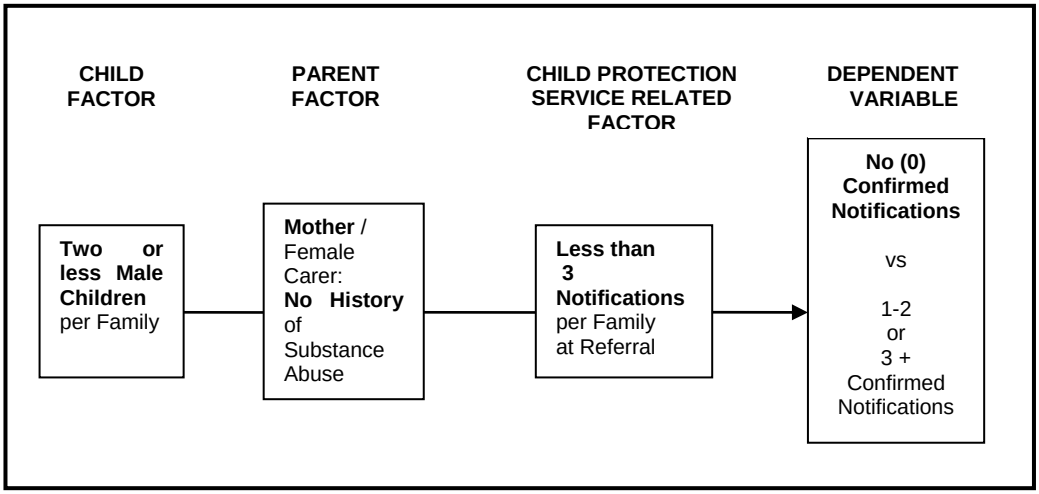
7.11.6 Confirmed Notifications Per Family, Three Years After Referral.

Three years after referral, there are more Assessed Group families with No Confirmed Notifications and more Comparison Group families with Three or More Confirmed Notifications. The mean difference in the number of confirmed notifications per family in the three years before and three years after referral declines at a greater rate for Assessed Group (-3.00 per family) compared with the Comparison Group at -1.99 per family.

In the Main Effects Model for Number of Confirmed Notifications per Family Three Years after Referral (Fig. 7.40), the factors most strongly associated with the number of Confirmed Notifications are:

1. *Three or More Notifications per Family at Referral* - significantly associated with Three or More Confirmed Notifications in the three years after referral, rather than none, or 1-2.
2. *Past or Current Substance Abuse in Mother/Female Carer* - significantly associated with Three or More Confirmed Notifications in the three years after referral, rather than 1-2 Confirmed Notifications.
3. Families with *Three or More Male Children* - significantly associated with Three or More Confirmed Notifications in the three years after referral, rather than none or 1-2 confirmed notifications.

Fig 7.40. Predictive Model: Confirmed Child Protection Notifications.



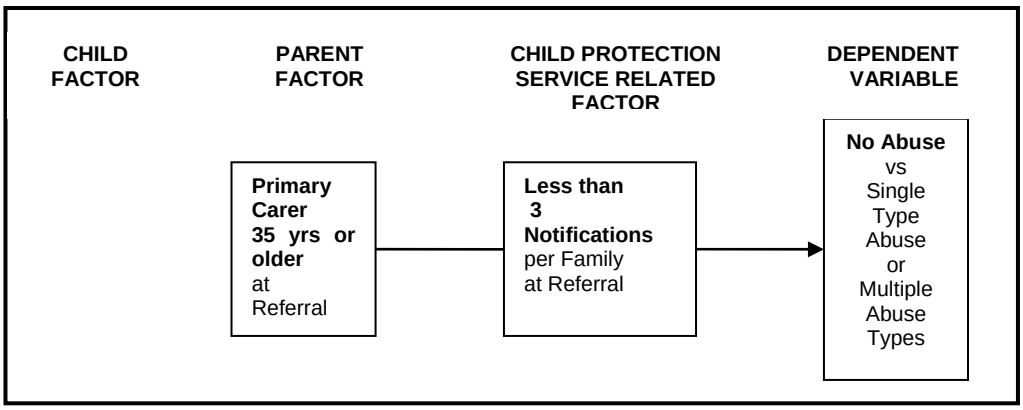
7.11.7 Abuse Type Three Years after Referral.

Families with Multiple Abuse Types three years after referral are associated with poor outcomes in other Outcome Variables (Family Outcome, Children's Outcome, Legal Status and Children's Placement). The Main Effects Model for Abuse Type Three Years after Referral (Fig. 7.41) found only two independent variables with significant relationships to Abuse Type Three Years after Referral.

1. Families with *Three or More Notifications at Referral* - significantly associated with the Multiple Abuse Types category three years after referral, rather than No Abuse or Single Type Abuse.

2. Families with *Primary Caregivers aged 15-34 years* - significantly associated with Multiple Types of Abuse at follow-up.

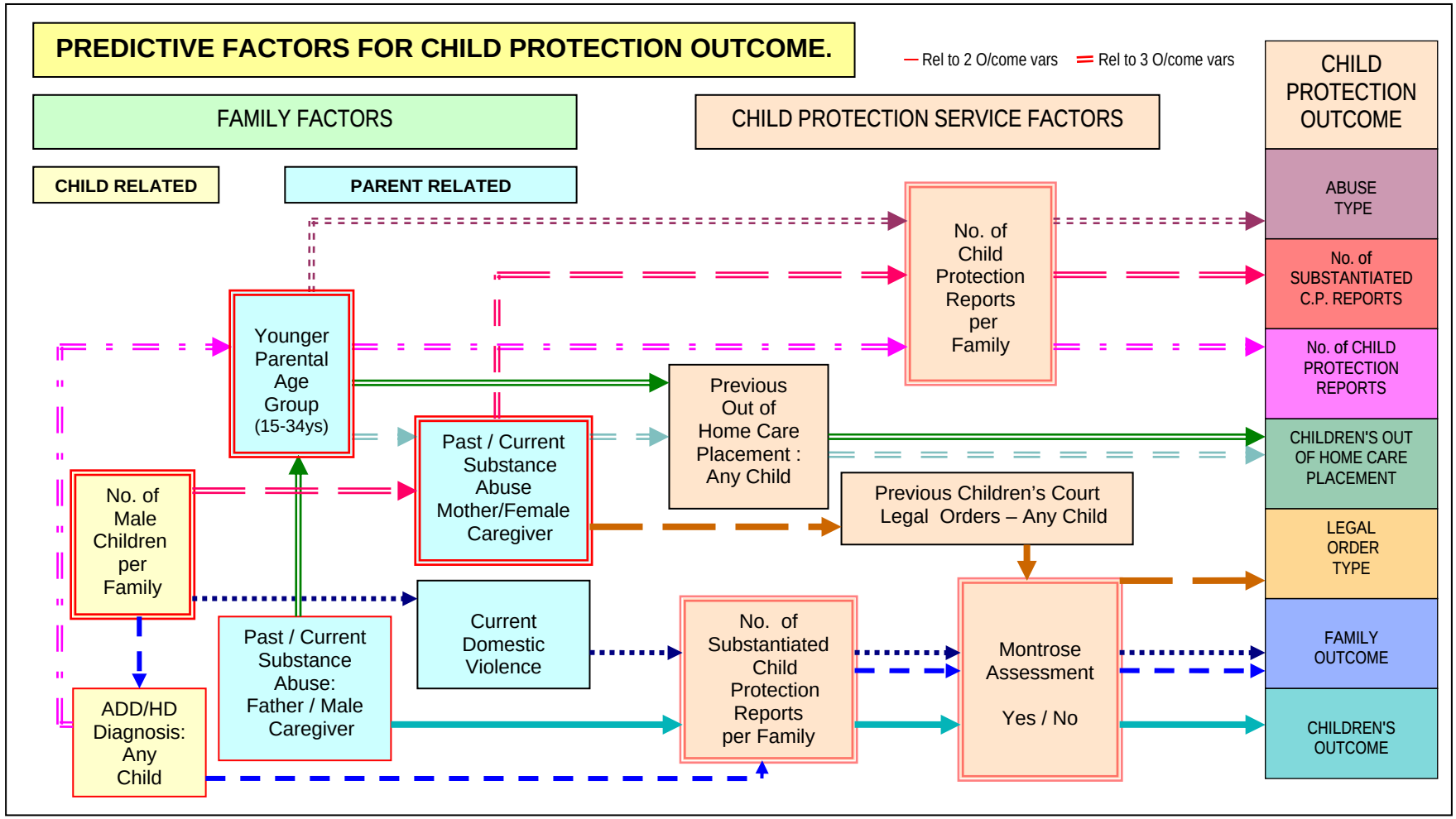
Fig 7.41. Predictive Model: Type of Abuse.



7.12 Predictive Model for Child Protection Outcomes in this Study.

Figure 7.42 depicts the combination of all the Main Effects Models for the seven Outcome variables used in this study. This Predictive Model describes the specific combinations of child factors, parent factors and child protection service factors that are most strongly associated with each specific Outcome variable used in this study. The implication of these findings are described in detail in Chapter 9.

Fig. 7.42: Predictive Model For Child Protection Outcome.



CHAPTER 8: IMPACT OF MONTROSE ASSESSMENT ON FAMILIES WITH FACTORS ASSOCIATED WITH NEGATIVE CHILD PROTECTION OUTCOMES.

This study's results for Family Outcome and Children's Outcome have demonstrated that there is a significant relationship between a family's participation in a Montrose Home-Based Family Assessment and positive child protection outcomes for the child and family. This section seeks to answer a further question:

> *Does participation in a Montrose Assessment have a mediating effect on other independent variables that have been associated in this study with poor child protection Outcomes?*

In other words, do Assessed Group families have better child protection outcomes overall than Comparison Group families, even when they have factors associated in the Main Effects Models with negative outcomes for children or families three years after referral. (e.g. younger parental age, parental substance abuse, more male children, children diagnosed with ADD/HD, previous legal orders or history of out of home care placement.)

8.1 Montrose Assessment and Family Outcome Factors.

Apart from a significant association between a family's participation in a Montrose assessment and improved Family Outcome, the two Main Effects Models for Family Outcome Three Years after Referral found an association between four other independent variables and Family Outcome:

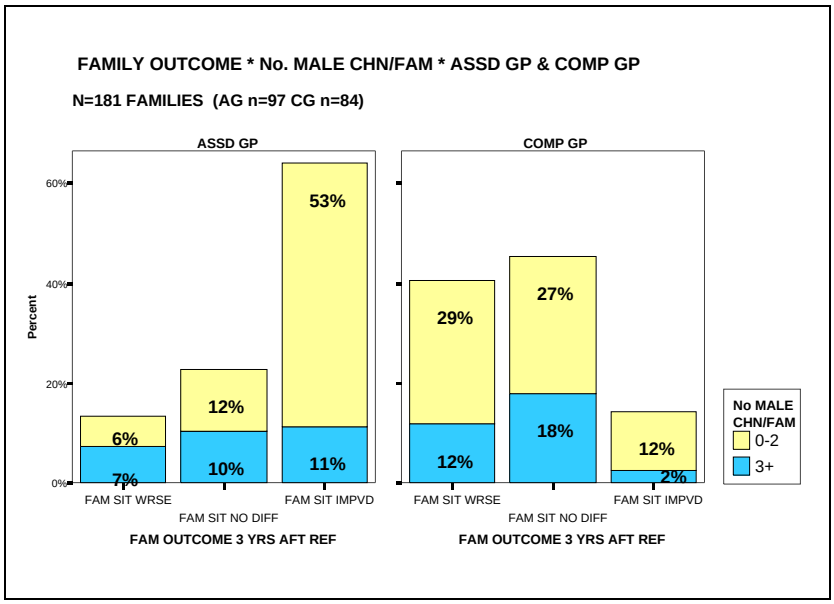
a. *No. of male children per Family.*
b. *No. of confirmed notifications per family at referral.*
c. *Current domestic violence in the family at time of referral.*
d. *Children in the family diagnosed with ADD/HD.*

Does the family's participation in a Montrose assessment have any mediating impact on the other independent variables in the Main Effects Models associated with Family Outcome?

8.1 a. Number of Male Children per Family.

Having three or more male children in a family is a factor associated with worse outcomes in the Main Effects Models for Family Outcome. There was no significant difference in the number of male children per family at referral between the Assessed Group (28%) and Comparison Group (31%). Family Outcome results for families with male children (Fig. 8.1) are clearly dominated by the Assessed Group families with two or less male children, with 53% rated as Improved, compared with only 12% of the equivalent Comparison Group families (p=0.005) (Appendix 8.1.1).

Fig. 8.1: Family Outcome 3 Years after Referral x No. Male Children/Family. (N =181 Families). Assessed Group n=97; Comparison Group n= 84.



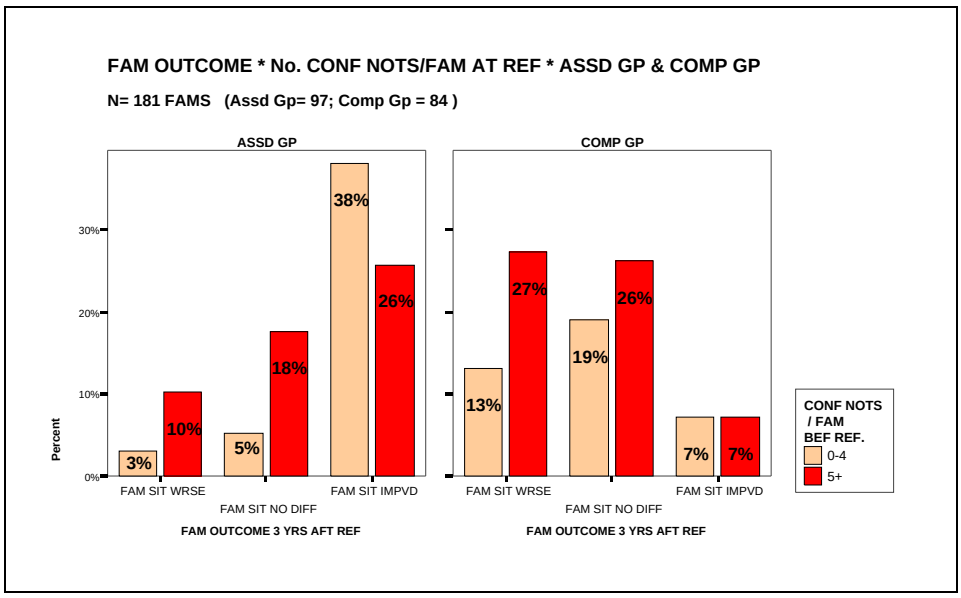
However, even for families with three or more male children, a factor associated in the Main Effects Model with poorer Family Outcome, a higher proportion of Assessed Group families are Improved (11% vs 2% Comparison Group), and fewer of the Assessed Group families are rated Worse (7% vs 12% Comparison Group) or No Different (10% vs Comparison Group 18%) three years after referral. A conclusion that may be drawn from these results is that in some way the Montrose assessment mitigates the potentially negative effects of the higher number of male children in the Assessed Group families.

8.1 b. Number of Confirmed Notification per Family at Referral.

Families with Five or More Confirmed Notifications at Referral are associated in the Main Effects Model with worse Family Outcomes than families with 0-4 Confirmed Notifications. The Assessed Group and Comparison Group are almost identical on this variable at time of referral (Family Outcome Main Effects Model 1: Section 7.5.1.c). When Family Outcome is analysed by Number of Confirmed Notifications at Referral and by Assessed Group and Comparison Group, significantly more Assessed Group families with 0-4 Confirmed Notifications at referral are rated as Improved three years after referral (p=0.002) (Appendix 8.1.2). This difference is not apparent in the equivalent Comparison Group families.

In the Assessed Group, Family Outcome for families with Five or More Confirmed Notifications at Referral follows the same directional trends from Worse (10%) to Improved (26%) as for families with four or less confirmed notifications. On the other hand, Comparison Group families with five or more confirmed notifications trend in the opposite direction, 27% of these families having Worse Family Outcome and only 7% being rated Improved (Fig. 8.2).

Fig. 8.2: Family Outcome x Confirmed Notifications before Referral. (N=181 Families). Assessed Group n=100; Comparison Group n=100.



Clearly, there is an advantage in intervening with families while the number of confirmed notifications per family is lower (0-4 confirmed notifications). However, these results also demonstrate that even when there are five or more confirmed notifications per family before referral, those families who participate in a Montrose assessment are more likely to be associated with Improved Family Outcome three years after referral.

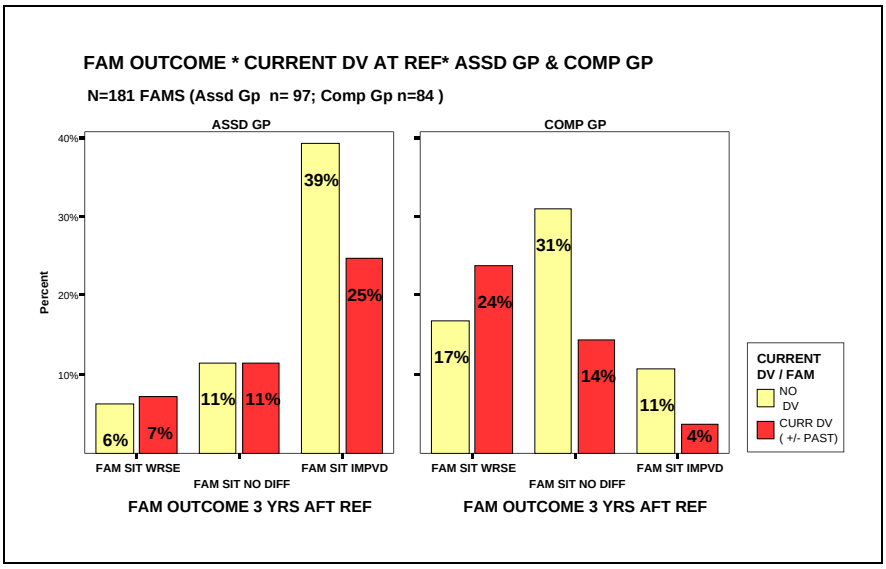
8.1 c. Current Domestic Violence at Referral.

At time of referral, there was a high rate of past and current domestic violence across all families in the study, with 78.5% of families with current and/or past domestic violence. The Assessed Group had 86% of families with reported domestic violence (43% current, 43% past) and the Comparison Group had 71% (40% current, 31% past) (Fig. 6.13; Chapter 6.).

In the Family Outcome Main Effects Model, *Current Domestic Violence at Referral* is associated with Worse Family Outcome three years after referral. When the Assessed Group and Comparison Group families are compared on this factor, there is a difference in outcomes. In the Assessed Group there is no significant difference in the Family Outcome ratings for families with or without Current Domestic Violence at Referral. This contrasts with the Comparison Group families, where there is a significant difference in Family Outcome for families with and without current domestic violence at referral ($p=0.029$) (Appendix 8.1.3).

Comparison Group families with domestic violence at time of referral and Worse Family Outcome make up 24% of the Comparison Group, as opposed to only 7% of equivalent Assessed Group families (Fig. 8.3) . By comparison, the Assessed Group has 25% of families with current domestic violence at referral and improved Family Outcome, compared with only 4% in the Comparison Group.

Fig. 8.3: Family Outcome x Current DV at Referral (N=181 Families.) Assessed Group n =97; Comparison Group n =84.



As the directional trends in Fig. 8.3 demonstrate, current domestic violence at referral has a clear impact on Family Outcome for Comparison Group families, with six times as many of these families being rated Worse as Improved three years after referral. The same trend is not apparent in Assessed Group families with current domestic violence at referral, which follow the same directional trend for Family Outcome as the families with no reported domestic violence. These findings demonstrate that Montrose assessed families have better Family Outcome results than Comparison Group families, even when the Assessed Group families have current domestic violence at referral.

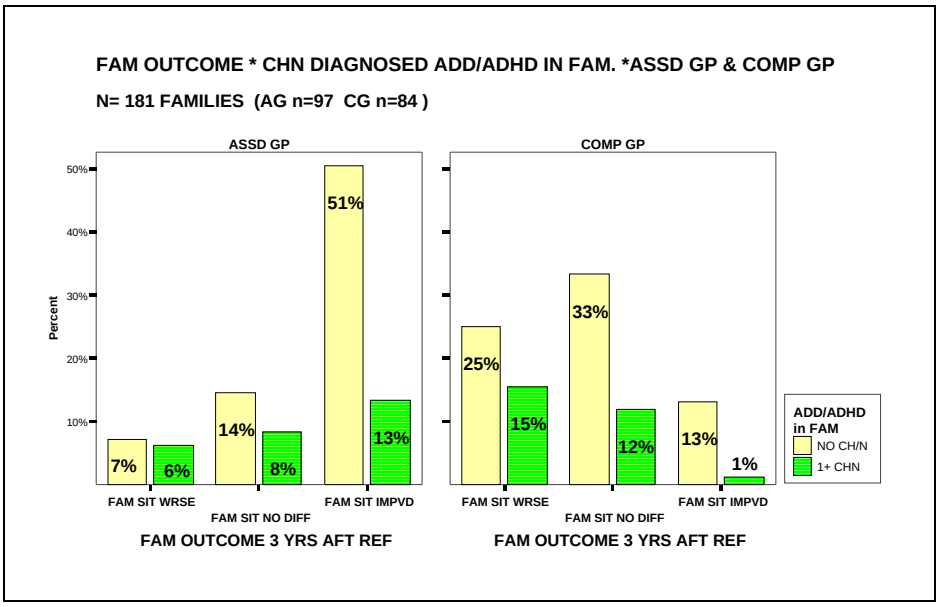
8.1 d. Number of Children per Family Diagnosed with ADD/HD.

The Main Effects Model for Family Outcome indicates that outcomes for families with one or more children diagnosed with ADD/HD are likely to be worse than for families with no such diagnosis. The number of families with children diagnosed with ADD/HD are comparable in the Assessed Group (n=27) and Comparison Group (n=29).

When Family Outcome is examined for differences between Assessed Group and Comparison Group families who have one or more children diagnosed

with ADD/HD, the trend in the Assessed Group mirrors that for families with no children diagnosed ADD/HD, i.e. from Worse to Improved, albeit with considerably fewer families in the Improved category, relative to families with no children diagnosed with ADD/HD (Fig. 8.4). In the Comparison Group, the trend is in the opposite direction, with 15% of families with children with ADD/HD rated Worse, and only 1% Improved (compared with 13% of the equivalent Assessed Group families).

Fig. 8.4: Family Outcome x No. Children Diagnosed ADD/HD / Family. (N=181 Families). Assessed Group n=97; Comparison Group n=84.



This result indicates that families who have a Montrose assessment are more likely to have positive outcomes, even when they have the potentially negative factor of one or more children diagnosed with ADD/HD.

Summary: Impact Of Montrose Assessment on Variables Related to Family Outcome.

The above findings demonstrate that Montrose Assessed Group families are more likely than Comparison Group families to be associated with positive Family Outcomes, even if they have factors identified in the Main Effects Models to be associated with negative Family Outcome – i.e. three or more male children, higher number of confirmed notifications, current domestic violence at time of referral or a diagnosis of ADD/HD in one or more children in the family.

8.2 Montrose Assessment and Children's Outcome Factors.

Apart from an association between a family's participation in a Montrose assessment and Children's Outcome, the Main Effects Model for Children's Outcome Three Years after Referral found an association between two other independent variables and Children's Outcome:

a. No. of Confirmed Notifications per Family at Referral.
b. Past or Current Substance Abuse by Male Caregiver.

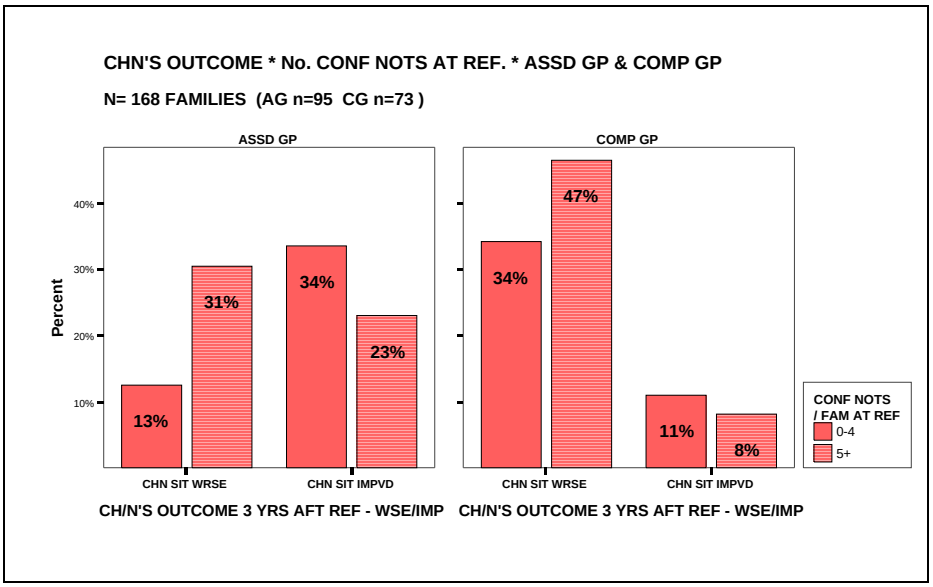
This section examines whether the family's participation in a Montrose assessment has any mediating impact on these two independent variables.

8.2 a. Number of Confirmed Notifications Per Family Before Referral.

Families with 0-4 confirmed notifications at referral fared better for Children's Outcome than those with 5 or more confirmed notifications (see 7.7.3 b.). However, the combination of a lower number of confirmed notifications at referral and participation in a Montrose assessment significantly enhanced the family's chances of being in the Improved, rather than Worse category for Children's Outcome (p=0.004; Appendix 7.7). Seventy-three percent of the Assessed Group families with 0-4 confirmed notifications per family at referral were Improved at follow up, compared with only 24% of the Comparison Group families.

When Children's Outcome is compared by number of confirmed notifications per family at referral for the Assessed and Comparison Groups, the results for the families with 0-4 confirmed notifications are clearly better for the Assessed Group, which has more than three times as many families as the Comparison Group in the Improved category (Fig. 8.5).

Fig. 8.5: Children's Outcome x No. of Confirmed Notifications per Family at Referral. (N=168 Families).
Assessed Group n=95; Comparison Group n=73.



Children from families with five or more confirmed notifications at referral fared less well in both the Assessed and Comparison Groups. However, the likelihood of an Improved Children's Outcome is enhanced by family participation in a Montrose assessment, even where the family has five or more confirmed notifications at referral these families accounting for 23% of the Assessed Group Improved category, compared with only 8% of equivalent Comparison Group families.

In the Comparison Group, 47% of families with five or more confirmed notifications at referral are rated as having Worse Children's Outcome, compared with 31% of the equivalent Assessed Group families.

The overall results reinforce the hypothesis that the likelihood of a positive outcome for the children is increased by intervening early in the family's contact with the child protection system, while the number of Confirmed notifications is low. However, the results also demonstrate that family participation in a Montrose assessment can mediate in Children's Outcome, even for families with higher numbers of notifications prior to referral.

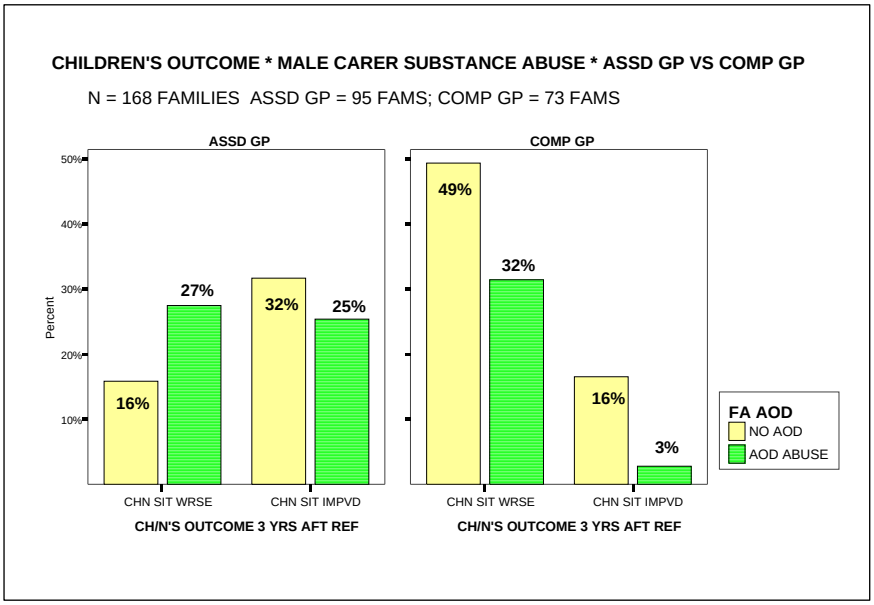
8.2 b. Past or Current Substance Abuse by Male Caregiver.

In the Children's Outcome Main Effects Model Male Carer Substance Abuse is significantly associated with Worse Children's Outcome (p=0.034; Appendix 7.5). For the 168 families for whom information was available regarding Children's Outcome, there were proportionally more families with reported past/current Substance Abuse by the Male Carer in the Assessed Group (53% of 95 families) than the Comparison Group (34% of 73 families).

Given this association and the fact that the Assessed Group has more families with Past or Current Substance Abuse by a Male Carer, it could be expected that the Assessed Group would have a higher rate of these families in the *Worse* Children's Outcome category three years after referral. This is not the case. Assessed Group families with Male Carer Substance Abuse are almost equally divided between Worse (52%; n=26) and Improved (48%; n=24) Children's Outcome. By contrast, 92% of the Comparison Group families with Male Carer Substance Abuse (n=23) are rated as having Worse Children's Outcome three years after referral, and only 8% (n=2) as Improved (p= 0.080) (Appendix 7.8).

While male carer substance abuse is associated with poor child protection outcomes generally, Figure 8.6 demonstrates that even Assessed Group families with past or current substance abuse by the male caregiver are more likely to have an Improved Children's Outcome than Comparison Group families. Eight times as many families with past or current substance abuse by a male carer are rated as Improved in the Assessed Group (25%) as in the Comparison Group (3%).

Fig. 8.6: Children's Outcome Three years after Referral x Past or Current Substance Abuse by a Male Carer. (N=168 families) Assessed Group n=95; Comparison Group n=73.



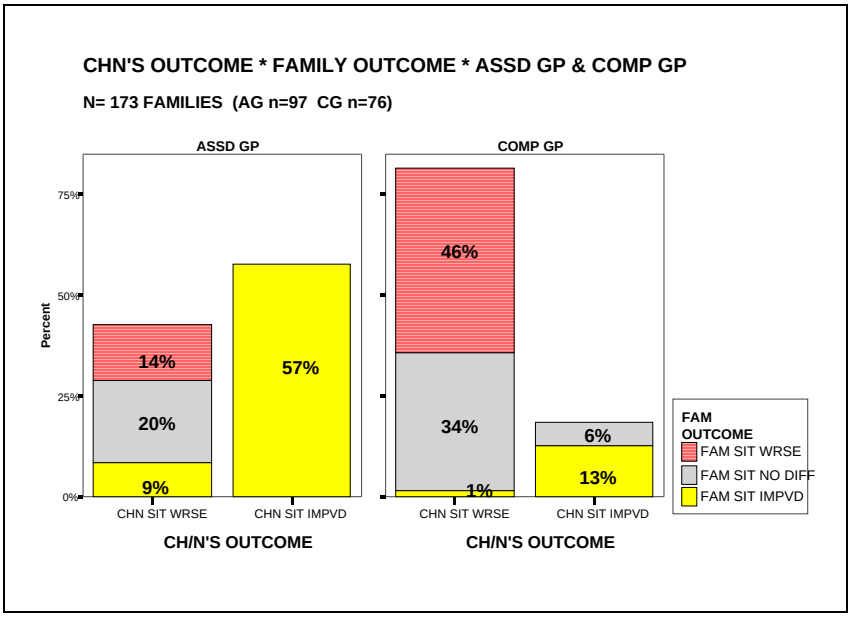
Summary: Impact of Montrose Assessment on Variables related to Children's Outcome.

The combination of a Montrose assessment and less than five Confirmed Notifications per family at referral increases the chances of a positive outcome for the children. However, participation in a Montrose assessment can still increase the likelihood of an Improved Children's Outcome, even where there are five or more Confirmed Notifications per family at referral. Similarly, male caregiver substance abuse in a family is associated with negative outcomes for children, but 25% of Assessed Group families with substance abuse by the male carer still had an Improved Children's Outcome, compared with only 3% of the equivalent Comparison Group families. These results clearly demonstrate that Assessed Group families are more likely than Comparison Group families to have positive Children's Outcomes, even if the families have either of the factors associated with negative Children's Outcome, i.e. higher number of confirmed notifications at referral, or past or current substance abuse by a male caregiver.

8.3 Impact of Montrose Assessment on the relationship between Children's Outcome and Family Outcome.

Because the outcome for all the children in a family was one of the measures used for rating Family Outcome, in most cases the results for Children's Outcome parallels those for Family Outcome. The Assessed Group has more families with Improved Children's Outcomes overall, and all the Assessed Group families with Improved Children's Outcome also have improved Family Outcome (Fig 8.7).

Fig. 8.7: Children's Outcome x Family Outcome. (N=173 families). Assessed Group n=97; Comparison Group n=76.



In both the Assessed Group and Comparison Group families, Worse Children's Outcome is correlated 100% with Worse Family Outcome, but the proportion of families with Worse Children's Outcome is more than three times higher in the Comparison Group than the Assessed Group.

The results indicate the moderating effect of the Montrose assessment on Family Outcome, which is in turn associated with a more positive outcome for the children living in those families.

8.4 Montrose Assessment and Legal Status per Family Three Years After Referral.

As well as a significant association between family participation in a Montrose assessment and Legal Status Outcome, the Main Effects Model for *Legal Status per Family Three Years after Referral* also found a significant association between the following independent variables and Legal Status Outcome:

a. No Legal Orders vs Legal Orders per Family at Referral.
b. Past or Current Substance Abuse by Mother/Female Caregiver.

This section examines whether the family's participation in a Montrose assessment has any mediating impact on the other independent variables in the Main Effects Model that are associated with the outcome variable Legal Status.

8.4 a. No Legal Orders vs Legal Orders per Family at Referral.

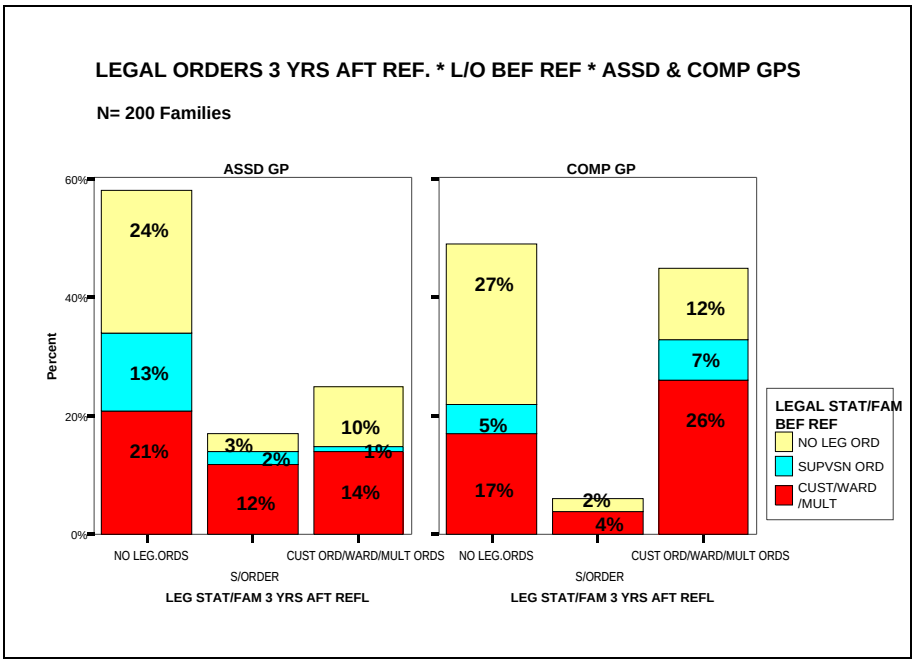
At referral, there was no significant difference between the Assessed Group and Comparison Group in terms of the proportion of families with No Legal Orders. (Assessed Group 37%; Comparison Group 41%), and the majority of families with no Legal Orders at referral tended to also be in the No Legal Orders category three years after referral (Appendix 7.12).

In terms of the *type* of Legal Orders in each group three years *after* referral, there is a significant difference between the Assessed Group and Comparison Group. The most serious category of Legal Orders - *Custody / Wardship / Multiple Order Types* - associated with out of home placement for one child or more, accounts for 45% of the Comparison Group, compared with only 25% of the Assessed Group (Assd Gp p=0.041; Comp Gp p=0.056) (Appendix 7.13).

Assessed Group and Comparison Group families with No Legal Orders three years after referral contain similar proportions of families who had No Legal

Orders (24% vs 27%) and Custody / Wardship / Multiple Order Types (21% vs 17%) at referral (Fig 8.8).

Fig. 8.8: Legal status per Family Three Years after Referral x Legal Status per Family at Referral. (N=200 Families). Assessed Group n =100; Comparison Group n =100.



However, the Assessed Group with No Legal Orders three years after referral has a larger proportion of families who had Supervision Orders before referral (13% compared with 5% in the equivalent Comparison Group families). Further, 12% of Assessed Group families with Supervision Orders three years after referral had been subject to more serious Legal Orders at referral, compared with 4% in the equivalent Comparison Group families. The Assessed Group has fewer families (14%) with serious Legal Order types three years after referral who also had serious Legal Orders at referral, compared with 26% of the Comparison Group families in this category.

These results indicate that the Assessed Group families demonstrate a trend towards less serious Legal Orders after referral, which is not apparent in the Comparison Group, and may be an effect of the Montrose assessment and its recommendations.

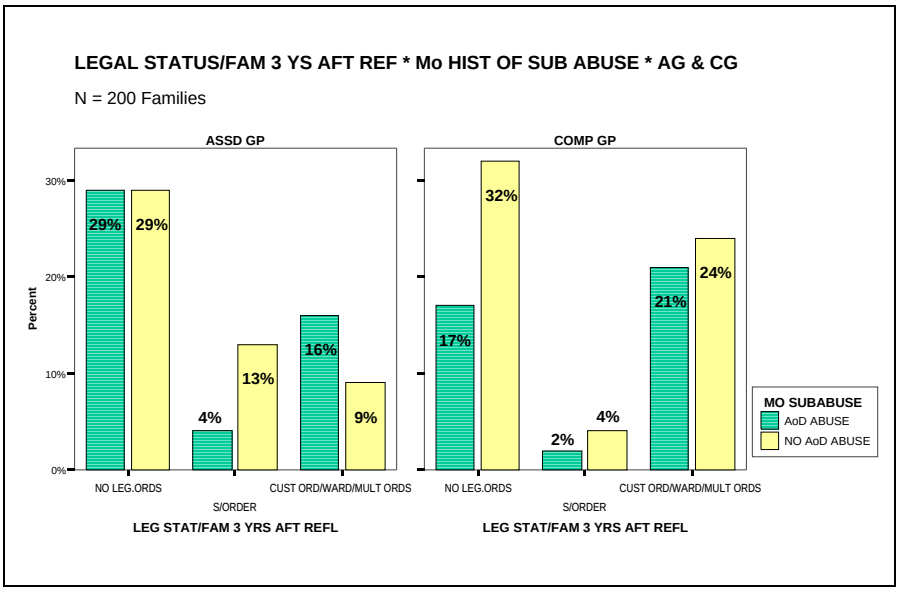
8.4 b. Past or Current Substance Abuse by Mother/Female Caregiver .

At time of referral, 44% of families in the study group had some history of past and/or current substance abuse by the mother/female caregiver, with no significant difference between the Assessed Group (49%) and Comparison Group (40%) (Appendix 7.21).

Three years after referral, there is a significant difference for Legal Status Outcome within the Assessed Group, in terms of more Supervision Orders associated with families with past or current substance abuse by the Mother/Female Caregiver (p=0.035) (Appendix 8.1.4). A proportion of these Supervision Orders may be the result of recommendations of the Montrose assessment, as explained in the Legal Status results section (7.6.1).

The Assessed Group has the same proportion of families with and without mother/female caregiver substance abuse (29%) in the No Legal Orders category three years after referral (Fig. 8.9). In contrast, the Comparison Group has only 17% of families with maternal substance abuse in the No Legal Orders category, compared with 32% of families without past or current substance abuse by the female caregiver.

Fig 8.9: Legal Status/Family Three Years After Referral x Past/Current Substance Abuse by Mother/ Female Carer. (N=200 Families). Assessed Group n =100; Comparison Group n =100.



These results indicate that the Montrose Assessment may have an impact on Legal Status Outcome with families with past or current Substance Abuse by the female caregiver. The mediating factor may be related to the specific recommendations for drug and alcohol interventions (detox program, rehabilitation or counselling) made by Montrose for 5% of the Assessed Group families, in addition to other recommendations (including short term placement) to improve the standard of parenting and the safety, welfare and wellbeing of the children (see Appendix 8.2: Montrose Recommendations).

Summary: Impact of Montrose Assessment on Variables related to Legal Status per Family Three Years after Referral.

The Main Effects Model for Legal Status per Family Three Years after Referral indicates a significant relationship between family participation in a Montrose assessment and Legal Status Outcome three years after referral, as well as between Legal Status Outcome and No Legal Orders (vs Legal Orders) per Family at Referral and Past or Current Substance Abuse by Mother/Female Caregiver.

Overall, there is a discernable difference between the Assessed Group and the Comparison Group in terms of children's Legal Status Outcome, suggesting that the Montrose assessment has a mediating effect on the two variables associated with negative Legal Status Outcome.

There is a significant difference between the Assessed Group and Comparison Group in the distribution of Legal Orders three years after referral, compared with Legal Orders per family before referral. The Assessed Group has more families who move from Supervision Orders before referral to No Legal Orders three years later, and from Custody / Wardship / Multiple Order Types before referral to Supervision Orders three years after referral. In addition, Custody/Wardship/Multiple Order Types account for 45% the Comparison Group compared with only 25% of the Assessed Group three years after referral.

These findings indicate a clear directional trend for Assessed Group families progressing to less interventionist Children's Court orders, which may be associated with the effects of the Montrose assessment and its recommendations.

Maternal substance abuse is strongly associated in this study with the most interventionist Children's Court Legal Orders (7.6.2). However, the same number of Assessed Group families with as without maternal substance abuse have No Legal Orders three years after referral, in contrast to equivalent Comparison Group families, where only half as many families with maternal substance abuse have No Legal Orders three years after referral. The Montrose Assessment may have a mediating role with families with maternal substance abuse, possibly related to specific Montrose recommendations in these families for drug and alcohol interventions aimed at improving the standard of parenting, and increasing the children's safety, welfare and wellbeing.

8.5 Montrose Assessment and Children's Placement Three Years After Referral.

The Outcome variable Children's Placement Three Years After Referral is divided into three categories, indicating increasing levels of intervention into children's placement in their families:

- All children living in the Family Home
- Some Children in Out of Home Care (Extended family or non-relative care)
- All Children in Out of Home Care (Extended family or non-relative care).

The Main Effects Models for Children's Placement Three Years After Referral shows a significant association between the following independent variables and Children's Placement Outcome:

a. Children's Placement History before Referral.

b. Age of Primary Caregiver.

c. Past or Current Substance Abuse by Father/Male Caregiver

d. Past or Current Substance Abuse by Mother/Female Caregiver.

This section examines whether family participation in a Montrose assessment has any mediating impact on the other independent variables in the Main Effects Model that are associated with Children's Placement Outcome.

8.5 a. Children's Placement History before Referral.

At referral, there was no significant difference between the Assessed Group and the Comparison Group with regard to history of children's placement types (Appendix 7.14).

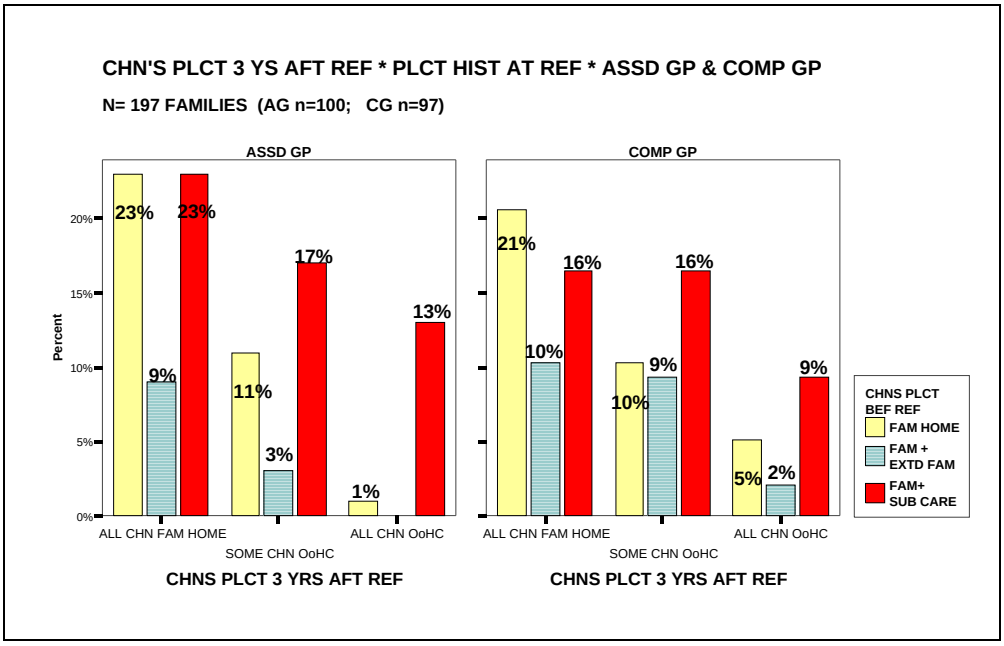
Three years after referral, there is a significant difference within the Assessed Group between the Children's Placement Outcome categories and the history of children's placement types before referral (p=0.017; Appendix 8.1.5). The Assessed Group families in the category All Children in Out of Home Care three years after referral almost exclusively have previous history of one child or more having been placed in substitute care (92%), while none has a history of extended family placement and there are only 7% where all the children had only lived in the family home before referral. This means that where there is not already a history of substitute care placement, only a small number of Assessed Group families have all children in Out of Home Care three years after referral.

By way of contrast, of the equivalent Comparison Group families with All Children in Out of Home Care three years after referral, 31% had no previous out of home care placement for any child, while 13% had used extended family care and 56% had previous substitute care history for at least one child.

The Main Effects Model for *Children's Placement Three Years after Referral* indicates that having no previous out of home care placement for any child in the family is significantly associated with having all children in the family home three years after referral. The Assessed Group has more families with

All Children Living in the Family Home three years after referral (55% vs Comparison Group 47%), yet of these a substantial proportion (32%) had previous placement of one child or more in extended family care (9%) or non-relative substitute care (23%) (Fig. 8.10).

Fig. 8.10: Children's Placement Three Years after Referral x History of Placement at Referral. (N=197 Families). Assessed Group n=100; Comparison Group n=97.



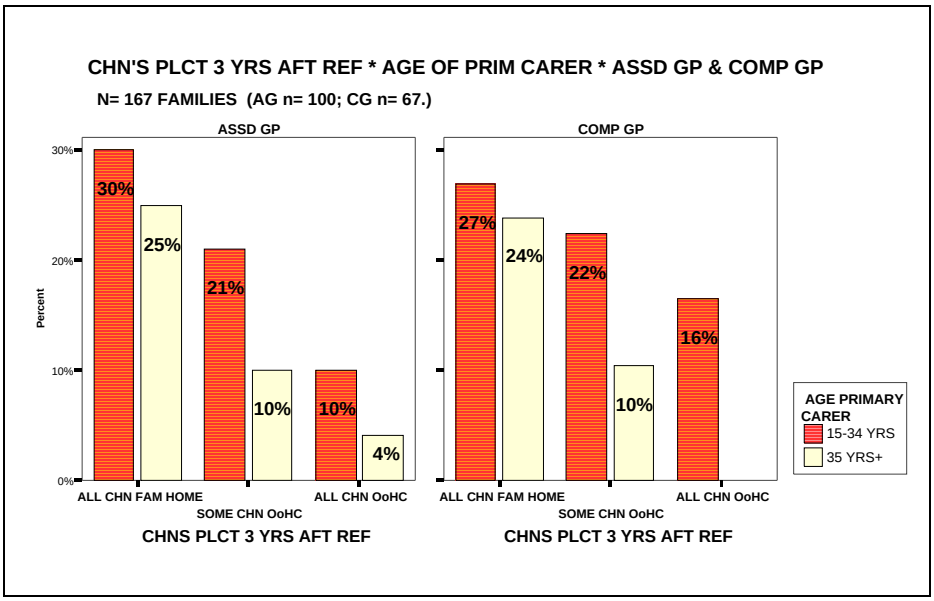
The link between placement of one or more children into non-relative Substitute Care and future placement of *all* children in the family into Out of Home Care is evident, for both the Assessed Group and Comparison Group families. This finding reinforces the need for early intervention with families, to provide services that prevent the need for initial placements. Where safety issues require placement of the children, extended family placements (which have a better prognosis for restoration to the family home), should be attempted before non-relative Substitute Care placements.

8.5 b. Age Group of Primary Carer at Referral.

At referral, there is no significant difference between the Assessed Group and Comparison Group in the proportion of Primary Carers in the 15-34 years and 35 or more years age groups (Appendix 7.23).

Three years after referral, in the Assessed Group there is no significant relationship between the age group of the Primary Caregiver and children's placement. By contrast, for Comparison Group families where Primary Caregiver's age and children's placement three years after referral could be determined, all families with All Children in Out of Home Care had Primary Caregivers aged 15-34 years at referral (p=0.016) (Appendix 7.25). Apart from this significant difference, the distribution pattern of children's placement by Primary Caregiver's age is similar in the Assessed Group and Comparison Group (Fig. 8.11).

Fig. 8.11: Children's Placement Three Years after Referral x Age of Primary Carer (N=167 Families).
Assessed Group n=100; Comparison Group n=67.



8.5 c. Past/Current Substance Abuse by Father/ Male Caregiver.

At time of referral, there was a significant difference between the Assessed Group and Comparison Group families in terms of history of male carer substance abuse (p=0.010; Appendix 7.19). The Assessed Group had 51% of families with reported past or current Substance Abuse by the Father/Male Carer, compared with 33% of the Comparison Group. While it is possible that this difference could be due to under-reporting in the Comparison Group because of the lack of previous comprehensive assessment of the families, individuals with serious drug or alcohol abuse issues are prone to come to

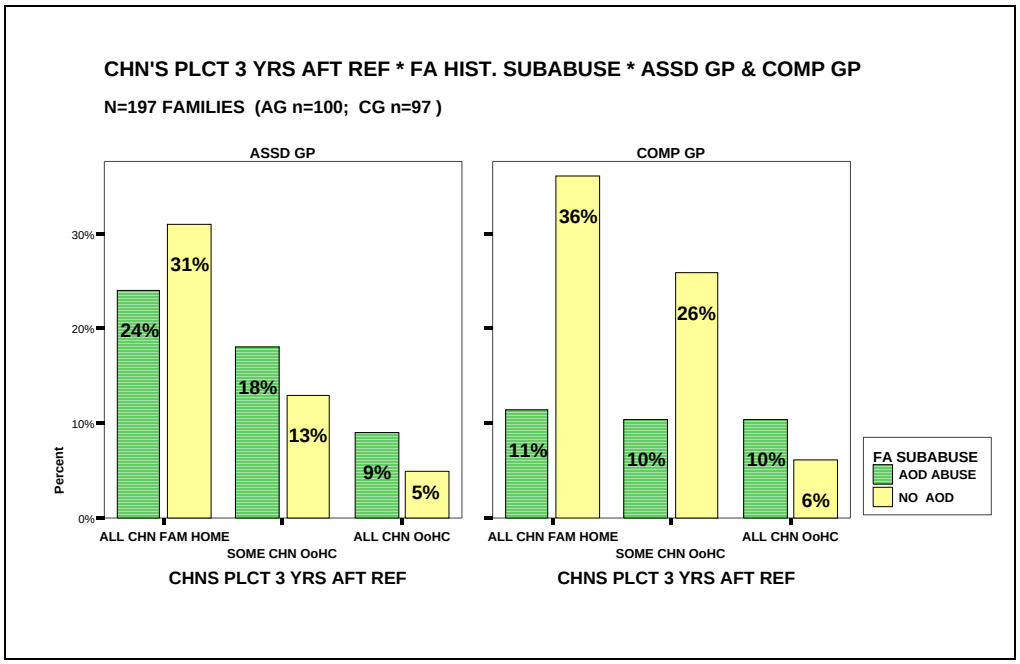
the attention of the authorities (police or child welfare) and it is unlikely that the most serious of these issues would have been omitted from the child protection histories.

Given the over-representation of male carer substance abuse in the Assessed Group, and the Main Effects Model link between male carer substance abuse and children's out of home care placement, it would be expected that placement outcomes would be worse for children from the Assessed Group families. However, this is not the case.

In fact, the relationship between substance abuse by father/male carer and Children's Placement Outcome three years after referral is only significant in the Comparison Group (p=0.015) (Appendix 7.20). The Comparison Group families with All Children living in the Family Home three years after referral, are divided between 76% with no past or current substance abuse by the male carer vs 24% with past/current substance abuse. By contrast, the equivalent Assessed Group families are more evenly split between those with substance abuse by the male carer (44%) and those without (56%) (Appendix 7.20).

The proportion of families with past or current substance abuse by the male caregiver and All Children in Out of Home Care three years after referral is comparable in the Assessed Group and Comparison Group (Fig. 8.12). However, there is a difference between the Assessed Group and Comparison Group in the other two placement categories - *All Children in the Family Home* and *Some Children in Out of Home Care*. Comparison Group families with past or current male carer substance abuse are almost equally distributed between the two placement categories and are substantially outnumbered by families with *no* substance abuse by male carer. In contrast, the Assessed Group has a large number of families with histories of male carer substance abuse where all the children are still in the family home (24%) or only some children are in out of home care (18%).

Fig. 8.12: Children's Placement Three Years after Referral x Past / Current Substance Abuse by Male Carer. (N=197 Families). Assessed Group n=100; Comparison Group n=97.



This difference in placement distribution suggests an impact by the Montrose assessment and its recommendations that allows some or all of the children to be maintained in, or restored to, the family home, even in families with past or current male carer substance abuse. This may be either by dealing directly with the male carer's current substance abuse, or by strengthening the family members to deal with the negative effects of past substance abuse on the children, so that the children can remain in, or return to, the family home.

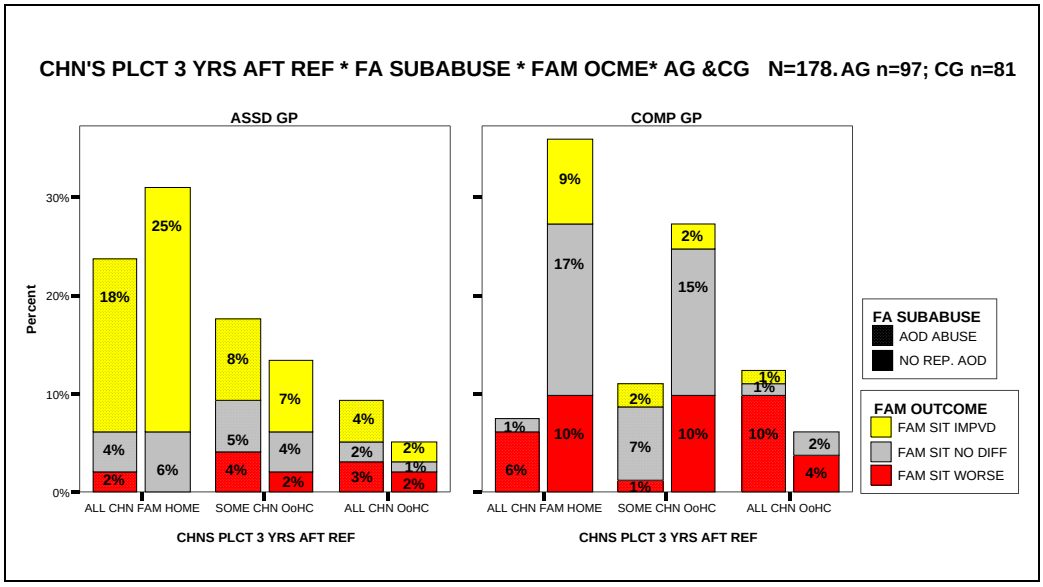
It is important to establish that the situation for these children was not subject to the ongoing effect of the male caregiver's substance abuse. In order to confirm that the family situation was actually improved in the families where the children were all in the family home three years after referral and there was also past/current male caregiver substance abuse, the two variables were crosstabulated with Family Outcome, and by Assessed Group and Comparison Group.

The results, illustrated in Fig. 8.13, show that families where all children are living in the family home three years after referral, <u>and</u> there is a history of

male caregiver substance abuse and the Family Outcome is rated Improved constitute 18% of the Assessed Group. In the Comparison Group, there are *no* families with this combination of factors.

The Family Outcome in Assessed Group families with substance abuse by the male caregiver and All Children in the Family Home three years after referral was No Different for 4% of families and worse for 2%.

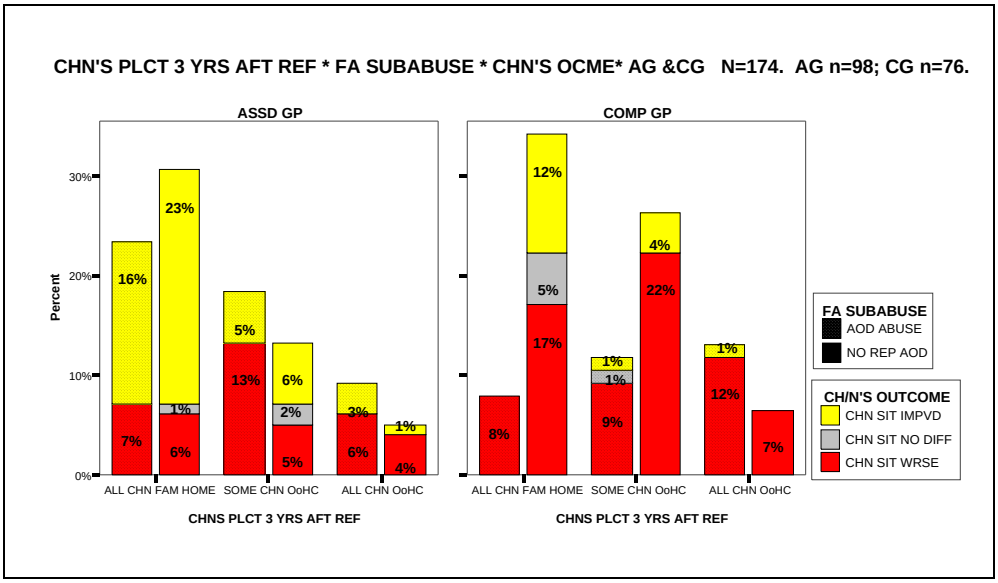
Fig. 8.13: Children's Placement Three Years after Referral x Past/Current Substance Abuse by Male Carer x Family Outcome. (N=178 Families). Assessed Group n=97; Comparison Group n=81.



As well as the Family Outcome, it is important to also assess the Children's Outcome after a Montrose assessment in these families with male caregiver substance abuse where all children are in the family home three years after referral. The results of crosstabulation of Children's Outcome with children's placement at home and substance abuse by the male carer, by Assessed Group and Comparison Group, indicate that in the Assessed Group and Comparison Group families where all children remained in the family home and there is past/current substance abuse by the male caregiver, the proportion of families where the children have Worse outcomes is equivalent (Assessed Group 7%; Comparison Group 8%), but the Comparison Group

has no families in the Improved category, compared with 16% of Assessed Group families (Fig. 8.14).

Fig. 8.14 Children's Placement Three Years after Referral x Past/Current Substance Abuse by Male Carer x Children's Outcome. (N=178 Families). Assessed Group n=97; Comparison Group n=81.



These results demonstrate that for the most part, the children in Assessed Group families have not simply remained in the family home where there is past/current substance abuse by the male carer, but that for a substantial number of families, an intervention has taken place to improve the family situation with regard to their safety, welfare and wellbeing. The same outcomes are not evident in the Comparison Group.

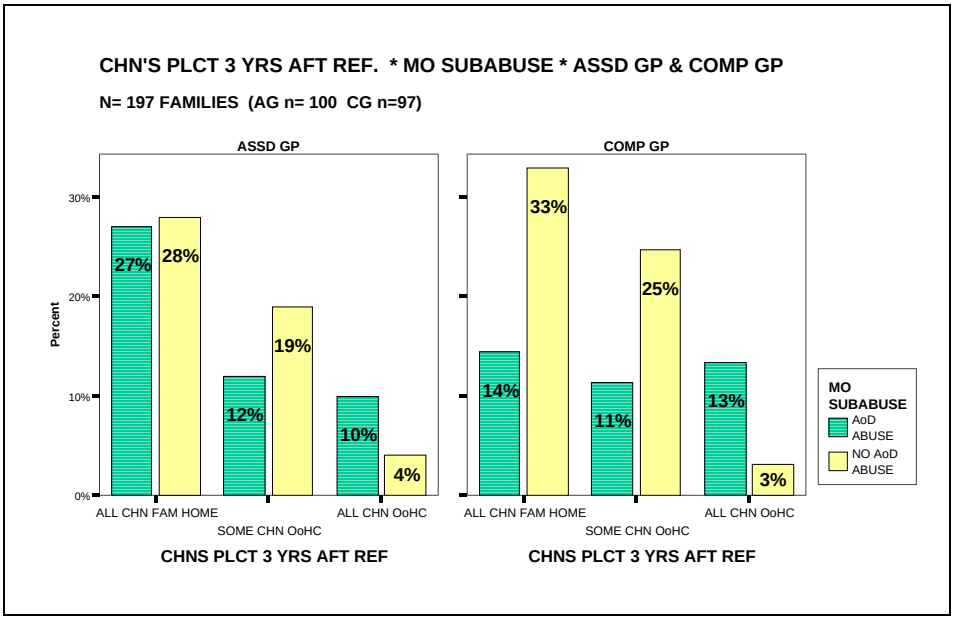
8.5 d. Past/Current Substance Abuse by Mother/Female Caregiver.

There was no significant difference at referral between the proportion of families with past/current substance abuse by the Female Caregiver in the Assessed Group (49%) and Comparison Group (40%) (Appendix 7.21).

However, three years after referral, there is a significant relationship between Children's Placement and Past/Current Substance Abuse by Female Carer in the Comparison Group families (p=0.001) (Appendix 7.22), but not in the

Assessed Group. Comparison Group families with maternal substance abuse are spread relatively evenly across the three placement outcome categories, while the families with no reported maternal substance abuse are much more likely to have All Children in the Family Home (33%) or only Some (25%) , rather than All Children, in Out of Home Care (Fig. 8.15).

Fig. 8.15: Children's Placement Three Years after Referral x Past/Current Substance Abuse by Female Carer. (N=197 Families). Assessed Group n=100; Comparison Group n=97.



In contrast to the Comparison Group, the Assessed Group families have comparable numbers of families with and without maternal substance abuse where All Children are in the Family Home three years after referral. As with the findings for Children's Placement and male caregiver substance abuse (8.5.c), this may be related to Montrose recommendations for specific interventions to address current, or the effects of past, maternal substance abuse. These recommendations may include detox, rehabilitation, counselling or monitoring, and may be accompanied by a short term placement order for the children so that the mother can attend to the substance abuse issues and then have the children restored to her care.

Although substance abuse by the female caregiver is a high risk factor for out of home care placement for some or all children in 22% of Assessed Group and 24% of Comparison Group families (Fig. 8.14), it would also appear from these results that it was still possible to successfully intervene and keep some or all the children in the family home in 39% of Assessed Group families with maternal substance abuse, compared with 25% of Comparison Group families.

Interrogating the data further to assess Family Outcome for these families, (Fig. 8.16), 20% of the Assessed Group families with All Children in the Family Home three years after referral and past/current substance abuse by the female caregiver also have improved Family Outcomes, compared with only 2% of the equivalent Comparison Group families.

Fig. 8.16: Children's Placement Three Years after Referral x Past/Current Substance Abuse by Mother/Female Carer x Family Outcome. (N=178 Families). Assessed Group n=97; Comparison Group n=81.

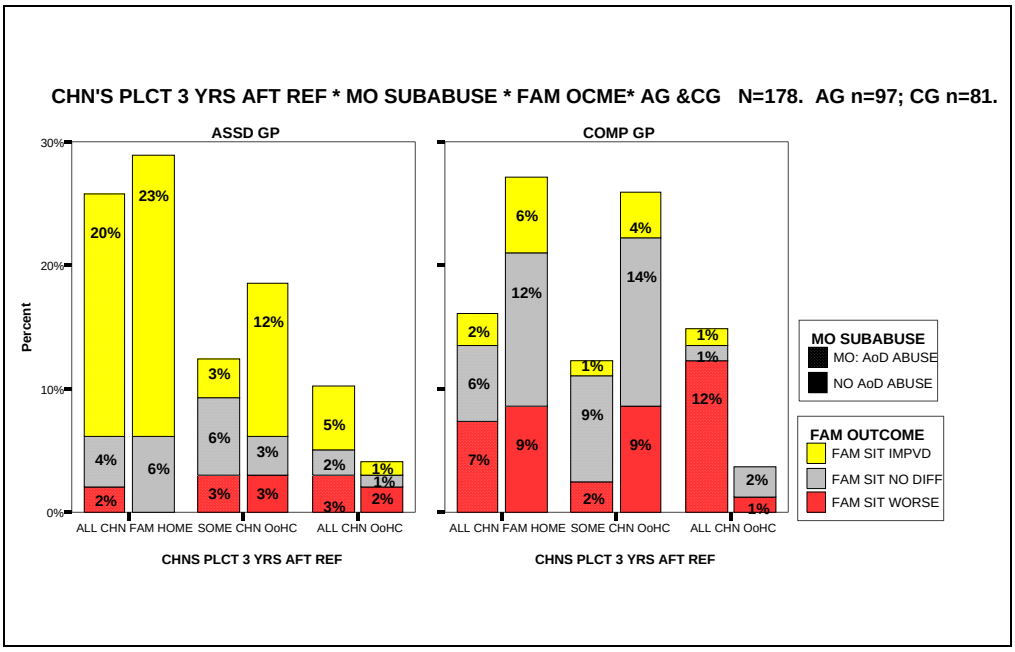
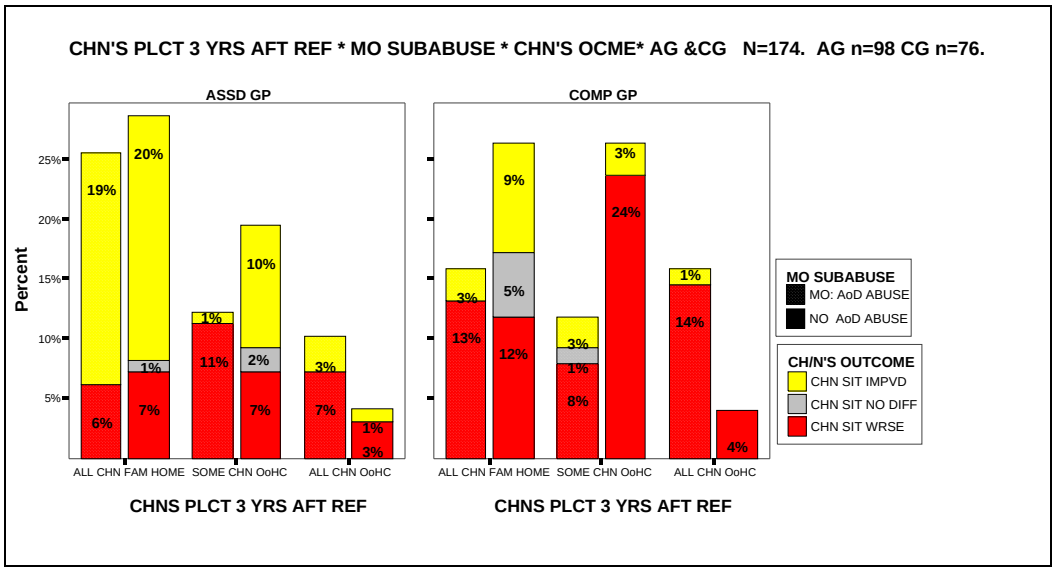


Figure 8.17 illustrates the impact of the Montrose assessment on Children's Outcome in families where All Children are in the Family Home three years after referral and there is past or current substance abuse by the

mother/female caregiver. In the Assessed Group, Children's Outcome is rated Improved in 19% of these families, compared with only 3% of the equivalent Comparison Group families. While 6% of these Assessed Group families have Children's Outcome rated Worse, this still compares favourably with 13% in the equivalent Comparison Group families.

Fig. 8.17: Children's Placement Three Years after Referral x Past/Current Substance Abuse by Mother/Female Carer x Chn's Outcome. (N=174 Families). Assessed Group n=98; Comparison Group n=76.



These findings demonstrate that the Montrose intervention has successfully addressed the safety, welfare and wellbeing issues for the families with All Children in the Family Home in a substantial number of families with current or past maternal substance abuse.

Summary: Impact of Montrose Assessment on Variables Related to Children's Placement.

These findings support the hypothesis that a Montrose assessment can have a positive impact, even with families where there are factors that would otherwise be associated with out of home care placement for some or all children – i.e. previous out of home care placement of any child, younger age group of primary caregiver, and past or current substance abuse by either the male or female caregiver.

Families where one or more of the children had spent time in Substitute Care prior to referral to Montrose have a much higher rate of all children being in out of home care three years after referral, in both the Assessed Group and Comparison Group. Where the children have *not* been in out of home care prior to referral *or* have only been placed with extended family, and the family has participated in a Montrose assessment, there is a substantially lower likelihood of all children being placed in out of home care three years after referral.

In terms of the impact of the age group of the primary caregivers on Children's Placement three years after referral, there is a significant association, in the Comparison Group but not the Assessed Group, between younger age group parents/carers (15-34 years) and all children being placed in Out of Home Care three years after referral.

Past/Current Substance Abuse in either Male or Female Parent/Caregiver is associated with higher risk of children being placed in out of home care. However, the relationship between parental substance abuse is only at a significant level in the Comparison Group, and for both male and female carers. Significantly fewer Comparison Group families with parental substance abuse have all children living in the family home, compared with families with no substance abuse history. While Comparison Group families with substance abuse by the male or female carer are almost equally distributed between the three placement outcome categories, the equivalent Assessed Group families have more than twice as many families with All Children in the Family Home at follow-up as opposed to All Children in Out of Home Care. Therefore, although substance abuse by carer/s may have a negative impact on the placement outcomes for children, participation in a Montrose assessment appears to have a moderating effect on this negative impact for a substantial number of the families.

In summary, there is a clear association between a family having participated in a Montrose assessment and an increased likelihood that all the children

will be placed in the family home at follow-up, even for families with the negative characteristics associated with children's out of home placement, i.e. previous out of home placements, younger parental age group or past or current substance abuse by either parent/caregiver.

Early intervention to prevent the need for initial removal of the children from the family home provides the most encouraging prospect for their future placement in the family home. The next best option to support eventual restoration to the family is placement with extended family members.

8.6 Montrose Assessment and Number of Notifications per Family Three Years after Referral.

The Main Effects Model found a significant association between three independent variables and Number of Notifications per Family three years after referral:

a. Number of Notifications per Family at referral to Montrose.
b. Age Group of Primary Caregiver.
c. Children in Family Diagnosed with ADD/HD.

This section examines whether the family's participation in a Montrose assessment has any mediating impact on these variables and the Number of Notifications per Family Three Years after Referral.

8.6 a. Number of Notifications per Family at Referral to Montrose.

At time of referral to Montrose, there was no significant difference in the number of notifications per family between the Assessed Group (n=1195 notifications) and Comparison Group (n=1107). (Appendix 7.25).

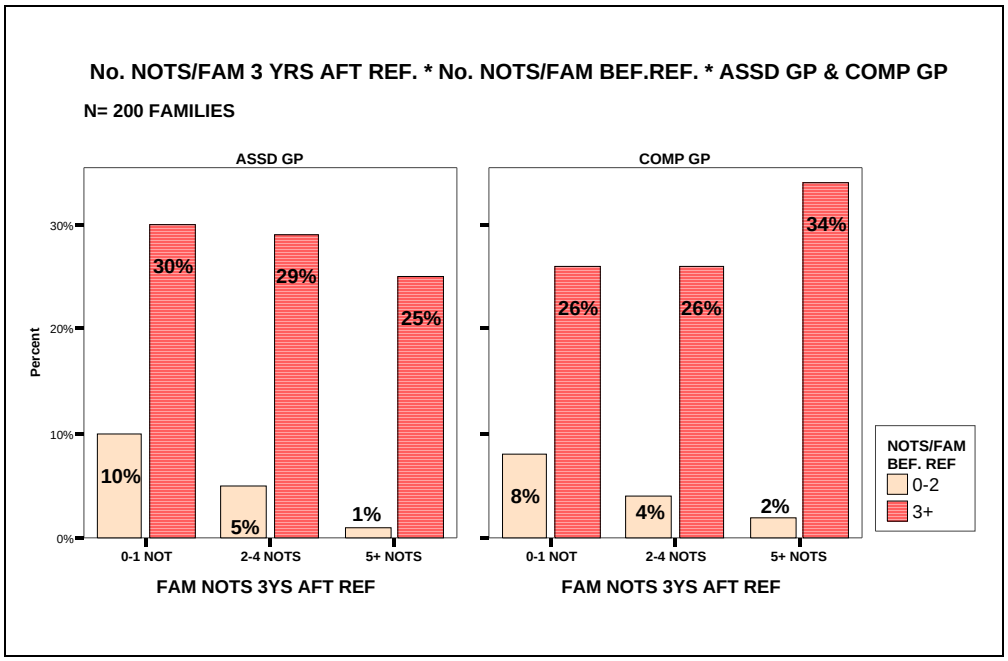
To prevent the small numbers of families with high numbers of notifications at referral affecting the analysis, the Outcome variable Number of Notifications per Family at Referral was divided into two categories:

- 0-2 Notifications and
- Three or More Notifications.

Higher numbers of notifications at referral are significantly associated with more notifications in the three years after referral (p=0.003; Appendix 7.28). This association occurs in both the Assessed Group (p=0.075) and the Comparison Group (p=0.090) (Appendix 8.1.6).

The Assessed Group and Comparison Group are comparable in distribution of Notifications per Family three years after referral, compared with Number of Notifications per Family at Referral (Fig.8.18). However, the Assessed Group has more families in the 0-1 and 2-4 notifications Outcome categories, while the Comparison Group has a greater proportion of families with five or more notifications (34% vs Assessed Group 25%).

Fig. 8.18: No. of Notifications/Family Three Years after Referral x No. of Notifications/Family at Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



The higher number of Assessed Group families with 1-4 notifications but fewer families with higher numbers of notifications may be related to the increased observation of Assessed Group families by the support services put in place on the recommendation of Montrose team. While high risk

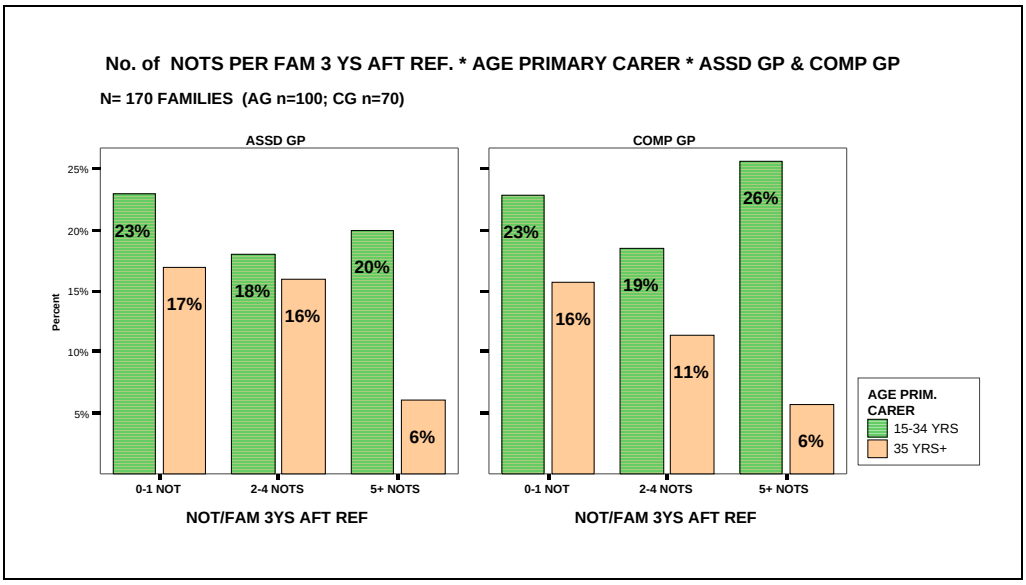
families are subject to notifications early after the assessment because of increased scrutiny by support services, this result may indicate that the Montrose assessment has an impact on minimising higher numbers of notifications in the three years after referral, even for those families with more notifications before referral.

8.6 b. Age of Primary Caregiver.

In the Main Effects Model for *Number of Notifications Three Years after Referral*, Younger age of Primary Caregiver is associated with higher numbers of notifications (five or more) three years after referral.

There is no significant difference between the Assessed Group and Comparison Group in the number of notifications per family three years after referral compared by Primary Caregiver age group (Fig. 8.19).

Fig. 8.19: Number of Notifications / Family Three Years After Referral x Age of Primary Caregiver. (N=170 Families). Assessed Group n=100; Comparison Group n=70.



The Assessed Group has slightly fewer families (6%) with younger aged Primary Carers and five or more notifications. However, it should be noted that the age of the Primary Caregiver was not known for a substantial

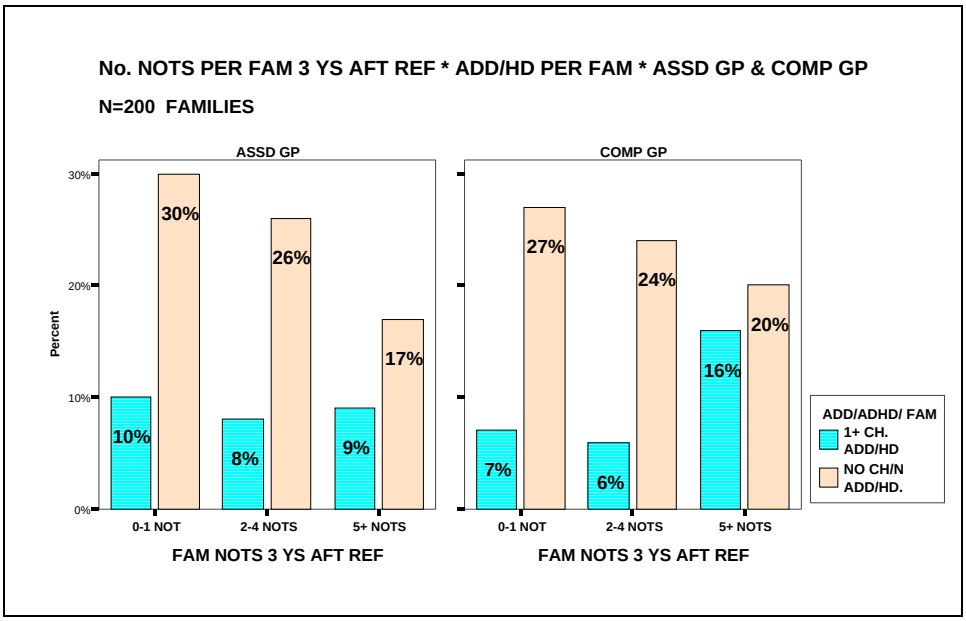
proportion (30%) of the Comparison Group, which may have affected the finding.

8.6 c. Children Diagnosed with ADD/HD per Family.

Having one child or more diagnosed with ADD/HD is associated with higher numbers of notifications per family three years after referral (Appendix 7.28). The Assessed Group and Comparison Group had similar numbers of families with children diagnosed with ADD/HD at referral.

Three years after referral, the distribution of numbers of notifications per family are comparable for the Assessed Group and Comparison Group families with *no* children diagnosed with ADD/HD. The Assessed Group families with children diagnosed with ADD/HD are also evenly distributed across the notifications categories (Fig 8.20).

Fig. 8.20: Number of Notifications/Family Three Years after Referral x Children Diagnosed with ADD/HD in Family. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



There is a significant relationship in the Comparison Group, but not the Assessed Group, between families with children diagnosed with ADD/HD

and higher numbers of notifications per family (p=0.038) (Appendix 7.31). Over half (55%) the Comparison Group families with child/ren diagnosed with ADD/HD had five or more notifications three years after referral, compared with roughly equal numbers of families with either 0-1 or 2-4 notifications.

This indicates that a diagnosis of ADD/HD is significantly associated with higher numbers of notifications in the three years after referral in Comparison Group families, but is *not* related in the same way in Assessed Group families, indicating that the Montrose assessment has had some effect on Outcome.

8.7 Montrose Assessment and Number of Confirmed Notifications per Family Three Years after Referral.

The Main Effects Model for *Number of Confirmed Notifications per Family Three Years after Referral* (Appendix 7.30) demonstrates an association between the following three independent variables and the Number of Confirmed Notifications per Family Three Years after Referral:

a. Number of Notifications per Family at Referral to Montrose.
b. Past or Current Substance Abuse by Mother/Female Caregiver.
c. Number of Male Children per Family.

This section examines whether family participation in a Montrose assessment has any mediating impact on negative effects of these independent variables on the Outcome variable Number of Confirmed Notifications per Family Three Years after Referral.

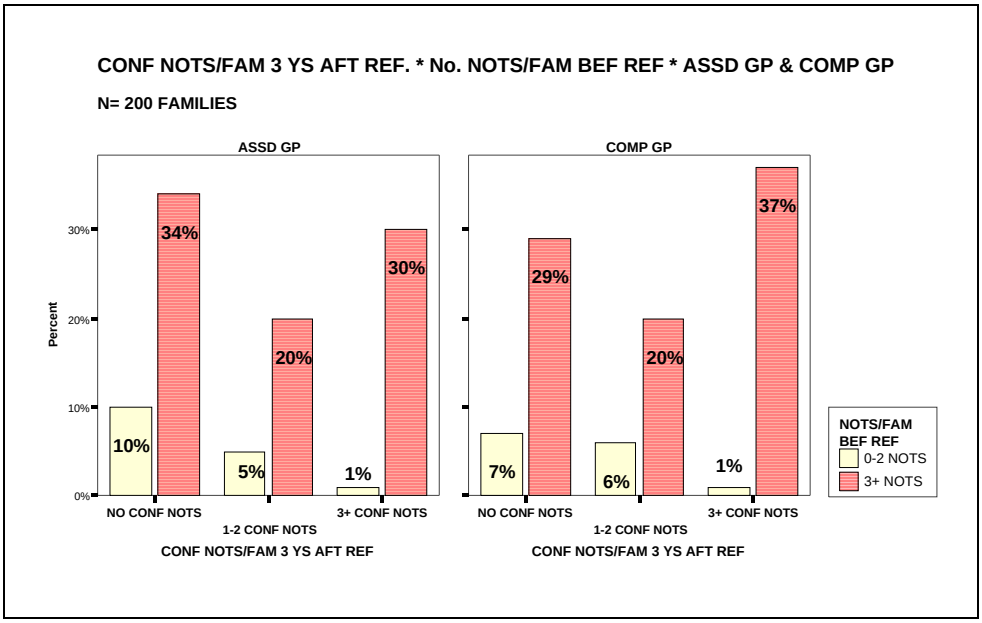
8.7 a. Number of Notifications per Family at Referral.

There is no significant difference between the Assessed Group and Comparison Group in number of notifications (0-2 vs three or more) per family at referral (Appendix 7.27). The Main Effects Model indicates that a higher number of notifications per family at referral (3 or more) is predictive of more Confirmed Notifications per family three years after referral (3 or more).

This significant association is present in both the Assessed Group, with 30 out of 31 (97%) of families with three or more confirmed notifications three years after referral having had 3 or more notifications per family at referral (p=0.063), and the Comparison Group, with 37 out of 38 families (97%) (p=0.034) having this combination of factors (Appendix 8.1.7).

The Assessed Group has more families with three or more notifications before referral and *no* Confirmed Notifications three years after referral (34% vs Comparison Group 29%) and fewer families with three or more confirmed notifications (30%) relative to the Comparison Group (37%), but the effect of the Montrose assessment on this Outcome variable is not statistically significant. (Fig. 8.21).

Fig. 8.21: Confirmed Notifications/Family 3 Years after Referral x No. of Notifications / Family before Referral (N=200 Families.) Assessed Group n=100; Comparison Group n=100.



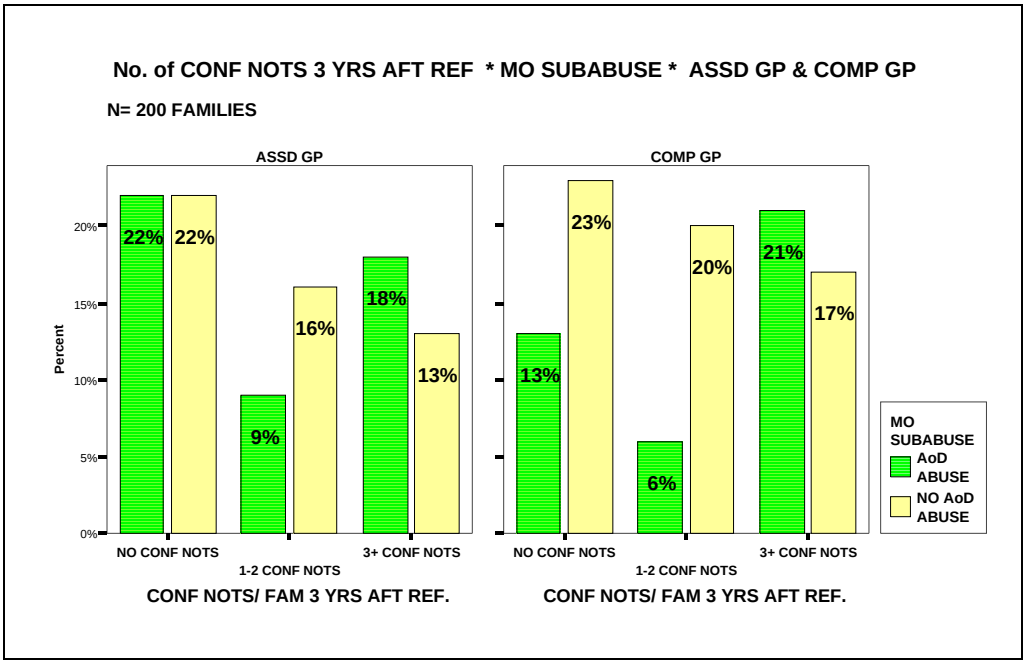
8.7 b. Past/Current Substance Abuse by Mother/Female Caregiver.

Past or current Substance Abuse by the Female Caregiver is associated with higher numbers of confirmed notifications (3 or more), three years after referral. There is a significant association only in the Comparison Group,

between families with no Past/Current Substance Abuse by Female Caregiver and 1-2 Confirmed Notifications, rather than three or more Confirmed Notifications, three years after referral (p=0.030) (Appendix 7.32).

In the Comparison Group there is a 10% difference in the number of families with and without substance abuse by the female caregiver who have *no* Confirmed Notifications Three Years after Referral. In the Assessed Group, the number of families with *no* Confirmed Notifications is the same for families, *whether or not* there is substance abuse by the female caregiver (Fig. 8.22). This finding indicates that for families with past or current female caregiver substance abuse, the Montrose assessment, and its recommended interventions, may have a mediating influence on the Number of Confirmed Notifications per Family three years after referral.

Fig. 8.22: Number of Confirmed Notifications / Family Three Years After Referral x Mother's Substance Abuse. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



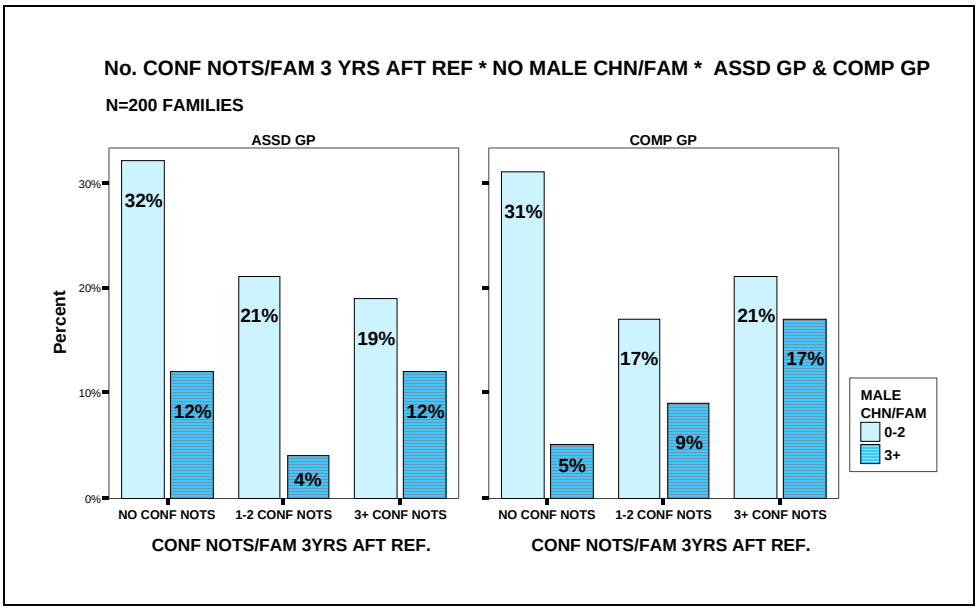
8.7 c. Number of Male Children per Family.

Number of male children per family is a factor in the Main Effects Model for the Outcome variable Number of Confirmed Notifications Three Years after

Referral. Three or more male children per family has an adverse impact on the number of Confirmed Notifications three years after referral in both the Assessed Group and Comparison Group. However, the relationship is statistically significant only for Comparison Group families, where families with three or more male children are under-represented in the No Confirmed Notifications category three years after referral (p=0.015) (Appendix 7.33).

For families with two or less male children, the distribution of numbers of Confirmed Notifications Three Years after Referral is comparable for the Assessed Group and Comparison Group (Fig. 8.23). Where there are three or more male children in the family, the Comparison Group has a clear trend towards more Confirmed Notifications, whereas the Assessed Group has the same proportion of families in the Three or More Confirmed Notifications category and the No Confirmed Notifications category.

Fig. 8.23: Number of Confirmed Notifications/Family Three Years After Referral x No. Male Children/Family. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



Three years after referral, the Assessed Group has more families with No Confirmed Notifications and fewer families with Three or More Confirmed Notifications than the Comparison Group, even for families with three or more male children.

Summary: Impact of Montrose Assessment on Variables related to Number of Notifications and Confirmed Notifications three years after referral.

Three years after referral the Assessed Group has more families with No Notifications and No Confirmed Notifications than the Comparison Group, and fewer families with higher numbers of Notifications (5+) and Confirmed Notifications (3+). This occurs even when the Assessed Group families have factors associated in the Main Effects Models with higher numbers of Notifications three years after referral (i.e. higher number of notifications per family at referral; younger age group of primary caregiver; one child or more diagnosed with ADD/HD) and factors associated with higher numbers of Confirmed Notifications (i.e. higher Number of Notifications per family at referral; past or current Substance Abuse by Mother/Female Caregiver; Three or More Male Children). These findings indicate that the Montrose assessment may have a mediating role on the factors associated with negative child protection outcome in these families.

8.8 Montrose Assessment and Abuse Type Three Years After Referral.

The Main Effects Model for *Type of Abuse per Family Three Years After Referral* describes an association between two independent variables and Type of Abuse per Family three years after referral:

a. Number of Notifications per Family at time of referral to Montrose.
b. Age of Primary Carer.

The Type of Abuse Outcome Variable is divided into three categories:

- *No Abuse* - where there has been no notification on the family during the follow-up period, or where the notification of abuse or neglect has not been substantiated.

- *Single Type Abuse* - where only one type of abuse or neglect is reported per family.
- *Multiple Abuse Types* - where there has been more than one type of abuse or neglect, or a combination of abuse and neglect, affecting one child or more in the family.

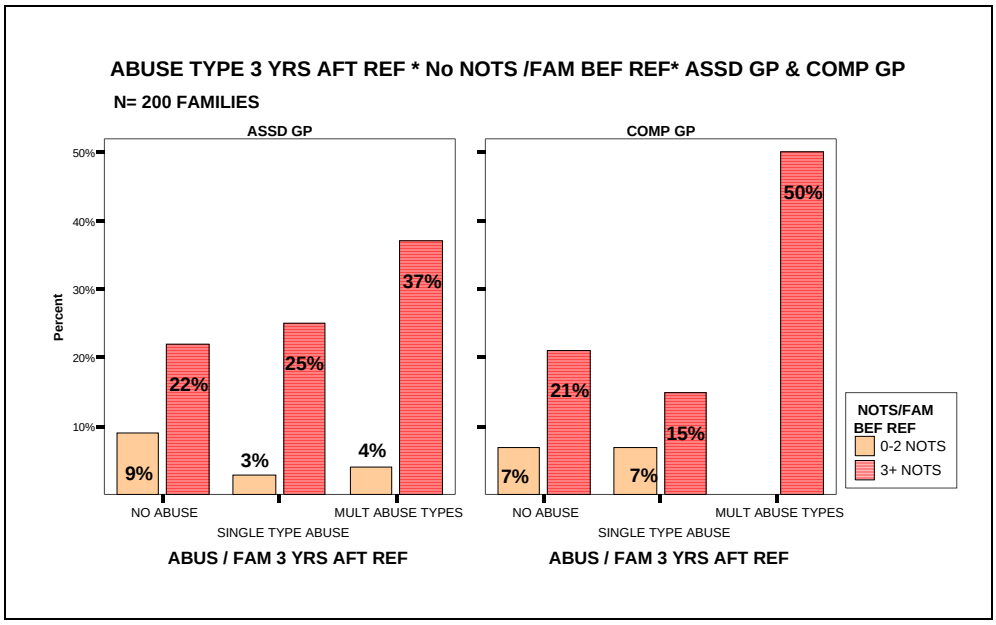
This section examines whether family participation in a Montrose assessment has any mediating impact on the two variables associated with Type of Abuse per family, three years after referral.

8.8 a. Number of Notifications per Family at Referral to Montrose.

There is no significant difference between the Assessed Group and Comparison Group in number of notifications (0-2; three or more) per family at referral (Appendix 7.27). Having three or more notifications per family before referral is significantly associated with Abuse Type three years after referral in both the Assessed and Comparison Groups. Families with three or more notifications before referral account for 90% of the Multiple Abuse Types category in the Assessed Group ($p=0.058$) and for 100% of the Multiple Abuse Types category in the Comparison Group ($p<0.001$) (Appendix 7.35).

There is no difference between the Assessed Group and Comparison Group in terms of families with three or more notifications before referral and No Abuse three years after referral (Fig. 8.24). However, there is a difference in both the Single Type Abuse and Multiple Type Abuse categories for families with three or more notifications at referral. The Assessed Group has 10% more families than the Comparison Group in the Single Type Abuse category, and 13% fewer families with Multiple Abuse Types.

Fig. 8.24: Abuse Type/Family Three Years after Referral x Notifications per Family Before Referral. (N=200 Families). Assessed Group n=100; Comparison Group n=100.



While there is room for debate as to the effects of Single Type Abuse vs Multiple Abuse Types, and it is clear that serious Single Type Abuse may have very severe immediate outcomes, there is some research to suggest that exposure to Multiple Abuse Types has more serious long term consequences for children (Higgins and McCabe 2000). In addition, because the variable Abuse Types is measured by family in this study, Multiple Abuse Types indicate more than one occasion of abuse, and/or more than one child in the family being affected. Therefore, if a Montrose assessment is associated with decreasing the likelihood of further abuse, or limiting abuse to a single type, this constitutes a positive child protection intervention.

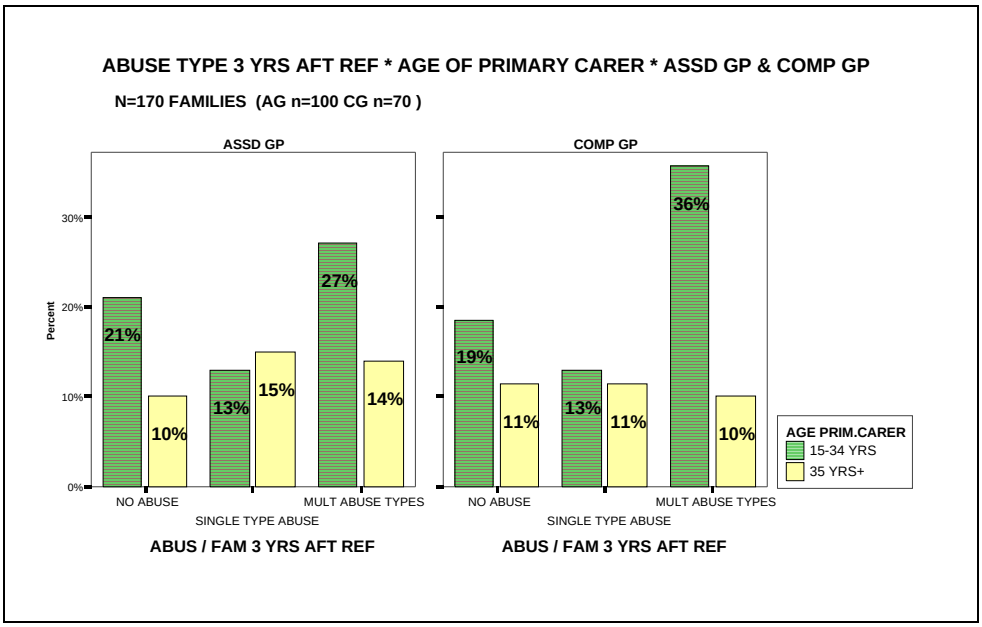
8.8 b. Age of Primary Caregiver.

Younger age group Primary Carers (15-34 years) are associated with Multiple Abuse Types three years after referral (p=0.047) (Appendix 7.36). At referral, there was no significant difference between the Assessed Group

and Comparison Group in the proportion of Primary Carers in the 15-34 years and 35 or older groups (Appendix 7.23).

Three years after referral, the older age group Primary Caregivers (35 years+) are distributed fairly similarly between the Abuse Type categories in both the Assessed Group and Comparison Group (Fig. 8.25). Younger age group Primary Caregivers are overrepresented in the Multiple Abuse Types category in the Comparison Group, relative to the Assessed Group, but the difference is not statistically significant.

Fig. 8.25: Abuse Type per Family 3 Yrs after Referral x Age of Primary Carer (N=170 Families). Assessed Group n=100; Comparison Group n=70.



The trend in the Comparison Group may be an under-estimation, given that the age of the primary caregiver is unknown in 30% of the Comparison Group families.

Summary: Impact of Montrose Assessment on Variables related to Abuse Type per Family three years after referral.

The Main Effects Model describes an association between *Type of Abuse per Family Three Years after Referral* and Number of Notifications per Family at Referral, and Age of Primary Carer. Three or more notifications per family at referral is significantly associated with Multiple Abuse Types three years after

referral. However, the Assessed Group has more families with three or more notifications at referral in the Single Type Abuse outcome category, while the Comparison Group has substantially more of these families in the Multiple Abuse Types.

Younger Primary Carers (15-34 years) are associated with Multiple Abuse Types three years after referral. The Assessed Group has 9% fewer families with younger Primary Caregivers in the Multiple Abuse Types category at follow-up than the Comparison Group. While the difference is not statistically significant, the financial and emotional implications of this difference are meaningful.

These findings indicate that for some families who participate in a Montrose Home-Based Family Assessment the children are less likely to be exposed to multiple types of abuse than non-assessed families, even in families with younger aged primary caregivers and higher numbers of notifications before referral.

There is some research to suggest that exposure to Multiple Abuse Types has more serious long term consequences for children (Higgins and McCabe 2000), therefore, if a Montrose assessment is associated with limiting abuse to a single type, it is a positive intervention.

8.9 Summary: Impact of the Montrose Assessment on Outcomes for Families who have One or More Factors Associated with Negative Child Protection Outcomes.

The question addressed in this section is: *Does family participation in a Montrose Assessment mitigate factors that have been associated in this study with poor child protection Outcomes?*

In other words, do Assessed Group families have better overall child protection outcomes than Comparison Group families, even when the families have factors associated in the Main Effects Models with negative outcomes?

FINDINGS.

The results of this study suggest that family participation in a Montrose assessment does appear to have a mediating effect on otherwise negative factors for child protection outcome three years after referral with regard to Family Outcome, Children's Outcome, Legal Status, Children's Placement, Numbers of Notifications and Confirmed Notifications and Type of Abuse.

Family Outcome.

Montrose Assessed Group families are more likely than Comparison Group families to be associated with improved Family Outcomes, even with factors identified in the Main Effects Models to be associated with negative Family Outcome – i.e. three or more male children, higher number of confirmed notifications per family at referral, current domestic violence at time of referral or a diagnosis of ADD/HD in one child or more in the family.

Children's Outcome.

Assessed Group families are more frequently associated with Improved Children's Outcome than Comparison Group families, even when they have five or more confirmed notifications at referral, or a male caregiver with past or current substance abuse.

Legal Status.

The results indicate a clear trend for Assessed Group families, including those with Children's Court Legal Orders at referral progressing to less interventionist orders, or no Legal Orders in the three years after referral. In contrast, the Comparison Group has nearly twice as many of these families in the most serious Legal Orders types, i.e. Custody/Wardship/Multiple Order Types. Montrose Assessment may also play a mediating role in Legal Status Outcome for families with past/current substance abuse by the mother/female caregiver. Comparable numbers of Assessed Group families with and without a maternal substance abuse have no legal orders three years after referral. In contrast, maternal substance abuse has a clear negative effect on Legal Status in Comparison Group families.

Children's Placement.

Families where one or more of the children has spent time in non-relative Substitute Care prior to referral have a much higher rate of all children being in out of home care three years after referral. However, Assessed Group families where the children have not been in out of home care prior to referral *or* have only been placed with extended family rather than in non-relative care, have a substantially lower likelihood of all children being placed in out of home care three years after referral, compared with the equivalent Comparison Group families.

There is a significant association, in the Comparison Group, but not in the Assessed Group, between younger age group Primary Caregivers (15-34 years) and all children being placed in out of home care three years after referral. Similarly, past or current substance abuse by either male or female parent/caregivers is only significantly associated with children's Out of Home Care placement in Comparison Group families, with fewer of these families having all children living in the family home three years after referral. Assessed Group families with past or current parental substance abuse have more than twice as many families with all children living in the family home than in out of home care at follow-up. The Children’s Outcome and Family Outcome results for these families indicates that the children’s safety, welfare

and wellbeing is not compromised, compared with the equivalent Comparison Group families.

Numbers of Notifications per family and Numbers of Confirmed Notifications per family, three years after referral.

The Assessed Group has more families with no notifications and also with no confirmed notifications than the Comparison Group families three years after referral. Assessed Group families also have fewer families with high numbers of notifications (five or more) and confirmed notifications (three or more), even when the family has factors associated with more negative outcomes - i.e. Number of notifications/family at referral, younger age group of primary caregiver, and children in the family diagnosed with ADD/HD (associated with Number of Notifications three years after referral), and number of notifications/family at referral, past/current substance abuse by female caregiver and number of male children per family (associated with Number of Confirmed Notifications three years after referral).

Type of Abuse.

Type of abuse per family three years after referral is significantly associated with families having three or more notifications/family at time of referral to Montrose, and primary caregivers in the younger age group (15-34 years).

Families with higher numbers of notifications at referral are significantly associated with Multiple Abuse Types three years later, in both the Assessed Group and the Comparison Group. However, there are more Assessed Group families with Single Type Abuse at follow-up, and fewer with Multiple Abuse Types, compared with the equivalent Comparison Group families.

The Assessed Group also has fewer families with younger primary caregivers in the Multiple Abuse Types category at follow-up, compared with the Comparison Group. Families who participate in a Montrose Assessment are therefore less likely to have children exposed to multiple types of abuse than

non-assessed families, even when they have younger aged primary caregivers and higher numbers of notifications before referral.

In summary, there is a clear association between family participation in a Montrose assessment and more positive child protection outcomes for the children and the family three years after referral, as well as less intrusive legal interventions, and less likelihood of all children being in out of home care placement. In addition, numbers of notifications and confirmed notifications per family decrease at a greater rate than the equivalent Comparison Group families, and children from Assessed Group families are less likely to suffer multiple types of abuse.

This increased likelihood of positive outcomes for Assessed Group families occurs even when the family has one or more factors associated with negative child protection outcomes in the Main Effects Models for the specific outcome variables.

CHAPTER 9: DISCUSSION AND CONCLUSION.

9.1 Results of this Study, Related to the Research Questions and Hypotheses.

This section reviews the major findings of the research project, explores the relevance of other child protection research to these findings, and assesses the implications of these findings for child protection policy and practice.

9.1.1 Research Questions and Hypotheses Revisited.

The Primary Research Goal of this study is to evaluate the Montrose Home-based Family Assessment Program, by comparing the three year child protection outcomes for 100 Assessed families and 100 Comparison Group families.

The other Research Goals are to identify demographic, family and child protection service factors, which impact, individually or in combination, on child protection outcomes for families at high risk for child removal because of abuse or neglect.

The need to investigate multiple factors associated with child protection risk for families has been summarised by Tomison (1996): "..current secondary prevention programs give scant attention to interactions among multiple variables in the determination of risk status for subsequent child maltreatment. Efforts to target a single risk factor are not likely to be as effective in preventing maltreatment as are programs based on a multivariate, interactionist model, particularly one focussed directly on the family. …An interactive approach is therefore advocated….where the influence of a constellation of factors in interaction (is) targeted in prevention programs." (p.9).

9.1.2 Results of this Study (1): Home-based Family Assessment as a Factor related to Child Protection Outcome.

The findings of this study demonstrate strong support for the value of the home-based family assessment model. The Assessed Group families have a higher rate of Improved Family Outcomes and Children's Outcomes three years after referral, compared with the Comparison Group families.

Participation in a Montrose assessment is a variable present in a number of Main Effects Models significantly associated with Outcome variables in this study:

1. Family Outcome for Montrose Assessed families is significantly more likely to be rated as Improved, rather than Worse or No Different, compared with Comparison Group families ($p<0.001$).

2. The overall life situation for children from Assessed Group families (Children's Outcome) is significantly more likely to be rated as Improved rather than Worse, relative to Comparison Group families ($p<0.001$).

3. Montrose assessed families are twice as likely as Comparison Group families to have no legal orders from the Children's Court three years after referral, rather than being subject to Wardship/Custody or Multiple Order Types, all of which are associated with child removal ($p=0.003$). Where Assessed Group families do have Legal Orders, these Orders are more likely to be Supervision Orders, meaning that the children remain within the family home under the supervision of the Department of Community Services, rather than placement or guardianship related orders (Wardship / Custody or Multiple Order Types) which signify removal of one child or more from the family home ($p=0.001$).

4. Three years after referral, Montrose Assessed families are significantly more likely to have all children living in the family home or with extended family (75% of Assessed Group families vs 55% Comparison Group

families), rather than have some or all children placed in Substitute Care* (p=0.062).

5. Assessed Group families in the study demonstrated a greater decrease in the both number of Notifications and Confirmed Notifications from the three years before to three years after referral, compared with Comparison Group families.

In addition to these results, as Chapter 8 demonstrates, families who participate in a Montrose assessment are also more likely to have positive results, compared with the Comparison Group families, in the other Outcome variables in this study, even where there are variables associated in this study and/or in the literature with negative child protection outcomes (e.g. parental substance abuse, domestic violence, previous Legal Orders or out of home care placements).

*Substitute care = non-relative, state or non-government foster care, residential care or other placement.

9.1.3 Results of this Study (2): Demographic, Family and Parent Factors Related to Child Protection Outcome.

The most strongly predictive sets of variables found by this study to be associated with child protection outcomes are *combinations* of parental factors, child factors and factors associated with child protection history, including the family's participation in a Montrose assessment. These include various *combinations* of variables from the following groups:

- ***Parent-Related Factors:***
  - Past/Current Substance Abuse by Mother/Female Caregiver
  - Past/Current Substance Abuse by Father/Male Caregiver
  - Current Domestic Violence at time of referral

and/or

- ***Child-related factors:***
  - Number of male children per family
  - Diagnosis of ADD/HD[#] in one child or more in the family

and/or

- ***Factors associated with the family's contact with the child protection system:***
  - Number of Child Protection Notifications before referral
  - Number of Confirmed Notifications before referral
  - Legal status history of the children
  - Placement history of the children
  - Family participation in a Montrose Family Assessment.

The relationship between specific parental factors and Outcome is discussed in the following section, and the relationship between family interaction with child protection services and Outcome is discussed later in this chapter.

[#] Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder.

Somewhat surprisingly, demographic factors such as socioeconomic status, marital status and locality are not as strongly associated with child protection outcomes in this study as they have been in other studies (Pelton 1981; Berger 2004). Demographic variables analysed in this study include residential location (city vs regional vs rural / remote), marital status, family structure, family size, main income source, ethnic/cultural affiliation, parent educational level, and gender of primary caregiver. While some of these variables have a linear association with Outcome, none is sufficiently strongly associated to appear in the Main Effects Models for Outcome.

The literature describes a number of factors related to parents' background and history that have been linked with compromised parenting ability. Specifically, parenting difficulties may occur for parents who have experienced significant childhood abuse themselves (Egeland et al 1988; Dale and Fellows 1999, p.10; Widom and Maxfield 2001, p.1), or have been raised in residential or foster care or had periods of homelessness or itinerant lifestyles (English et al 1999). In addition, child protection issues in families have been associated with parental exposure to substance abuse in their families of origin (Chaffin et al 1996; Grayson 1998), mental illness (Chaffin et al 1996; Grayson 1999a), and domestic violence (Folsom et al 2003).

9.1.3.1 Parental Factors Significantly Associated with Child Protection Outcome in the Main Effects Models in this study.

It is apparent that the parents in this study had often been exposed to models of child rearing that were poor or inadequate at best, and seriously abusive at worst. In some families there is an intergenerational pattern where the parents' parents had also had disrupted childhoods and/or suffered serious abuse or neglect during their formative years.

The findings of this study identify three specific parental factors, also commonly reported in the literature, as being associated with poor child protection outcomes - Parent/Caregiver Substance Abuse (past or current),

parental relationships involving Domestic Violence, and Younger Parental Age (15-34 years). There is substantial evidence to suggest that these three factors are themselves associated with parental histories of childhood maltreatment (Chaffin et al 1996; Kelley 2002, p.108; Prichard and Payne 2005).

The link between childhood abuse or neglect and later substance abuse or antisocial or delinquent activity has been documented (Prichard and Payne 2005), and the causal connections between these factors are not difficult to hypothesise. Young women escaping from abusive families, or those who have grown up in out of home care, may be susceptible to lower educational attainment and earlier involvement in relationships, perhaps to substitute for a positive family experience they feel they have missed out on. In these circumstances, and with less experience of role models for positive adult relationships, they may be less selective in choice of partner, leaving them vulnerable to relationships involving exploitation or domestic violence (Cashmore and Paxman 1996).

Similarly, young men suffering early life circumstances of domestic violence or child maltreatment may seek independence at a younger age, at the expense of completing formal education, leaving them vulnerable to unemployment or underemployment. They may join with negative peers and engage in antisocial behaviour, including substance abuse and violence, including domestic violence. Likelihood of future delinquency and adult criminal behaviour (frequently associated with violence) has been found to be 29% higher for children who suffer childhood physical abuse and neglect (Widom and Maxfield 2001, p.1). Given that childhood maltreatment has clear links to future adult and parental behaviours, it is useful to reflect on how parent-related factors were found to impact on child protection outcomes in this study.

9.1.3.1 a. Parental Factors: Substance Abuse.

The strong association that this study found between parental substance abuse and child maltreatment is well supported in the literature (Sheridan 1995; Chaffin et al 1996; Ammerman et al 1999; Walsh et al 2003; National Clearinghouse on Child Abuse and Neglect 2003; Goldman et al 2003; US Department of Health and Human Services 2005). Parental substance abuse has been associated with physical and emotional neglect, increased physical and medical risk due to lack of supervision and increased risk of physical and sexual abuse when children are living in environments where adults are abusing alcohol or drugs, or manufacturing or distributing illicit substances.

At the most serious end of the child protection spectrum, parent/caregiver substance abuse has been associated with as many as two thirds of all child maltreatment fatalities in one US study (Reid, Machetto and Foster 1999). Child fatalities occur as a result of illicit or prescribed drugs (including methadone) being accidentally ingested or as a result of the drug being administered by a parent/caregiver, usually to sedate a child. In NSW, the Child Death Review Team reports that parental substance abuse was a significant factor in up to 8% of child deaths between January 1996 and June 1999 (NSW *Child Death Review Team* 1999). The 1999 CDRT Report indicates that, in addition to four infant deaths from acute toxicity, families with parental substance abuse are significantly overrepresented in child deaths from Sudden Infant Death Syndrome, 'undetermined/suspicious' circumstances, and non-accidental injury.

In this study, substance abuse by either the female or male caregiver is associated with poor child protection outcome in the Main Effects Models for four of the seven Outcome variables (Fig.7.42) – Children's Outcome (male caregiver), Legal Order Type and Number of Confirmed Notifications (female caregiver) and Children's Placement (either caregiver), although there are some differences in the areas of impact depending on whether the substance abuse is by female caregivers or male caregivers, as outlined below.

- **Mother / Female Caregiver Substance Abuse**.

The potential child protection issues associated with maternal substance abuse are well documented in the literature (Dore, Doris and Wright 1995; Ammerman et al 1999). These may involve physical neglect, including lack of provision of adequate nutrition, clothing and medication. Maternal substance abuse may also be associated with supervisory neglect and with emotional neglect, including failure to recognise children's needs for a warm and loving relationship with their primary attachment figure and for the security provided by a safe, predictable environment and regular daily routine.

Studies into the effects of parental substance abuse have reported psychosocial problems in the children that include hyperactivity and conduct disorder. These may be more common in male children, particularly where the mother is the substance abusing parent (Dore et al 1995, p.535). There are significant physical safety issues arising from lack of supervision for the children whose mothers are affected by drugs or alcohol, and also specific risks relating to ingestion or accident when children are in premises where drugs are manufactured, stored, sold and/or consumed. Children are also at risk of passively breathing the smoke from drugs in poorly ventilated rooms, with serious, sometimes with fatal effects (Grayson 1998, p.4).

Other physical consequences for children associated with maternal substance abuse include irreversible risks of foetal exposure to drugs or alcohol, e.g. developmental delay, facial malformation, foetal alcohol effect and foetal alcohol syndrome. Neonatal withdrawal from prenatal drug exposure can be associated with greater child protection risk due to increased demands associated with these babies, who can be more prone to crying and more difficult to settle. In addition, breastfed infants of substance abusing mothers have been reported to be at risk of ingesting toxic levels of alcohol and drugs from their mothers (Kelley 2002).

Dore et al (1995) and English et al (1999) report an increased rate of child protection renotification and a substantially increased risk of children being

placed in out of home care when parents abuse drugs or alcohol. This study supports these findings, with a higher rate of Confirmed child protection Notifications (three or more) in the three years after referral to Montrose in families where mothers have past or current substance abuse (p=0.004).

In terms of Legal Orders, the study found that children from families with maternal substance abuse are more likely to be subject to Custody, Wardship or Multiple Legal Order types, indicating removal or one of more children from the family home, rather than Supervision Orders, where the children remain in the family home (p<0.016).

With regard to Placement Outcomes, families with histories of maternal substance abuse are more likely to have all children in out of home care, rather than all children in the family home three years after referral (p=0.042), and also more likely to have *all*, rather than only *some*, children in out of home care (p=0.021). The significant implication of this finding is that maternal substance abuse jeopardises the future placement of *all* children in the family, not only those who may be perceived to be at higher risk because of age or vulnerability.

Similar to the findings of other studies (Famularo, Kinscherff and Felton1992; Ammerman et al. 1999, p.1233), the effects of maternal substance abuse in this study are related to *past* as well as *current* substance abuse. This has important casework implications for child protection services. It is necessary to monitor these families for some time after the mother/female caregiver attends treatment programs, because the child protection risks are not necessarily reduced simply by the caregiver being in treatment or ceasing to be an active user of drugs and/or alcohol.

- **Father / Male Caregiver Substance Abuse.**

This study found that current substance abuse, or a history of substance abuse, by either the biological father of the children or the mother's past or current partner/s has a negative impact on Children's Outcome and also

Children's Placement, three years after referral. The ongoing impact may be through the effects of the substance abuse on the economic and/or emotional life of the family, or as a result of domestic violence, abuse or neglect, or a combination of all these factors.

In this study, families with a substance abusing male caregiver are more likely to have Worse, rather than Improved Children's Outcome, compared with families where there is no history of male caregiver substance abuse (p=0.026). These families are also more likely to have all children in out of home care rather than all children in the family home three years after referral, relative to families with no substance abuse by male carer/s (p=0.021).

The continuing effect on children, even after the cessation of the male caregiver's substance abuse, is consistent with the ongoing negative effect of maternal substance abuse noted above. The impact occurs whether the male caregiver is currently abusing alcohol or drugs, and even *whether or not* he is resident in the family at time of referral.

The effects of parent/caregiver substance abuse are both serious and long-standing, and have direct impact on the viability of the placement of all children in the family. Given these findings, the practice implications are that it is essential for caseworkers to undertake a comprehensive history of *past* as well as *current* substance abuse in the family, including substance abuse by any past partners of the mother.

It is possible that a substance abusing male caregiver may have left the family, and the mother may have a new, non-using partner, but the impact of the previous partner's substance abuse is still covertly impacting on the family's functioning and the children's wellbeing. Unless the caseworker has knowledge of the history of drug and alcohol issues and their ongoing impact on the family, this hidden effect may be incorrectly ascribed to other, more recent or obvious events.

No other factor in this study was more strongly associated than parental substance abuse with placement of all children outside the family three years after referral. In a comparison of a number of the parental variables often associated in the literature with negative child protection outcomes, parental substance abuse rated more highly as a single risk factor for out of home placement of all the children in a family than parental mental health issues, developmental disability (one or both parents) or a combination of all three factors. (Appendix 7.38)

9.1.3.1 b. Parental Factors: Domestic Violence.

The direct effects on children living in families where domestic violence occurs are complex and go beyond the risk of physical harm, either as a target of the abuse or when the child intervenes to protect a parent or sibling. Witnessing (or hearing) incidents of violence or seeing the after-effects in terms of property damage, parental injury or parent victim behaviour due to fear of further abuse, can have serious and long-standing emotional effects on children (Grayson 2001). In addition, indirect developmental and emotional effects of domestic violence have been reported in terms of mothers' diminished capacity for nurturing their children as a result of fear and tension in the parental relationship (Marshall, English and Stewart 2001, p.291; Folsom et al 2003).

Recent crime statistics on domestic violence in NSW (People 2005), indicate that domestic violence involving physical assault occurs predominately in residential premises (86%) and most usually between 6pm and 9 pm, which in most families coincides with the evening meal and the children's bedtime routine. More domestic assaults occur between 3pm and midnight than at any other time. This means that the time and place that domestic violence is most likely to occur directly coincides with the likely presence of children in the home, many of whom will witness the conflict and some of whom will be involved in it. In addition, children may be put to bed at some point in the conflict, in an anxious state, not knowing how the situation might end, and not

confident of their own safety or that of their primary attachment figure and siblings. Living in such traumatic circumstances is known to have a direct physiological effect on the developing brain in young children, and to be associated with behavioural and emotional problems in children of all ages (Perry 1997).

Past and/or current domestic violence was reported in 78.5% of the 200 families in this study. The reported violence was predominantly adult to adult (39%), or adult to adult *and* children (18%), but in 15% of families, the violence involved multiple perpetrators, including adult to adult as well as children to parents or siblings. At time of referral, 41.5% of the families were reported to be experiencing *current* domestic violence. This family violence predominantly involved a combination of physical violence, and/or verbal aggression and in some cases emotional and/or financial control.

The findings of this study indicate that families who are experiencing domestic violence at the time of referral (with or without a previous history of domestic violence) are more likely to have a Worse Family Outcome, rather than Improved ($p=0.016$) or No Different ($p=0.046$), relative to families with no current domestic violence at time of referral. This is to say, not only does the family situation deteriorate rather than improve when there is domestic violence present, it does not even maintain its original level of functioning over time.

In this study, the effect of the domestic violence is most strongly associated with negative Family Outcome when in combination with higher numbers of male children per family and higher numbers of previous confirmed child protection reports.

The long term effects of domestic violence on families pose an important practice issue regarding current child protection policy in families where domestic violence occurs. Consistent with the literature, in this study most of the perpetrators were male, either male caregivers, or in a small but

significant number of cases, male children. To date, child protection interventions with families in NSW and elsewhere have mainly focussed on the mother's role in keeping her children safe, even though the mother is usually the target of the domestic violence. This concentration on mothers stems from an assumption that the mother is usually seen as the parent responsible for the safety and physical care of the children, and is also their primary emotional attachment figure.

However, when the results of this and other studies demonstrate that domestic violence has such a negative effect on the outcome for the family, then the question must be asked whether child protection policy is targeting its strategies in the most effective direction. While the mother's parenting skills may be enhanced through parenting classes, and her self esteem may be raised and depression lowered through mental health interventions, if she and the children continue to live in a home situation that is subject to family violence, this is likely to outweigh any positive effects of other interventions.

Mothers in families where there is domestic violence are expected to protect their children, physically and emotionally, from effects of that violence or risk the placement of their children outside the family. However, the substantial proportion of families in this study who had experienced domestic violence indicates that this problem is substantially under-reported, and that the expectation that the mother must take responsibility for removing herself and the children from the domestic violence situation has not been successful and may be unrealistic. The literature demonstrates that in many cases, for a variety of personal, financial and social reasons, a woman returns to the same partner a number of times before she permanently leaves (if ever) (Bragg 2003). In many cases, mothers move into new relationships with equally abusive partners.

The fact that the male perpetrators of the domestic violence are seldom the target of active intervention in the same way as their female victims may have the effect of allowing the same male to create poor outcomes for more

families as he moves out of one family and re-partners, potentially repeating the same violent behaviour in another family. Breaking this pattern requires targeted intervention to engage abusive males in a process of understanding the nature and effect of their violent, abusive or controlling behaviour, and changing the behaviours that are associated with the domestic abuse. Without such intervention, the problem may continue, through the original perpetrator's contact with more families and also through the mimicking of the perpetrator's behaviour by the boys and young men who have witnessed it in their families.

This possibility is supported by this study, where the Main Effects Model predicting negative Family Outcome included a combination of domestic violence and the number of male children in the family. This indicates that there is a propensity for the violent behaviour to be carried on, even after the original perpetrator leaves the home, through the emulation of the abusive behaviour by male children on their female parent or on their siblings.

The potential long term effect of combining of childhood maltreatment and social or emotional deprivation with exposure to domestic violence is eloquently described by Perry (1997): "*the most dangerous among us have come to be this way because of a malignant combination of experiences – lack of critical early life nurturing,.. chaotic and cognitively impoverished environments,.. pervasive physical threat,.. persisting fear,.. and finally, watching the most violent in the home get what he wants...*" (p.135).

9.1.3.1 c. Parental Factors: Age of Primary Caregiver

In this study, the variable Age Group of the Parent/caregiver, i.e. the person with primary responsibility for the care and welfare of the children, is present in the Main Effects Models associated with three Outcome variables - Number of Child Protection Notifications, Type of Abuse and Children's Placement (Fig. 7.42). These findings support links in the child protection literature between lower parental age and increased risks for child abuse and neglect (Egeland 1988; Oates 1996; Goldman et al 2003; Slee 2006),

although some authors indicate that age in itself is not a direct factor, but is mediated by other factors such as social disadvantage (Browne and Saqi 1988).

This study found that families with younger parent/caregivers (15-34 years) are more likely to have five or more child protection notifications in the three years after referral, rather than 2-4 notifications (p=0.008) or 0-1 notification (p=0.006), compared with families where the parents are aged 35 years or older. In addition, the child protection notifications are more likely to involve Multiple Types of abuse (combinations of physical and/or sexual and/or emotional and/or neglect) rather than single abuse types (p=0.008). These findings are relevant, because children subjected to more notifications are more likely to be exposed to multiple abuse types, which has been associated with greater degrees of later impairment than children exposed to a single type of abuse (Ney, Fung and Wickett 1994; Higgins and McCabe 2000; Arata et al 2005, p.48). In addition, the younger age group parents (15-34 years) are more likely than older age group parents to have all children placed in out of home care, rather than have all children in the family home, three years after referral (p=0.009).

Forty percent of families in this study with a Primary Caregiver aged 15-34 years had 3 or 4 children, 8% had 5 or 6 children and three families had 7, 8 and 9 children respectively (Appendix 9.1). Removal of all children in larger families has a major impact on the children, often meaning that they will be divided across a number of placements, frequently at some distance from each other and their parent/s. This in turn affects the likelihood of successful restoration, because the family unit becomes fragmented, and the management of sibling contact as well as parent/child contact is much more complex and time consuming.

Overall, these results indicate that the children of younger age group parents are at greater risk for more incidents of abuse, more types of abuse and for long term placement away from their birth parents.

There is a substantial emotional and financial cost associated with this child protection outcome, but the problem also goes to another level. If there is no intervention other than removing all the children, there can be little expectation that the parents will spontaneously improve their parenting skills. Because they are in the younger age group, there is a strong possibility that they will have more children in the future, with the current or new partners. Without intervention to improve their parenting skills and address any other areas of difficulty, the cycle potentially starts again.

9.1.3.2 Other Parental Factors Significantly Associated with Child Protection Outcome in this Study.

9.1.3.2 a. Parental Intellectual Disability.

In addition to the parental factors found in this study to be associated with child protection outcome, i.e. Substance Abuse, Domestic Violence and Younger Parental Age, the issue of parental intellectual disability is often raised as a significant factor in child protection outcomes. In this study, 15% of the 200 families had intellectual disability in one or both parents, although this was only reported as the Primary Presenting Problem in 9 (4.5%) families. Primary Presenting Problems frequently associated with parental intellectual disability were Physical and Emotional Neglect, and Parent/s' Inability to Manage the Children's Behaviour.

While this small group of families fared somewhat better than those with parental substance abuse, the outcome was not positive (Appendix 9.2). Nearly three times as many families with parental intellectual disability were in the Worse or No Different category for Family Outcome rather than being Improved, and the Children's Outcome was rated Worse in twice as many families as it was Improved. Sixty percent of the families were subject to court orders three years after referral, 93% had two or more notifications, and over 50% had five or more notifications. A large proportion of the families were reported for Multiple Abuse Types, which have been associated with

poorer later adjustment for children (Ney, Fung and Wickett 1994). These results indicate that the difficulties families experience when parents have intellectual disability are likely to be ongoing, increasing in both frequency and complexity, and frequently leading to court intervention and/or child removal.

There is clearly a need to direct services to families with intellectual disability as early as possible and to maintain a monitoring role with the children for many years. A positive approach would be to engage with these families in antenatal clinics and direct them towards generic early intervention programs. If their needs are assessed as more serious, they can be provided with targeted assistance. Long term monitoring is essential to ensure that the parents have the ability to cope with the changing situation as their children increase in age and number. Experience indicates that parents with intellectual disability may cope with one child, but that the arrival of subsequent children can put pressure on their personal resources, leading to diminished parenting and increasing risk for the children.

9.1.3.2 b. Parental Mental Health Issues.

A further parental factor that was investigated for association with child protection Outcome was parental mental health issues. Surprisingly, contrary to anecdotal evidence and to other studies that report parental mental illness as a child protection risk factor for children (Chaffin et al 1996; Grayson 1999a), the results of this study did not support these findings. Parental mental health did not feature in any of the Main Effects Models, and in general, families where there was a history of parental mental illness or emotional disorder tended to do better in terms of Family Outcome and Children's Outcome than families with other conditions found to be associated with poor child protection outcomes (i.e. Parental Substance Abuse, Developmental Disability and Domestic Violence) (Appendix 7.38). There was also a significantly more positive result for Family Outcome and Children's Outcome in the Assessed Group families with parental mental health issues than the equivalent Comparison Group families (Appendix 9.5).

It would appear from this result that parental mental illness or emotional disorder alone is not necessarily a high risk factor for children's safety or placement, as long as the condition is recognised and appropriately treated. This result is partly supportive of the findings of Chaffin et al, 1996, p.200, who found that depression was a risk factor for physical abuse, but was not associated with neglect unless there was also parental substance abuse. Similarly, schizophrenia was not associated with child abuse or neglect, unless it coexisted with either depression or substance abuse. The finding that substance abuse exacerbates the problems associated with mental illness is supported in the literature (Grayson 1999a, pp.2-3).

9.1.3.3 Child-Related Factors Significantly Associated with Child Protection Outcome in the Main Effects Models in this study.

The study found two significant child-related factors associated with child protection outcomes - Number of Male Children per Family and Children Diagnosed with Attention Deficit Disorder or Attention Deficit / Hyperactivity Disorder.

9.1.3.3 a. Child Related Factors: Number of Male Children per Family

A number of authors have reported the effects of child maltreatment on boys and young men, particularly when it occurs in combination with family violence, parental substance abuse and socially disadvantaged environments (Borowsky et al 1997; Garbarino 1999a; Khan and Paluzzi 2006). There is also some support for concurrence of male gender and other factors associated in this study with poor child protection outcomes, i.e. diagnosis of ADD/HD and domestic violence (NSW Dept Health 2004, p.2). However, the association between child protection issues and the *number* of male children in the family has not been specifically documented.

This study found that a higher number of male children (three or more) per family is significantly associated with the Main Effects Models for two child

protection Outcome variables – Family Outcome and Confirmed Child Protection Notifications Three Years after Referral (Fig.7.42), whether or not all the male children were living in the family at referral.

Relative to families with one, two or no male children, families with three or more male children are more likely to be rated as having a Worse (p=0.045) or No Different (p=0.006) Family Outcome, rather than Improved.

Families with three or more male children are also associated with a higher rate of Confirmed Notifications three years after referral. These families are significantly more likely to have 3 or more Confirmed Notifications (p=0.011), or 1 or 2 confirmed notifications (p=0.054), rather than no Confirmed Notifications.

The Australian Temperament Project (Prior 2001) describes a gender difference in the temperament of children between 3 and 7 years of age, male children being less socially competent, more prone to hyperactivity and aggression and having more difficulty adjusting to the demands of school. That study found that the temperament of children as early as 3 or 4 years old was predictive of externalising and internalising behaviours later in their childhood and early adolescence. Children with aggressive, antisocial behaviour at age 9-10 years were more likely to be boys, to have had difficult mother-child relationships and to have been subject to more harsh parental discipline than comparison children. Early aggressive behaviour proved predictive of aggressive and antisocial behaviour in early high school, again with boys predominating. These children were reported to be less socially competent and many had a combination of behavioural and learning difficulties. Several of the same features that these children displayed are associated with children diagnosed with Attention Deficit Hyperactivity Disorder.

Other implications for the difference between boys' and girls' response to neglectful or abusive backgrounds are apparent in the fact that in NSW boys

account for 80% of the children suspended from school, boys are more likely to be suspended for violent behaviour, and are also more likely than girls to appear before the Children's Court or local courts (Fletcher 2001).

The findings of this study indicate that the child protection problems associated with families with more male children are more serious (i.e. more have substantiated abuse or risk of harm), and may be more resistant to intervention, given these higher numbers of confirmed notifications. As male children grow into their adolescence and as the number of boys per family increases, those with challenging and disruptive behaviour are likely to place more strain on the family unit, particularly in families headed by a single female.

9.1.3.5. b. Child Related Factors: Attention Deficit / Hyperactivity Disorder (ADD/HD).

In 28 percent of the families in this study, one or more of the children was diagnosed with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (ADD/HD). This number is substantially higher than the incidence rate of between 2.3% and 6% in the general population of children and youth in New South Wales (NSW Dept Health 2004, p.2), or the rate in the United States of 3%-5% (American Psychiatric Association 1994).

The NSW Department of Health (2002, p.11) reports that a number of other psychiatric conditions can be found in the children diagnosed with ADD/HD. These include mood disorders in 20%, conduct disorders (20%) and oppositional defiant disorders (40%), with oppositional behaviour being commonly reported in children of preschool age.

In this study, a diagnosis of ADD/HD in one child or more in a family is a significant variable in the Main Effects Models associated with Family Outcome and Number of Notifications Three Years after Referral (Fig 7.42).

Families with one child or more diagnosed with ADD/HD are more likely to be rated as having a Worse (p=0.003) or No Different (p=0.054) Family Outcome, rather than being Improved, compared with families with no children diagnosed with ADD/HD. These families are also more likely to have five or more Notifications in the three years after referral, rather than 2-4 Notifications (p=0.032), or 0-1 Notifications (p=0.022).

A definite gender difference has been reported in the rate of diagnosis of ADD/HD with more male children being diagnosed with the disorder, estimated at a ratio of between 3:1 and 9:1, decreasing with age (NSW Health Dept 2002, p.11; NSW Health Dept 2004, p.2). The Australian Mental Health Survey (Sawyer et al 2000) found a rate of just over twice as many boys (15.4%) as girls (6.8%) diagnosed with ADD/HD in the age group 6-17 years (NSW Health Dept 2002, p.11). In NSW, male children and adolescents are four times more likely than females to be treated with stimulant medication for ADD/HD, in all age groups (2-17 years) except for children under four years old, where the rate is 7:1 for males to females (NSW Health Dept 2002, p.5).

Although boys are diagnosed with ADD/HD at roughly twice the rate of girls, it is thought that females may be under-diagnosed because they are less likely than males to display hyperactivity and impulsivity. This may explain both the higher numbers of boys than girls diagnosed with ADD/HD, and the higher rate of treatment of boys with stimulant medication.

In families where there is child abuse and neglect, Attention Deficit Hyperactivity Disorder may be incorrectly diagnosed, based on observed impulsivity and hyperactivity in the child. Perry (1997) points out that while females are more likely to internalise their response to trauma and neglect through dissociation, males are more likely to produce an externalised response to the same situation, with aggressive, impulsive and hyperactive behaviours. The boys' externalising behaviour may in fact be hypervigilant, hyper-reactive behaviour resulting from a self-protective adaptation to living

in a violent or chaotic family or neighbourhood (Haddad and Garralda 1992; Perry 1997, 2000; Crittenden 2000, p.29).

NSW mental health research has found that ADD/HD tends to be more prevalent in sole parent, step parent or blended families and in non-working or low income families (NSW Health Dept 2004, p.12). In addition, mothers in families where there is a child diagnosed with ADD/HD are more prone to depression and siblings have an increased risk of developing similar problems to the affected child (NSW Health Dept 2004, p.6). There is a growing body of evidence that there may be a genetic factor involved, and that the child of a parent with ADD/HD may have a 50% chance of developing the disorder, and relatives of children with ADD/HD may be up to 5 times more likely to develop the disorder compared with children without an affected relative (NSW Health Dept 2004, p.10). This finding may explain the high number of families in this study with more than one child diagnosed with ADD/HD, and the fact that the distribution of families with children diagnosed with ADD/HD was almost identical in the Assessed and Comparison Group families referred for a Montrose assessment.

9.1.3.4 Effects of a Combination of Parent and/or Child Related Risk Factors.

This study demonstrates that child protection Outcomes for children and families are dependent on a complex *interrelationship* of factors, and certain combinations of parental factors, and combinations of parent - child factors, are significantly linked with poor child protection outcome. (Table 9.1)

Families with past or current parental substance abuse combined with current domestic violence have substantially worse Family Outcome, worse Children's Outcome and increased likelihood of placement of all children in the family in Out of Home Care. The combination of female carer substance abuse with domestic violence is significantly also associated with higher numbers of confirmed child protection notifications and the most serious categories of Legal Order, involving out of home placement of children.

Table 9.1: Combinations of Specific Parent and Child-Related Risk Factors x Child Protection Outcome. (N= 200 families)

OUTCOME MEASURE RATING Three years after referral	**Combination of Risk Factors Types * Outcome Rating**					
	Mat.* sub. abuse plus Cur. DV× n=40 Fams	**Pat. # sub. abuse plus Cur. DV** n=43 Fams	**Mat. sub. abuse plus Ch/n ADD/HD** n=25 Fams	**Pat. sub. abuse plus Ch/n ADD/HD** n=19 Fams	**3+ male Chn plus Pat. sub. abuse** n=21 Fams	**3+ male Chn plus Cur. DV** n=25 Fams
FAMILY OUTCOME: WORSE	**41%***	**44%****	**44%****	**-**	**-**	**48%****
CHN'S OUTCOME: WORSE	**74%****	**78%****	**87%****	**82%****	**85%****	**90%****
LEGAL ORDERS: CUST / WARD MULT ORDS♦	**50%***	-	**-**	**-**	**-**	**-**
CHN'S PLACEMENT: ALL CHN IN OOHC	**27%****	**28%****	**-**	**-**	**-**	**-**
NO. NOTIFICS: 5+ NOTIFI-CATIONS	-	-	**56%****	**-**	**-**	**56%****
NO. CONF NOTS : 3+ CONF. NOTIFICATIONS	**50%****	-	**68%****	**-**	**-**	**60%****
ABUSE TYPE: MULTIPLE TYPES			**72%****	**-**		

*** = Significant at p<0.10 ** = Significant at p<0.05**

This high risk associated with a combination of parental substance abuse and domestic violence is highlighted in the NSW Child Death Review Team's 2000-2001 Annual Report (NSW *Child Death Review Team* 2001), where 13 of 20 children who died as a result of abuse, neglect or in suspicious circumstances came from families with a history of parental substance abuse <u>and</u> domestic violence. The following year, the CDRT reports that parental drug or alcohol abuse was noted in 17 out of 21 families where children had died as a result of abuse or neglect, and a combination of substance abuse and domestic violence was present in nine of the families (NSW *Child Death Review Team* 2002).

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* History of, or current substance abuse by Mother or female carer
× Current DV (+/- Past DV) at time of referral to Montrose.
History of, or current substance abuse by Father or mother's partner (past or present)
♦ Involves Out of Home Care placement of at least one child.

In terms of the effect of a combination of child related factors on child protection outcomes, twenty families in this study had Three or More Male Children and One or More Children Diagnosed with ADD/HD. Family Outcome is rated Worse or No Different in 18 of 19 of these families for whom information was available, and Children's Outcome is Worse rather than Improved in 14 of 16 families. Ten of the 20 families have Custody/Wardship/Multiple Type legal orders (indicating long-term placement of at least one child out of the family home). Six families have *some* children and two families have *all* children placed out of the family home three years after referral. Thirteen families have Five or More Notifications, and 14 families have Three or More Confirmed Notifications in the three years following referral.

The findings of this study support the hypothesis that a combination of specific parental or child related factors is associated with worse child protection outcomes for children than if only one factor is present. In particular, the child-related factors of higher numbers of male children in the family and diagnosis of ADD/HD in one child or more, and the parental factors of substance abuse and domestic violence have a significant negative impact on the prognosis for the children in those families. Specific combinations of two of these variables dramatically affect the child protection outcomes for the children in these families, as demonstrated in Table 9.1.

Children's Outcome is rated Worse, rather than Improved, in 74%-87% of families with a combination of parental substance abuse and either domestic violence or children with ADD/DH. The combination of three or more male children and current domestic violence is significantly correlated with a Worse Children's Outcome for 90% of the families where both factors are present and the combination of three or more male children and male carer substance abuse is significantly associated with a Worse Children's Outcome for 85% of those families.

Current domestic violence and three or more male children in the family is associated with negative impacts on Family Outcome, Children's Outcome and the numbers of notifications and confirmed notifications per family, but not on legal status or placement.

The combinations of maternal substance abuse and either current domestic violence or having children in the family diagnosed with ADD/HD are significantly associated with worse child protection outcomes in five categories each. The difference between the child protection outcomes for these two groups is that families with a combination of maternal substance abuse and children with ADD/HD have worse Family Outcome and Children's Outcome and more notifications, more confirmed notifications and more types of abuse, but are *not* significantly associated with legal orders or placement. In these families, it would appear that although the children's situation was seriously compromised, they remained in the home without legal intervention.

On the other hand, where maternal substance abuse and current domestic violence are combined, the Children's and Family Outcomes deteriorated to the extent that Legal Orders involving placement of at least one child were required in 50% of the families and out of home care placement of all children in the family occurred in 27% of the families.

Clearly, maternal substance abuse has a very significant impact on the outcomes for the children in the families where it occurs, especially in combination with other risk factors. This finding supports many of the studies already cited with regard to the child protection risks associated with maternal substance abuse. In addition, it advances the theory that when the female caregiver is substance affected, the family's ability to manage other risk factors is also severely compromised. Ammerman et al (1999, p.1234) note that past *or* present substance abuse in one parent has the potential to diminish the parenting capabilities and psychological functioning of the other

parent, whether or not s/he is a substance abuser. This finding has significant implications for family assessment and child protection caseplanning.

All these findings support the need for very close monitoring of child protection issues in families where parental substance abuse is, or has been, a risk factor, especially when in combination with other child protection risk factors. In present child protection practice, families with current maternal substance abuse come under some degree of scrutiny. However, awareness that *past use* can also impact strongly on child protection outcomes needs to be promoted in casework practice.

Intervention with families who have any of the combinations of risk factors outlined above needs to target not only the substance abusing mother, but also her partner if he is also a substance abuser or is a perpetrator of domestic violence. Corby (1987; 1993) notes that little has been done to engage fathers in child protection casework, meaning that there is little change in their abusive behaviour. The children, especially male children also need to be offered life experience and/or counselling that reinforces respectful treatment of females in general, and the females in their family in particular.

9.1.3.5 Summary of Findings Regarding Effects of a Combination of Family Risk Factors Associated with Child Protection Outcome.

The findings of this study support the hypothesis that if there is a combination of specific parental or child factors the child protection outcomes for children in the family will be worse than if only one factor is present. There is a complex interplay between child factors and parental factors that bring families to the attention of child protection services. This finding is highly relevant, because it supports the systems or ‘ecological’ approach to child protection (Bronfenbrenner 1979; Belsky 1980; 1993) that underpins the Montrose Home-Based Assessment Program.

The Home-based Family Assessment approach incorporates assessment of child factors, parental factors, family strengths and support systems, and the child protection history of the family, all in the context of the community within which the family lives and the services available to it.

It is possible that the Montrose approach has been successful in intervening with families at high risk for child removal because, by engaging the family and its support services in the assessment process, the team is able to accurately gauge the particular *combination* of risk factors for each family, and match this with the appropriate services for the family.

9.1.3.6 Relationship of Primary Presenting Problem to Child Protection Outcome.

Somewhat surprisingly, the variable Primary Presenting Problem is not present in any of the Main Effects Models related to Outcome in this study. The major categories of Primary Presenting Problem for the 200 families at time of referral to Montrose were as follows (Table 9.2).

Table 9.2: Major Primary Presenting Problem Categories * Percentage of Families. N=200 Families

Primary Presenting Problem	% Families
Parents not able to manage child/ren's behaviour (aggressive, defiant, risktaking etc)	34%
Chronic/Severe Neglect	16%
Parent's Mental Health affects Child's Safety/Wellbeing	12%
Severe Physical Abuse	9.5%
Parent's Substance Abuse affects Child's Safety / Wellbeing	8%
Parent's Developmental Disability affects Child's Safety/ Wellbeing	4.5%
Sexual Abuse	2.5%
Other categories	13 %

Although Primary Presenting Problem did not feature in any of the multivariate Main Effects Models, the study did find that the presenting problem is related to some child protection Outcome variables.

Specifically, Primary Presenting Problem is significantly associated with types of Children's Court Legal Orders and placement of children in Out of Home Care three years after referral. More than 50% of the families with primary presenting problem of Parent's Substance Abuse, Child Sexual Abuse or Parent's Developmental Disability, are in the Outcome category involving the most serious types of legal orders (Custody, Wardship or Multiple Order Types) three years after referral (p=0.012) (Appendix 9.3).

In terms of Out of Home Care placement, in 50% of the families with Primary Presenting Problem of Parent's Substance Abuse and 44% of those with Parent's Developmental Disability, *all* children from the family were placed in Out of Home Care three years after referral (p=0.003) (Appendix 9.4).

While there are only nine families with the Primary Presenting Problem of Parent/s' Developmental Disability Affects Children's Safety, Welfare or Wellbeing, between them those nine families contain 37 children. Six families alone account for at least 21 children placed in out of home care three years after referral, although this figure is skewed by one family with 11 children, all placed in substitute care.

The 16 families with Primary Presenting Problem of Parental Substance Abuse Affects Children's Safety, Welfare or Wellbeing, contain 48 children. Three years after referral, half of these families had *all* children placed in out of home care (19 children) and a further 2 families had *some* children in out of home care, representing a total of at least 21 children in out of home care.

Therefore, in this study, Primary Presenting Problems associated with Parent's Drug and/or Alcohol Abuse or Parent's Developmental Disability have a significant impact on the legal status and placement of the children in those families three years after referral. Families where parents' substance abuse or intellectual disability prevents them from improving their standard of child care, even with specialised training and support, create substantial policy and practice implications for child protection services. In addition to the

financial costs associated with providing either out of home care placement or long term support for such families, there is an enormous individual and social cost associated with the developmental, physical and emotional impact of neglect and/or abuse that accompanies chronically inadequate parenting.

These findings related to Primary Presenting Problem need to be placed in the context of child protection referral processes. The Presenting Problem often represents the tip of the iceberg in terms of child protection issues in the family. The Montrose experience indicates that the child protection concern named by the referrer (or the family) as the Primary Presenting Problem is not always the most significant problem area, but may be the most observable issue, which brings the family to the attention of the child protection service. Another factor related to presenting problems is that the main issues identified at referral frequently relate to *children's* behaviour, whereas the actual problem established by assessment may be primarily associated with parental issues – substance abuse, domestic violence, mental health, etc, or a combination of parent-related and child-related issues.

Comprehensive family assessment, particularly with complex families who have had previous contact with child protection services, must involve investigation of *all* the risk factors in the family, not just those that they, or their referrer, nominate on first presentation.

In discussing Primary Presenting Problem, it is important to concede a limitation of this study. In 1993 when the Montrose program began taking referrals, children's *Exposure to* Domestic Violence was not seen as having the serious level of impact on children's welfare as it is today. As a result, children's exposure to domestic violence was not nominated as the Primary Presenting Problem frequently enough to rate as a category in its own right. However, in 24% of families in the study, current domestic violence at time of referral was noted as a Secondary Presenting Problem, increasing the primary child protection risk.

In addition, while exposure to *past* domestic violence would not constitute a Primary Presenting Problem, it may be noted as a Secondary Presenting Problem, or be referred to in the DoCS computerised child protection history (CIS). When the reported incidence of past *and* current domestic violence is combined, children from 78.5% of families in this study had been exposed to domestic violence, yet this significant factor for child protection Outcome was not captured as a specific variable in the Primary Presenting Problem category.

Similar to the findings about the type of Primary Presenting Problem, the issue of determining the *severity* of the Primary Presenting Problem is not a straight-forward process, because of the number of abuse types and the dilemma of comparing maltreatment types in terms severity versus chronicity. An example of this complex issue involves balancing the perceived long-term impact of a single, severe incident of abuse with a chronic history of neglect, i.e. how do the potential long term effects of a single, serious incident of physical abuse due to uncharacteristically overzealous discipline in a family with otherwise adequate parenting compare with chronic physical neglect that results in global developmental delay, or with chronic lack of supervision that results in child sexual abuse?

By way of shedding light on this common practice dilemma, a clear finding of this study is that it is the *number* of child protection Notifications, rather than the stated *reason* for the Notification (i.e. the Presenting Problem) that is significantly associated with the number of Notifications and Confirmed Notifications in the three years after referral and the abuse type (single vs multiple types) associated with the renotifications. This finding has some support in child protection literature (Higgins 2005).

A higher number of Notifications before referral is strongly predictive of a higher renotification rate in the years following referral. This result is consistent with the findings of Marshall and English (1999), that in families

with histories of multiple referrals to child protection services, the initial referrals reflect a set of conditions that increases the likelihood of further referrals. The period of time between re-referrals tends to decrease with the increasing number of referrals.

Research also indicates that the more notifications that are made on a family, the more likely that the reason for the referral will expand to include more categories of abuse and neglect (English et al 1999, p.305). As discussed earlier, a major issue for consideration and further research is the impact of *combinations* of risk factors present for the children in a family (Higgins 2005; Arata et al 2005, p.48).

Thus, the usefulness of Primary Presenting Problem *alone* as a predictor of outcome is dubious, unless it is considered in the context of the *total* child protection history of the family, i.e. the currently reported child *and* all other children who live, or have lived in the family. It is clear that the *number* of child protection notifications, rather than the *reason* for notification (i.e. the Presenting Problem), is significantly associated with the future numbers of notifications and confirmed notifications, and the abuse type (single or multiple types).

9.1.4 Results of this Study (3): Child Protection Service Factors Related to Child Protection Outcome.

The third area of investigation in this study relates to the roles of the Montrose Program, and other child protection services (including the children's court and the out of home care sector), in the child protection outcomes for the 200 families in the study. The goal is to provide feedback on ways in which families' interaction with child protection services can contribute to positive outcomes for serious secondary and tertiary level cases, where children's placement is in jeopardy due to child protection risks.

Participation in a Montrose assessment is a significant factor in the Main Effects Models for three Outcome variables – Family Outcome, Children's Outcome and Legal Orders Three Years after Referral (Fig 7.42), however,

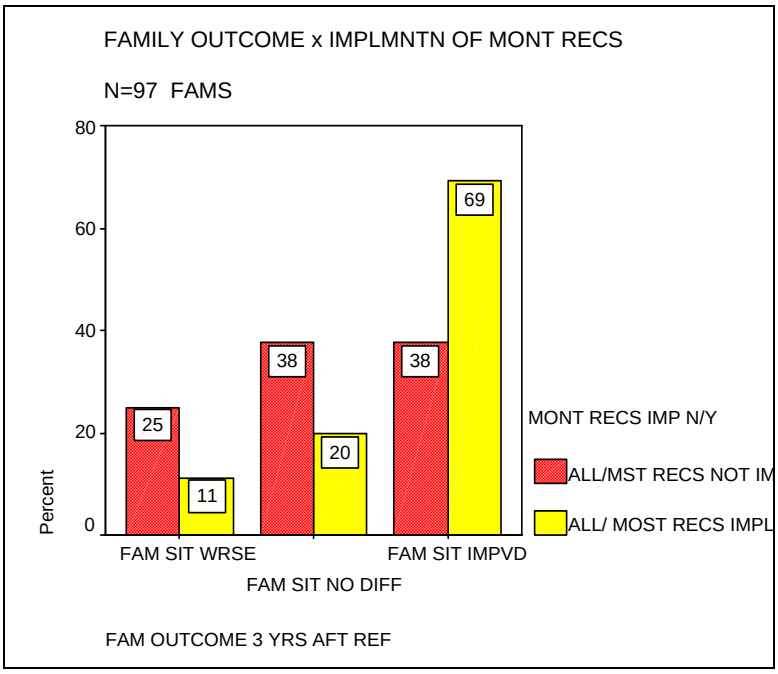
the question also relates to whether the Montrose assessment has any unforeseen positive effects on the assessed families, i.e. does the *assessment process itself* operate as an intervention, independent of whether the recommendations made as a result of the assessment are put into action by the referring Caseworker, other services and/or the family? How do outcomes for families where the Montrose recommendations were *not* implemented compare with outcomes for families where the recommendations were fully or substantially implemented? How do outcomes for families who were assessed but recommendations were not implemented compare with outcomes for the Comparison Group families who were not assessed at all?

9.1.4.1. Montrose Program Factors Associated With Outcome.

Some or all of the Montrose team recommendations were put into action in the majority (84%) of the 100 Assessed Group families. In the remaining 16% of families, the Montrose recommendations were not substantially implemented due to family, agency or child protection service issues. Where the recommendations were implemented, the proportion of families with Improved Family Outcome is almost twice that of the families where the recommendations were not implemented (p=0.053) (Appendix 9.6.2).

The reverse trend applies for the *No Different* and *Worse* ratings of Family Outcome categories. (Fig. 9.1).

Fig. 9.1: Family Outcome: Montrose Recommendations Implemented / Not Implemented. (n=97 Families.)



This finding indicates that in a majority of cases, the recommendations made by the Montrose team accurately reflects the needs of the family and the services required to address those needs, and that the implementation of the recommendations makes a discernable difference in Family Outcome three years after referral.

The other category where some positive change might have been anticipated is Children's Outcome. Sufficient information was available to compare this factor for 95 families. While the difference in is not statistically significant, Children's Outcome is clearly better for families where the Montrose recommendations were substantially or fully implemented, 60% (48 families) having Improved Children's Outcome, compared with 40% (32 families) where Montrose recommendations were not implemented. (Appendix 9.6.3).

Anecdotal evidence before the study suggested that some families appeared to have improved, even when the Montrose recommendations were not implemented and there was no other formal intervention.

The UK Framework for Assessment of Children in Need and Their Families (2000) supports the concept of assessment as intervention, and emphasises the concept of *partnership* between the state and the family, stating: "Undertaking an assessment with the family can begin a process of understanding and change by key family members …. The process of the assessment should be therapeutic in itself." (UK Department of Health 2000, p.15.)

The findings of this study show no specific indication that the assessment process, by itself, served as a long-term intervention in those families where the recommendations were not implemented. As mentioned earlier in this section, Family Outcome is significantly better for the families where the Montrose recommendations are fully or substantially implemented (p=0.053; Appendix 9.4.2), and Children's Outcome is also better for families where the Montrose recommendations were substantially or fully implemented, although this difference is not statistically significant (Appendix 9.4.3). Child and Family Outcome are clearly enhanced by the implementation of the Montrose recommendations.

A strength of the home-based assessment process is its potential to develop a positive partnership with family members. This increases the likelihood of eliciting the most relevant family information, allowing the Montrose team to determine the specific risk factors and needs for each family and formulate a unique caseplan, based on the results of the assessment.

9.1.4.2. Other Child Protection Service Factors Associated with Outcome.

In discussing child protection service factors associated with outcomes, it is necessary at the outset to emphasise the importance of using interventions that target the parents as well as the children in order to improve outcomes for children. Interventions such as increased access to child care / preschool or medical services or counselling for children will not substantially enhance

their long-term outcomes unless they are accompanied by services to support parents and/or increase their parenting capacity.

This study demonstrates a significant relationship between Family Outcome and Children's Outcome ($p<0.001$; Table 9.3). In 88% of families where Family Outcome is rated Improved three years after referral, the Children's Outcome is also rated Improved. On the other hand, in 100% of the families where Family Outcome is rated Worse, the Children's Outcome is also rated Worse. Where Family Outcome is rated No Different, the Children's Outcome is rated Worse in 77% and No Different in 16% of families. Clearly, children's life situations do not improve in families where no change occurs, and in most cases, the children's circumstances deteriorate.

Table 9.3: Family Outcome by Children's Outcome. (N=173 Families)

FAM OUTCOME 3 YRS AFT REF * CH/N'S OUTCOME 3 YRS AFT REF Crosstabulation

			CH/N'S OUTCOME 3 YRS AFT REF			
			CHN SIT WRSE	CHN SIT NO DIFF	CHN SIT IMPVD	Total
FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	45	0	0	45
		% within FAM OUTCOME 3 YRS AFT REF	100.0%	.0%	.0%	100.0%
	FAM SIT NO DIFF	Count	43	9	4	56
		% within FAM OUTCOME 3 YRS AFT REF	76.8%	16.1%	7.1%	100.0%
	FAM SIT IMPVD	Count	9	0	63	72
		% within FAM OUTCOME 3 YRS AFT REF	12.5%	.0%	87.5%	100.0%
Total		Count	97	9	67	173
		% within FAM OUTCOME 3 YRS AFT REF	56.1%	5.2%	38.7%	100.0%

9.1.4.2 a. Child Protection Service Factors: Number of Notifications at Referral.

The number of child protection notifications in Australia has risen exponentially over recent years, reflecting a broader international trend. In 2003-04, there were 219,384 notifications across Australia, with NSW accounting for 52% of these (115,541). The Australian figure was 10% higher than in the previous 12 month period (Commonwealth of Australia 2005, p.9).

There has been some debate regarding issue of using the number of child protection reports (notifications) of *suspected* maltreatment as an outcome measure, rather than the number of those reports that are subsequently *substantiated* (Hussey et al 2005). English (1997) and English et al (1999) maintain that the re-reporting rate alone is a sufficient baseline measure for child protection outcome, rather than whether or not the report is substantiated. In a large U.S. study of re-referrals in Washington State over an 18 month period, they found that the rate of *substantiation* is affected by the rate of *investigation* of notifications, and this is in turn directly affected by issues such as workload capacity, screening criteria and standard of proof "…that have little or nothing to do with whether abuse or neglect has actually occurred." (p298). Hussey et al (2005) also assert that substantiation alone is not a sufficient measure of child protection risk. They found no difference in behavioural and developmental outcomes for a group of over 800 children, whether or not their child protection reports were substantiated.

These findings are equally valid for NSW at the time of this study. For a proportion of reports, decisions were made not to substantiate allegations of maltreatment because workload constraints prevented an investigation, or in some cases, because the family could not be located. In both these cases, the notification would be rated as 'not confirmed', which is clearly not related to whether maltreatment did or did not occur. The same issues continue to be relevant for child protection services today, with continually increasing numbers of child protection reports and finite child protection staffing resources.

Given the above findings, the Number of Notifications per Family before Referral is likely to be as useful a measure in this study as the number of notifications that were substantiated. However, the number of previous confirmed (substantiated) notifications did prove to be predictive for some child protection Outcome variables, as demonstrated in section 9.1.4.3.

In this study, the families who participate in a Montrose assessment have fewer notifications *and* fewer confirmed notifications three years after referral than Comparison Group families. Interventions that decrease the *number* of notifications are doubly positive, in that they also decrease the opportunity for exposure to multiple *types* of abuse, a factor associated with worse outcomes for children (Bromfield and Higgins 2005, p.4). In families with subsequent notifications, later child protection reports are frequently related to a different type of abuse. Research indicates that neglect is frequently the type of maltreatment associated with second or subsequent referrals, regardless of the type of maltreatment in the initial referral (Drake et al 2003).

Across the 200 families in this study, the number of notifications per family before referral for a Montrose assessment was found to be highly associated with number and type of renotifications. The variable Number of Notifications per Family at Referral formed part of the Main Effects Models for three Outcome variables three years after referral - Number of Notifications, Number of Confirmed Notifications and Type of Abuse (Fig. 7.42).

Families with two or less notifications at time of referral are more likely to have 0-1 Notifications, rather than five or more, in the three years after referral (p=0.005; Appendix 7.28). These results support the findings of English et al (1999), that re-referral rates to child protection services increase in direct proportion to the rate of previous referral.

In terms of Confirmed Notifications, families with two or less notifications at referral are more likely to have no Confirmed Notifications in the three years after referral (p=0.009), or only one or two Confirmed Notifications, rather than three or more (p=0.013; Appendix 7:30).

As a direct consequence of the lower rate of re-notification after referral, these families are also more likely to have No Abuse (p=0.003) or only a Single Abuse Type (p=0.022) three years later, rather than multiple abuse types (Appendix 7.34). This finding is important because, as noted earlier,

children subjected to multiple abuse types have been reported to experience greater degrees of later impairment than children exposed to a single type of abuse (Higgins and McCabe 2000; Arata et al 2005, p.48).

9.1.4.2 b. Child Protection Service Factors: Number of Confirmed Notifications at Referral.

Confirmed Notifications are a subset of the total number of notifications received by child protection services. A notification is 'confirmed', or substantiated, if it is concluded after DoCS investigation that the child has been, or is at risk of being, abused or neglected. Notifications receive investigation of varying levels of intensity. As noted earlier, some reports are deemed to be low level risk at intake, and closed at that point without further investigation. Staffing constraints may mean that other potentially serious reports are also closed with little or no further investigation because other reports are prioritised as having higher risk for the child. Where investigations take place, these usually involve interviews with the reporter (where possible), the child (where appropriate), the alleged perpetrator, and if necessary with staff of other services e.g. school or child care, medical practitioner, etc.

English et al 1999 report that only 36% of referrals to US child protection services were substantiated at that time (p.297). Similarly, in Australia, across all state and territory jurisdictions, a large proportion of investigated child protection reports are not substantiated (Commonwealth of Australia 2005, p.9). The Australian substantiation rate in 1990-91 was 45% (James, 1994, p.3) and in 1997-8 the rate ranged from 23%-54% across the Australian states and territories, with NSW substantiating 44% of notifications (Australian Institute of Health and Welfare 1999, p.11). The ability to compare substantiation rates has become increasingly difficult in Australia in recent years, due to the differing policies on how child protection notifications are collected, classified and responded to, and also the differing definitions of

harm and risk that are applied under the various Australian state and territory legislations.

The debate concerning the use of notifications, rather than *confirmed,* or substantiated, notifications was discussed in the preceding section, and has some support in this study. That having been said, the variable Number of Confirmed Notifications per Family at Referral is present in the Main Effects Models associated with both Family Outcome and Children's Outcome three years after referral.

Relative to families with 0-4 Confirmed Notifications at Referral, families with five or more Confirmed Notifications are more likely to be rated as having a Worse (p=0.014) or No Different (p=0.031) Family Outcome, rather than Improved three years after referral (Appendix 7.2). In addition, the life situation of children (Children's Outcome) from families with five or more Confirmed Notifications at referral is more likely to be rated Worse than Improved at follow-up, relative to families with four or less Confirmed Notifications at referral. (p=0.006; Appendix 7.5)

The process of substantiating a notification should routinely involve some degree of investigation into the history of all previous child protection notifications for the notified child/ren and also for any other children in the family, as well as a thorough assessment of the current functioning and current risk factors associated with the family. The results of this study indicate that where there has been a substantial history of previous risk of harm in a family (i.e. a high number of confirmed notifications) before referral to Montrose, the prognosis for successful intervention is much lower than if the family is referred earlier, before the number of notifications (and by implication, confirmed notifications) escalates.

9.1.4.2 c. Child Protection Service Factors: Legal Orders at Referral.

Previous Children's Court orders in a family indicate a serious level of abuse or neglect, because the child/ren have been designated as being sufficiently

"in need of care and protection" under the relevant child protection legislation to require Court intervention. Children's Court orders in place during the years of this study (1993-99) range from Formal Undertakings with the Court, to Supervision Orders❖, to Custody Orders# or Wardship Orders◆ for a specific number of years, or up to the age of 16 or 18 years.

The findings of this study indicate that previous contact with the Children's Court system that results in Legal Orders is predictive of future contact, possibly with more serious interventions on the subsequent occasion/s. Families who have No Legal Orders at time of referral to Montrose are significantly associated with having No Legal Orders three years after referral, rather than having either Supervision Orders (p=0.004) or Custody/Wardship/Multiple Order Types* (p=0.005), compared with families where children have been the subject of legal orders before referral (Appendix 7.11).

These results indicate that if the family can be kept out of the Children's Court system by way of an earlier intervention that reduces the child protection risks to the children, the Legal Status Outcome is likely to be less intrusive for the family and less disruptive for the children. The concept of intervention to promote change as early as possible in the child protection careers of families is a continuing theme throughout the findings of this study.

❖ *A Supervision Order* means that the child remains in the family home and in the care and custody of the parent/s, but the family is subject to formal supervision by DoCS for a specific period of time (ranging from months to years, with 1 and 2 year orders being common at the time of this study.) It may also include formal written undertakings by the parent/s and/or the Department, (and/or the child, if appropriate).

Custody Orders at the time of this study reallocated the parental responsibility for care of the child to someone other than the parent, usually either a relative or the Senior Officer of a non-government agency which provided foster care.

♦ Wardship Orders at the time of this study reallocated the guardianship of the child to the state, through DoCS. Placement may be with relatives or with non-government or government out of home care services (most frequently foster care, but also residential care, especially for older children and for young people).

* This variable indicates the removal of one or more children from the family, short or long-term.

9.1.4.2 d. Child Protection Factors: Children's Placement History at Referral.

Non-voluntary placement of children in out of home care is linked to the Children's Court process and Legal Status, so it is no surprise that the findings regarding Children's Placement three years after referral are similar to those concerning Legal Orders, i.e. earlier interventions that prevent the first out of home care placement for a child can have a significant impact on reducing later instances of placement, both for that child and for other children in the family.

In this study, having all or some children placed in *Substitute Care*▪ (i.e. not with extended family) at some time prior to referral to Montrose is associated with a reduced likelihood that all children will be living in the family home three years after referral.

Where all children had always lived in the family home at referral, rather than some or all the children having been in substitute care, it is significantly more likely that all children will be living in the family home three years after referral, rather than all children being in out of home care* (p=0.006) (Appendix 7.17). It is important to note that even if only *some* of the children have previously been in substitute care, there is an increased risk of future out of home care placement for ***all*** the children in the family.

As distinct from the findings for substitute care placement before referral, families where some or all children have been in *Extended Family Care*# at referral are significantly more likely to have *all* children living in the family home three years after referral, rather than have all children living in out of home care (p=0.041) (Appendix 7.17).

▪ Government or non-government foster care or residential care.
* Out of Home Care = Extended family care or non-relative Substitute care (foster care or residential).
# Placed with relatives / extended family members.

Placement of one child or more with extended family members reduces the risk of *all* children in the family being in out of home care placement in the future. However, placement of *any* child in a family into non-relative Substitute Care, regardless of the type of care, is a significant predictive factor for future placement of *all* the children outside the family home.

The important practice implication of these findings is that children who can be safely maintained in their own homes, while an intervention takes place to increase the parent/carers' capacity to care for them, are less likely to be placed in out of home care in the future. Providing support services for families to avoid the *first* out of home care placement for even one child may avert a future long term career in out of home care for one or all children in the family. Placement with suitable relatives is the next best alternative to increase the likelihood of restoration to the family and to avoid future placement of all children outside the family home.

There is some tension in the practical application of this concept for caseworkers, who may assess an immediate child safety situation where they feel that there is no option but to remove the child/ren. However, the NSW *Children and Young Persons (Care and Protection) Act 1998* is guided by the principle of least intrusive intervention, s.9(d), which means that good casework must include consideration of *all alternatives to placement* that will satisfy the need to ensure the safety, welfare and well-being of the child. The philosophy behind this section anticipates that the caseworker will consider all the less intrusive interventions, including bringing support into the family home, or removing the perpetrator of the abuse, and only removing the children as a last resort.

Part of the casework dilemma surrounding placement, especially in crisis situations, is balancing the need for timely resolution of the safety issues for the children with the potential cost of engaging a service or locating suitable relatives to go into the family home to support the parents and/or children in the short term while other services can be arranged.

However, the reality is that once the initial placement is made, without well planned case management, the child is highly vulnerable to 'drift' in care (Browne and Herbert 1997, p.145). Once the immediate crisis has been resolved by a placement where the child is deemed to be safe, it is very easy for the caseworker to be distracted by other cases involving immediate child safety issues, so that the child in placement becomes a less urgent priority for action. Implementing a restoration caseplan, which is likely to be time-consuming and complex, may take second place to the perceived need to attend to more serious child protection matters. This is particularly the case where caseworkers are responsible for both child protection and out of home care cases.

As a result of the findings of this study, it is clear that the short term financial and time related cost effectiveness of developing and implementing a clear restoration caseplan at the beginning of the placement must be measured against the costs of the alternative, i.e. that if an emergency placement is made without a clear restoration caseplan, future placement/s may continue or increase, in terms of number of placements, amount of time in care, and the number of children from that family who will be placed outside the family.

While out of home placements can be very positive and will always be necessary to protect the safety of some children, even positive placements involve threats to a child's capacity for attachment and his/her sense of identity. Education and social contact with peers and neighbours are disrupted. Placement changes, which are unfortunately common, especially in non-relative care, are damaging for the child's sense of security, and moving between placements often negatively affects the child's ongoing contact with parents, siblings, extended family and peers.

There is a substantial need for child protection and out of home care policy to be more open to the commitment of time and funds on services to prevent the initial placement of children outside the family, or at least to attempt to

place them with suitable extended family members while child protection issues in the family home are resolved. The effect of such a policy change would have an enormous impact on reducing the financial and emotional costs associated with long term out of home care placements for children.

9.1.4.3 Summary: Child Protection Service Factors Related to Child Protection Outcome.

The results of this study demonstrate that participation in a Montrose home-based family assessment is significantly associated with improved Family Outcome and Children's Outcome in tertiary level child protection cases. In addition, a clear message from the research findings is that child protection service interventions that minimise the number of initial notifications per family will have a positive impact on both Family Outcome and Children's Outcome. Similarly, interventions that prevent initial Children's Court action or Out of Home Care Placement will reduce the future likelihood of children being the subject of Children's Court action or placement outside the family.

9.1.5 Unexpected Results.

The study's results demonstrate a number of unanticipated findings, in terms of factors that are associated with child protection outcomes in other studies, but not present in the Main Effects Models for this study.

9.1.5.1. Demographic factors.

Demographic variables analysed in this study include residential location (city vs regional vs rural / remote), marital status, family structure, family size, main income source, ethnic/cultural affiliation and parent educational level.

Contrary to other research findings (Gil 1970; Pelton 1981; Horowitz and Wolock 1981; Daro 1988; Sidebotham and Heron 2006), while some demographic factors have a simple linear association with outcome in this study, demographic factors including low socioeconomic status and single

parent families, do not appear in any of the Main Effects Models for child protection outcome.

The most strongly predictive variables in this study are combinations of parental factors, child factors and factors associated with child protection service intervention.

9.1.5.2 Indigenous status.

Indigenous status is not present as a variable in any of the Main Effects Models. This is surprising because indigenous families are over-represented in child protection services and out of home care in Australia (Australian Institute of Health and Welfare 2005, p.22). This is also the case in this study, where parents of Aboriginal and Torres Strait Island heritage account for 10.5% of the study group, compared with 2.4% of the Australian population who identify as Aboriginal or Torres Strait Islander (Australian Bureau of Statistics 2004, p.2).

The fact that indigenous status is not in any of the Main Effects Models for child protection Outcome is tempered by the finding that there are some significant bivariate correlations between indigenous status and negative child protection outcome that are consistent with the Australian figures for Aboriginal families in child protection services. Families in this study where at least one parent identified as of Aboriginal or Torres Strait Island heritage have significantly worse results for Family Outcome (p=0.005), Children's Outcome (p=0.024), Legal Status (more serious Children's Court Orders: p=0.072) and Number of Notifications (p=0.005) than families of non-indigenous background (Appendix 9.7). More than twice the proportion of indigenous families (30%) as non-indigenous families (14%) have all children placed in out of home care three years after referral (Appendix 9.7.7).

The indigenous families who participated in a Montrose assessment did slightly better on almost all outcome measures than the Comparison Group

indigenous families, but the difference is generally not statistically significant. Low numbers of indigenous families may have affected the analysis in several outcome categories, however, overall the Montrose assessment did not significantly influence outcome for the indigenous families, as opposed to the significant improvement rate for non-indigenous families.

Further research is required, and could be done using the current database, to investigate the specific issues and needs of indigenous families and to identify any trends in terms of child, family or child protection factors that are different for this group. The Montrose team routinely works with Aboriginal caseworkers from the referring Community Services Centre when assessing indigenous families, in order to accommodate cultural issues. However, this does not seem to have been a sufficient strategy to make a difference between the Assessed Group and Comparison Group indigenous families. The implications for this finding is that more work needs to be done on ensuring that the Montrose assessment process is sufficiently attuned to the cultural requirements and specific service needs of this group.

Two strategies to address this issue could be the development of a specific process for working more closely with any aboriginal community to which the family relates, and/or the secondment of a local indigenous caseworker to the Montrose team for all assessments with Aboriginal families. Both these interventions may assist with the assessment and with more culturally appropriate intervention and referrals for service provision and local community support after the assessment.

9.1.5.3 Parents' Childhood Maltreatment or Negative Life Experiences.

Contrary to some other research findings (Egeland, Jacobvitz and Stroufe 1988; Widom and Maxfield 2001), parent's history of childhood maltreatment and/or out of home care are not represented in any of the Main Effects Models for child protection Outcome in this study.

There are some methodological limitations in the study that may account in part for this. The complexity of trying to account for all the childhood experiences of a large number of parents/step-parents per family created a level of complexity not foreseen in the original design of the study's database. A considerable number of parents had suffered multiple childhood traumas, including abuse, neglect, out of home care, placement breakdown, violent relationships, life on the streets, and multiple placements including residential, mental health, substance abuse treatment programs and juvenile detention and/or incarceration. The number of categories available was often exceeded by the number of parental issues, and the number of parent/caregiver figures per family in some cases.

Future research could include a more detailed examination of the information available on each parent/caregiver in the current database, with a reworking of the database to include all available information, rather than being limited to the current number categories for parental childhood maltreatment and placement in this study.

9.2 Themes from This Study and Related Research.

9.2.1 Comprehensive Family Assessment, Risk Assessment and Safety Assessment in Child Protection Practice.

Montrose is a statewide child protection assessment and caseplanning service of the NSW Department of Community Services (DoCS). Montrose's role is to provide a time-limited, home-based assessment, engaging the family members in the process of recognising the child protection risks in their family and developing options to address those risks. The aim of the assessment is to assist children to remain safely in their home and to enhance their welfare and wellbeing in the family, working in collaboration with the services that will be supporting the specific caseplan for each family. Montrose has no ongoing role with the family, but provides an objective 'snapshot' of the family, at a fixed point in time, based on a full review of the child protection files for all family members who are living, or have lived in the family, as well as an intensive 5 day period of interaction with the parents, children and local community agencies.

Over the past decade, in response to the increasing demand for child protection services and growing constraints on available resources, there has been a movement towards the development of structured, formalised 'risk assessment' tools to assess current or potential child protection risk in families reported to child protection services. These may be constructed using a professional *consensus-based* approach, with risk factors agreed by a group of practice and/or research experts. Alternatively, the *actuarial* model uses research evidence to determine a set of specific factors associated with risk of child abuse and neglect. These factors form a structured checklist or assessment tool, based on the demographic, child and parental characteristics that research has determined to be most strongly associated with child abuse and neglect (Baird 1997).

Hawkes (2004) describes assessment is an ongoing cycle of planning, information gathering, analysis and review. Assessment models used in child protection services fall into three main categories – safety assessment, risk

assessment and strengths and needs assessment, with some models concentrating on one or two of these categories and some combining all three categories at different stages of the one process (Children's Research Centre 1999). Dalgleish (2003) suggests that risk and needs assessments are essentially linked and should be completed concurrently.

9.2.1.1 Safety Assessment

The safety assessment model is aimed at determining the level of immediate or imminent risk of harm to a child, compared with the protective factors present within the family. It is a short, focussed assessment that must be conducted by statutory services in response to reports of risk of harm, and can also be conducted by other child protection workers as part of a wider family assessment. It is required to assess the immediate safety of the child/ren within the family, and determine the need to remove them to an alternate short or long term placement if their safety is deemed to be compromised. It is also used to assess safety issues in families prior to restoration of children from out of home care.

9.2.1.2 Risk Assessment

There are numerous risk assessment tools available, designed to assist the professional judgement of caseworkers who need to determine the severity of current abuse or neglect and the likelihood of future maltreatment, so that preventative intervention can be taken. Risk assessment tools are also used to aid the decision of whether to restore children to their families following admissions into care.

In the opinion of some researchers, the reliability and validity of risk assessment tools has not been sufficiently established. There is no consensus about which specific factors accurately assess risk, and the number of items in different instruments varies widely. (Saunders and Goddard, 1998; Knoke and Trocme 2004). Other authors suggest that risk assessment models are adjuncts to, rather than substitutes for, professional

judgment and experience and that best practice is to incorporate both (Cicchinelli 1995, p.7; Turnell and Edwards 2003; Lennings 2005).

Korbin et al (1995) argue for a more ecological approach, extending the concept of risk assessment to include assessment of *neighbourhood* risk and protective factors. In addition to these issues, these tools, which are mainly designed for North America, have not been thoroughly tested for application to an Australian population. There is some movement in this direction with the Michigan Structured Decision Making (SDM) tool for Family Risk Assessment of Abuse and Neglect (Children's Research Centre 1999), currently being trialled in some Australian states.

While there may be a role for both safety and risk assessments, they comprise only a part of the comprehensive assessment process required for families referred to child protection services. One role of risk assessment tools is to determine the urgency level for a child protection response, so that the children deemed at highest risk of immediate harm will be prioritised to receive the most immediate response. The results of this study and other research (English et al, 1999; Knoke and Trocme 2004, p.1) indicate that the types of abuse or neglect likely to cause the most serious *long term* problems are not necessarily those which would be placed high in the priority list for immediate response in the existing range of structured decision making tools. Currently, urgency of child protection response is most likely to be allocated to reports of physical abuse or sexual abuse. Child protection reports associated with chronic low level neglect or exposure to domestic violence (without actual physical harm to the child) are likely to be rated as lower risk, and less likely to be prioritised for a home visit to assess the situation. Yet it is exactly these cases that in fact constitute a large proportion of the re-referrals to child protection services (English et al 1999, p.304). There is a current policy shift in NSW towards raising the priority of these types of cases in the light of recent research linking child fatalities to chronic and supervisory neglect (Lawrence and Irvine 2004), but this strategy is in its early days of implementation, and has not yet been subject to review.

There has been some criticism of the use of risk assessment tools, on the basis of their shift in focus from what *has* happened to what *might* happen, and also because they are "derived from statistical generalisations believed to be predictive of the behaviour of groups of like individuals … (while)...child protection workers are not attempting to predict the behaviour of groups of parents or groups of families. They are required to know which particular abusive parent will abuse which particular child, when, and in what particular circumstances." (Goddard et al, p.254). In addition, there has been concern that "the same instruments are being used in different cultures, for different purposes, and in different systems with different services." (Goddard et al, p.255).

9.2.1.3 Family Strengths and Needs Assessment.

As with structured risk assessment tools, many family strengths and needs assessment tools are based on an actuarial model. This style of instrument has advantages in being relatively quick to administer and score, and being able to be used by a range of professionals, with different levels of experience, who have been trained in the specific tool's application. The risk associated with this last 'advantage' that less experienced caseworkers will lack the practice knowledge to have a full understanding of the complex nature of *interaction* between factors associated with child protection risk. Simply counting the risk factors is not an adequate use of any child protection instrument, and close supervision is required with new caseworkers to assist them to interpret the assessment tool results in the context of each specific family.

There is ongoing debate about the usefulness of this type of tool, compared with a more traditional holistic assessment approach which relies on the professional judgement of the caseworker interpreting the relative importance of a number of categories of information about the child, the family and the social support system available to the family. This approach uses the child protection history and a social assessment of the family and its

circumstances, to place any professional judgement into a context relevant to the specific family.

9.2.1.4 Comprehensive Family Assessment vs Structured Assessment Tools.

It is acknowledged by authors of some family strength and needs assessment tools that the application of the actuarial style tool is enhanced by the use of professional judgement (Cicchinelli 1995; Children's Research Centre 1999, p.6). A complementary view would be that actuarial tools are useful in augmenting professional judgment, but do not replace it.

Because of the reliance of many strengths and needs assessment tools on self-report by family members, the soundness of any results are likely to be increased by application of the tool in the context of a relationship with the family that will promote honesty and openness in their responses. However, in the case of substance abuse, domestic violence or mental health issues, tools based on self report are likely to underestimate of the severity of the effect on the children, where family assessment conducted in the context of an interagency approach allows family responses to be verified by observations and professional reports.

Self report tools, again particularly in the case of parental mental illness, substance abuse or domestic violence, may also underestimate potential support systems such as the extended family. Grandparents or other family members may be very positively disposed towards assisting with child care or respite for the children, but if the parent-grandparent relationship is tenuous (due to the parents' issues), this possible source of assistance for the children may not be factored into a strengths and needs assessment.

Lloyd and Taylor (1995) suggest that there are three essential elements of assessment that are common to traditional and contemporary literature:

- The assessment is shaped by a clear philosophy and values base, which seeks to empower service users and counteract discrimination in marginalised social groups
- Assessment balances individual, familial and societal dimensions
- Whatever its specific purpose, assessment is located within a view of the broader situation. (p.697)

The Montrose Home-based Family Assessment is a comprehensive family assessment model which combines aspects of risk assessment with aspects of strengths and needs assessment and may also use aspects of safety assessment if required. Rather than listing the risk factors for the particular family, and then making recommendations based on the number and/or severity of the risk factors, the Montrose assessment takes an ecological approach. The Montrose assessment process is designed to elicit all the individual and family factors impinging on children's safety and welfare in each family assessed, and then to examine the complex *interaction* of parent, child, and social factors that impact that particular family, within its specific social and community context.

Montrose team members use the individual assessment goals for each family to assist family members to identify their current child protection and family issues, from their perspective, and the Montrose team then works with the family wherever possible to formulate recommendations that will best meet the needs of that particular family and its unique situation.

While there is a need in the child protection service system for immediate risk and safety assessments at intake and in crisis intervention, there is also a role for comprehensive family assessment, with a broader focus on the welfare and wellbeing of the children in a family, and not entirely based on the investigative model with its need for forensic evidence regarding actual harm or risk of harm.

The Montrose Home-based Family Assessment model works by engaging the parents and children in the process of defining their own needs and solutions, and uses shared knowledge about the family's history and current functioning to develop a caseplan which can be focussed on the safety, welfare and wellbeing of the children. Assessment conducted in the family home also allows a relationship to be developed between parent and caseworkers that may assist the parent to accept feedback in a context of assistance and support rather than as criticism. Where this is not possible, quoting a parent's or child's own words about a situation in the assessment Report assists in overcoming parental resistance to hearing the concerns about child protection or family dynamics contained in the Report.

In the years covered by this study, the Montrose Reports were used in Children's Court evidence in numerous cases where a Supervision Order or children's out of home care placement was recommended by the assessing team. Because the Montrose assessment process encourages the active participation of the parents, Children's Court action was frequently not contested by the parents, and an Order was made with the consent of the parents. This was particularly common where the Montrose recommendation was for a short term placement order with a restoration caseplan, to allow the parent to seek treatment for substance abuse, mental health or other issues, while the children were cared for by relatives or in foster care with regular contact with the parent/s.

9.3 Cost Effectiveness of the Montrose Home-Based Family Assessment Model.

9.3.1 Evaluating the Cost Effectiveness of Child Protection Prevention and Intervention Programs.

The short and long term social costs of child abuse and neglect have been well documented, along with the adverse relationship between childhood maltreatment and later physical health, mental health and parenting capacity (Higgins and McCabe 2000; Feletti 2004; Schuetze and Das Eiden 2005; Richardson 2005). The present and future social costs of abuse and neglect are borne by the community in terms of resources for treatment or support for victims of maltreatment and in the lost productivity associated with adult survivors whose childhood experiences diminish their ability to reach their educational, vocational and social potential (Zielinksi 2005). Costs are associated with physical consequences (e.g. immediate injury and its effects, as well as later physical illness or injury associated with increased stress and/or risk-taking behaviour), developmental consequences (e.g. language delay, academic problems), and psychological effects (e.g. depression, anxiety, substance dependence, aggression) (Fromm 2001; Layton 2003; Kovacs and Richardson 2004; US Dept of Health and Human Services 2004; Richardson 2005).

Child maltreatment has been associated with later antisocial behaviour, including delinquency and criminality (Widom 1989). Although the majority of abused and neglected children do not become violent offenders in adulthood, clearly there is a group for whom the effects of childhood abuse and neglect generate significant social costs for decades after the actual child maltreatment ends. Their behaviour in adolescence may influence or limit future life opportunities and/or choice of partner, contributing to future family and social problems. Widom (1989, 1992) describes the phenomenon of "the cycle of violence", where childhood physical abuse, and to almost the same extent neglect, have been associated with future delinquency, violence and criminal behaviour.

Widom and Maxfield (2001) demonstrate that the likelihood of future delinquency and adult criminal behaviour is 29% higher in children who suffer childhood maltreatment. Their study found that "being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59%, as an adult by 28% and for a violent crime by 30%." (p1). Victims of physical abuse and neglect are younger at first arrest and commit nearly twice as many offences as their non-maltreated peers. It is of interest that maltreated females are also at increased risk of arrest for violent juvenile and adult offences, which has clear implications for their roles as parents.

Fromm (2001) conducted a national cost-of-injury analysis in the United States to determine the total annual financial cost to society of child abuse and neglect. She conservatively estimates the direct and indirect cost of child abuse and neglect to the United States as $US94 billion per year. These costs include direct costs for hospitalisation, chronic health problems, mental health care, child welfare interventions, law enforcement and court associated costs for child protection cases. The indirect costs cover expenditure associated with special education, mental health and health care, substance abuse treatment, interventions for domestic violence, juvenile delinquency, lost productivity and adult criminality.

The Michigan Children’s Fund Trust conducted a 10 year study (1992-2002) into the costs of child maltreatment compared with the benefits of prevention. Their findings indicate that a statewide prevention program for all families having their first child would cost less than 3% of the money that the state was spending on the consequences of child maltreatment (Michigan Children’s Trust Fund 2003).

The Washington State Institute for Public Policy (2006) estimates that Intensive Family Preservation programs based on the "Homebuilders" model produce $2.54 of benefits for each dollar of cost (p.1).

In the UK, the Institute of Public Finance provided a costing of the direct costs of child abuse for the National Commission of Inquiry into the Prevention of Child Abuse (*Childhood Matters:* King 1997). This costing estimates the total expenditure on direct prevention and intervention services related to child abuse in the UK at £735 million per annum. When the costs of indirect effects, such as adult mental health and corrective services are added, the cost is conservatively estimated at £1 billion per annum (pp.12-13).

In Australia, the financial cost of child abuse and neglect and the associated need for out of home placement for a proportion of the affected children imposes a substantial and continually increasing financial burden on the community. The estimated cost of child protection services across all Australian states in 2000-01 was $712 million, with 57.8% of this being used for out of home care services (Australian Government Productivity Commission 2002, p.797). The Commonwealth Parliament's Senate enquiry into child protection in Australia, estimates that the national recurrent expenditure on child protection and out of home care services in 2003-4 was at least $1,041.14 million, an increase of 11.9% on the previous twelve month period, with out of home care services accounting for 61.3% of the total expenditure ((Commonwealth of Australia 2005, p.13).

Recurrent expenditure in Australia on all child protection and related support services has grown from $1.165m in 2000-01 to $1.645m in 2004-5 and now represents 11.4% of the national Community Services budget. (Australian Productivity Commission Report on Government Services 2006, p. F.4)

As previously noted, notifications to child protection services have risen exponentially in most western countries over recent years. In 2003-4, the number of notifications across Australia totalled 219,384, with NSW accounting for 52% of these (115,541). The Australian figure was 10% higher than in the previous 12 month period (Commonwealth of Australia 2005, p.9). Yet, in all Australian states and territories, a large proportion of

the investigated reports are not substantiated, ranging from 39%-74% across all jurisdictions in 2003-04 and 38%-74% in 2004-05 (Australian Institute for Health and Welfare 2005; 2006).

This means that a large part of the millions of dollars allocated to child protection services each year is being spent on investigation of reports, many of which will not be substantiated and in many cases no intervention will take place. This increased funding of the investigative process reduces the amount of funds available for prevention and early intervention programs that may actually assist to stem the rising numbers of notifications and renotifications.

There are both social and economic costs associated with renotifications to child protection services, either where previous interventions have failed, or where the families are prioritised initially as of insufficient immediate risk to warrant a child protection intervention or referral. English et al (1999) note that "prior CPS involvement greatly increases the likelihood of rereferral and… the rate of rereferral increases with the number of prior referrals." (p302). The highest rates of re-referral in their study are associated with cases that were initially rated as having moderately low or moderate risk, suggesting that the risk level in these cases had been underestimated initially, or the lower level risk factors had escalated without intervention.

The findings of this study support the findings of English et al (1999) and suggest that there is a clear cost benefit associated with more comprehensive family assessment from the time of the first child protection notification. This early intervention strategy may assist by providing referrals to services which appropriately meet the family's needs. This can minimise repeated child maltreatment and divert many families away from a long career with the child protection service, possibly including the need for out of home care placement.

9.3.2 The Cost of a Montrose Assessment.

The estimated current cost of each Montrose Home-based Family Assessment is $16,904. This figure is based on the 2004-5 Montrose annual program budget ($422,603) divided by 25 families assessed per year (based on a 10 year average - January 1993 - December 2002). The estimated cost is averaged to take into account the additional expenses (travel, accommodation, etc) of assessments that are conducted outside the Sydney metropolitan area (over 50% of annual assessments are in regional centres or rural / remote locations).

The estimated assessment cost covers the referral process and development of the specific assessment plan for the family, the salaries of two Montrose Caseworkers allocated to the assessment, travel to the family's home community within NSW, accommodation and all costs associated with both the home-based assessment week and the office-based report writing, as well as travel or long distance teleconference for the Case Conference. The estimated cost per assessment also includes the costs associated with supporting the Program, i.e. salaries for the Montrose Manager and an administrative officer and all other on-costs associated with the program.

The Montrose assessment cost includes numerous professional services in each of the three stages associated with the assessment.

Pre-assessment includes:

- Work-up of a file history including extensive investigation of the child protection files of *all* children from the referred family (including children who have been removed and/or are living elsewhere). This file review is available to the referring caseworker, whether or not the family is accepted for assessment.
- Development of an assessment plan and individual assessment goals for each family accepted.
- Development of an alternative caseplan for use by referring CSCs if the family is not accepted for assessment because of a determination by

Montrose, based on all available information, that there is too high a degree of immediate risk to the children.

- Pre-assessment telephone contact with the family and the referring CSC to ensure clarity about the goals and possible implications of the assessment for the family and the referring caseworker.
- Telephone contact with the relevant services in the family's local community to arrange interviews in the assessment week.

Assessment week in the family's home and community.

- Observation of the family's usual routines
- Observation of physical care, parent-child interaction and safety monitoring
- Extensive history-taking with each parent including history of parent's childhood abuse, out of home placement, substance abuse and/or mental health histories.
- A detailed developmental history and observational assessment for each child.
- Individual, group and sibling interviews with each child living in the family to gain the children's perspective on their life circumstances. Children living outside the family may also be interviewed if appropriate.
- Visits to all agencies and services involved with the family
- Interviews with relevant extended family members.
- Ongoing consultation with the parents and children during the week, to reinforce the goals of the assessment, and to give feedback about family strengths being observed and also about any concerns.
- Formal consultation with the referring CSC at least twice during the assessment week.

Report Writing, Feedback Session with Parents and Case Conference includes:

- Production of a comprehensive report (described in detail in Chapter 4), which synthesises all information gathered before and during the assessment week and concludes with a formal, written caseplan outlining the roles and responsibilities of all parties.

- A formal feedback session between the parents and the assessing team immediately before the Case Conference, with parents' responses recorded and attached to the Montrose Report.
- Attendance at the Case Conference, in person or by teleconference, by the two assessing caseworkers and the program Manager.
- A formal evaluation process which surveys the referring CSC staff and the parents immediately following the assessment and three months later.

Each Montrose assessment is aimed specifically at the needs of the target family, and when the process is concluded, an appropriate caseplan is in place which will be supervised by the original referring CSC. The costs associated with the ongoing casework are borne by that CSC.

9.3.3 Cost benefits of a Montrose Assessment with Community-based Interventions.

Contrary to what may be thought, under-servicing is not usually an issue for families referred for a Montrose assessment. In fact, because of the longevity and severity of their problems, many of the families are well known to DoCS and other Departments and support services, and many have been in receipt of a high level of service provision, often over a prolonged period. However, there are frequently problems with the family's attendance or compliance with services, and very often there is a problem with co-ordination between the service providers, resulting in confusion between services and sometimes conflict between the family and the services, producing a less than effective result.

For 73% of the Assessed Group families in this study, one of the Montrose recommendations was that the caseplan, involving current and any new services, be co-ordinated by the DoCS caseworker. In many of these cases, the only additional cost for DoCS and support services is associated with the DoCS caseworker's and agency staff's time in attending caseplanning meetings and reviews for a specified period of time. When the coordinated

caseplan is successfully implemented, this time commitment is often balanced by the cost savings made in terms of better targeting of interventions to the family's identified areas of difficulty, fewer missed appointments, increased family engagement with services and greater compliance with interventions, with less resistance to change and increased numbers of fully completed intervention contracts.

9.3.4 Cost savings of a Montrose assessment compared with Children's Court action.

An imputed cost for court staff in Western Australian Family Court matters where there are also child protection issues is estimated at $3,000 for each day the matter is heard, excluding preparation time (Murphy and Pike 2003). In NSW, Children's Court matters that proceed to final placement orders may run for up to 12 months (and occasionally longer), with numerous hearing days throughout the process. The cost of such a process, or even one involving the making of a Supervision Order, can easily run to tens of thousands of dollars per family. Any intervention that can reduce the need for court intervention, or remove the adversarial element and obtain an Order by Consent, will have an impact on reducing the cost for every family where a protracted court process is avoided. At the most serious end of the spectrum, there is a huge saving in terms of the Children's Court and associated legal costs if a home-based family assessment program like Montrose can avoid the need for the most serious Court Orders, i.e. those for placement of children involving transfer of parental responsibility to the Minister for Community Services or to a relative of the child or another party.

9.3.5 Cost savings of a Montrose Assessment Compared with Out of Home Care Expenses.

For children in NSW who require out of home care, the Department of Community Services provides payments for a range of service options that

include non-parental care allowance*, standard foster care, two levels of special foster care, and professional foster care. Carer allowances are a fortnightly payment made to a carer as a contribution towards the expense of caring for a child (under 16 years old).

At time of writing, child age-related carer allowances for non-parental care and basic foster care range up to around $14,000 per child per annum, and the two levels of special foster care total nearly $22,000 and $29,000 per child per annum. Professional foster care rates are considerably higher, up to over $55,000 per year (DoCS *Business Help* 2006; DoCS Factsheet 2006a). Although there may be some economies of scale for sibling groups, the costs of out of home care are clearly enormous for a family of children placed in foster care, often for many years.

For children and young people who cannot be sustained in a foster care placement, there is a narrow range of residential placement options available. In NSW residential care is not generally used for children under 12 years of age. Residential care costs vary, depending on the needs of the child, and based on the staffing and management costs of maintaining a residential unit, in addition to the actual costs directly related to the child. Depending on the service provided, current annual costs to the Department may range between tens of thousands of dollars per person (for young people sharing a facility) to hundreds of thousands of dollars for 24 hour 1:1 supervision of a young person with very high support needs.

The findings of this study indicate that there is a clear association between a family having participated in a Montrose assessment and the likelihood that all the children will be living in the family home at follow-up. Based on the costs of the various placement models, intervention in the child protection careers of families that can prevent the need for out of home care placement for one or more children represents a substantial cost saving to the state.

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* Non Parental Care Allowance is available for some family and kinship carers and some other persons with full time care of non-related children who are at risk of entering out of home care or homelessness should the financial assistance be declined. (DoCS Business Help (2005): NPCA)

9.3.6 Summary: Cost Effectiveness of Comprehensive Family Assessment.

Wulczyn and Orlebeke (2006) assert that: "Investments in families and communities that are designed to keep children safe at home have to be evaluated for their return on investment using lower maltreatment rates and lower placement rates as measures." (p.8). Based on the expenses for Children's Court costs and out of home care, there is a substantial cost associated with removing children from their families and supporting them in alternate care, even with extended family. More concerning than the financial cost is the emotional cost to the child of being separated from parents and possibly siblings, moving away from a familiar location, losing friends, changing schools and facing the stigma of not being raised in his/her birth family. This emotional cost is greatly increased for the many children who suffer one or more placement breakdowns. The foster home breakdown rate in the United Kingdom has been estimated at 40% of placements, with one in ten children having 10 or more foster care or residential placements (Browne and Herbert 1997, p.145). Clearly, there is considerable cost associated with the casework and counselling associated with trying to sustain these youngsters through the emotional trauma associated with repeated placement breakdown.

In the light of the alternatives, even with costs for provision of support services following a Montrose assessment, there are clear financial advantages if a successful family assessment results in fewer child protections reports, requiring less investigations, less Children's Court action, fewer out of home care placements and more children safely remaining within their birth family, or at least living with extended family, with less damage to their sense of identity and belonging. Given the obvious economic and emotional savings associated with avoiding the child protection actions listed here, the Montrose Home-based Assessment program represents a cost effective alternative model of child protection intervention with high risk families.

9.4 How Does the Montrose Assessment Improve Child Protection Outcomes?

9.4.1 Introduction: Impact of the Montrose Assessment on Child Protection Outcome.

The results of this study suggest that Home-based Family Assessment has a significant positive effect on the life circumstances of the children and families, and this effect is still evident three years later. Relative to Comparison Group families, children from Assessed families are the subject of fewer child protection notifications, and where notifications are made, less are substantiated. Fewer children from Assessed families are the subject of Children's Court legal orders, and if an Order is made, it is more likely to be an Order for Supervision of the children, within the home, rather than for removal and change of parental responsibility (Wardship or Custody Orders). In addition, Assessed Group families are more likely to have all children placed in the family home, or with extended family, three years after referral, rather than placed in non-relative substitute care. The results reported in Chapters 7 and 8 strongly suggest a positive impact of the Montrose assessment on the child protection careers of a large proportion of Assessed Group families, and the primary research hypothesis is therefore supported, i.e. the Assessed Group families do have a significantly higher rate of positive child protection outcomes compared with the Comparison Group families.

It is important then to speculate about what specific factors in a Montrose assessment may affect the families and the services involved with the family, to produce more positive child protection outcomes for assessed families and children.

9.4.2 Montrose Program Factors that Support Successful Intervention.

This thesis proposes that there are six key Montrose program-related factors associated with increased positive outcomes for families (Fig. 9.2):

Fig 9.2: Program-Based Factors Associated with Increased Likelihood of Positive Child Protection Outcomes for Families.

Program-Based Factors Associated with Increased Likelihood of Positive Outcomes for Families.

1. The comprehensive assessment process.
2. Respectful engagement - successfully gaining the trust and co-operation of family members.
3. The assessment Report, recommendations and caseplan.
4. The interagency relationship between the assessment team, the referring Community Services Centre and the support services involved in the assessment and caseplan interventions with the family.
5. The training and supervision of staff.
6. An organisational climate that supports individualised assessment and caseplanning for high risk families.

9.4.2.1 Comprehensive Home-Based Family Assessment .

The home-based assessment process comprises a number of components which may impact on child protection outcome. Some of these factors are part of many well designed assessment interventions, but the Montrose process routinely combines *all* the factors in one model.

- *Goal Focussed Approach.*

Setting three or four significant but achievable goals for the assessment increases the chances of successfully completing the task. These are documented in the parents' consent form. (Appendix 4.5), remain the focus of the assessment and are addressed in the recommendations of the Report. If parents are agree to the goals of the assessment (which in essence are

always about the children's best interests), then the parents and assessment team are part of the same process, and less likely to be working at cross-purposes.

- *A Child-centred, Family- focused Approach.*

The assessment and intervention are family focused, but all aspects of the process relate to the child protection implications for the child. All information and observations in a Montrose assessment are weighed against the question: "*What does this mean for this child in this family*?" Experience has shown that when the Report clearly describes the impact of parental behaviour on the child's life situation, this is a strong motivator for parental change.

- *Strengths-based Philosophy.*

Almost all families have some strengths that can potentially be developed, with the assistance of community supports, and/or extended family. Although the strengths based perspective is always balanced realistically with the program's primary focus - the safety, welfare and wellbeing of the child, recognising parents' strengths tends to increase their engagement with the assessment and also increases the likelihood that they will follow through with the recommendations.

- *A Systemic Perspective.*

The Montrose model takes an ecological/systems perspective (Bronfenbrenner 1979; Belsky 1980) on the complex individual, family, social and cultural relationships that impact on families. Recommended caseplans for each family target interventions to the various levels of the family's ecological network, and cumulative systemic changes have more sustained impact for the family than changes in only one or two systems.

- *Conducting the Assessment within the Family Home.*

Home based assessment enables close observation of the family's home environment and relationships, including the level of physical care of the children and the emotional climate of the household. This proximity allows immediate feedback to parents and/or children, and small interventions can

be put in place to test the family members' motivation and / or capacity for change.

The immediate living environment has a substantial impact on referred families. Home based assessment allows the team to observe the physical, social and psychological *neighbourhood* and *community environment* of the family (Garbarino and Crouter 1978; Garbarino and Sherman 1980; Tanner and Turney 2000; Korbin 2005). It also allows them to determine the services available to the family, so that recommendations are realistic and involve the most relevant support services. Correctly matching services to the family's needs enhances engagement and increases the likelihood that the family will complete the intervention.

- *Gathering a Comprehensive Family History.*

The importance of child protection history as a predictor for future child protection contact has been a major finding of this study. In addition, detailed information about how each individual family was formed provides valuable information about the etiology of current difficulties and possible interventions. Campbell (1997) describes it as: "Understanding the past provides a context for the present, gives perspective on the tasks to be confronted, and helps differentiate chronic difficulties from crisis reactions. … It offers family members new ways to see the past; validation of the debilitating feelings they bring from past experiences of misunderstanding, deprivation and abuse; and opportunities to recall achievements." (p.7). Family history around previous interventions allows the assessment team to consider what factors will enhance the likelihood of success for the current recommendations.

- *A Direct and Honest Approach.*

The Montrose caseworkers maintain an open and honest approach with the family throughout the assessment process, including respectfully questioning the reasons for family behaviour. Immediate, direct feedback, including challenge or confrontation if necessary, can clearly delineate behaviours that are acceptable from behaviours that are considered to be unacceptable or

abusive. Parent feedback rated the team's honesty very highly, even when the content was not necessarily palatable. Honest feedback - being talked to, not about - helped parents feel that they were respected and a meaningful part of the process. This lowers resistance to the recommended interventions.

- *An Interagency Approach.*

The Montrose Program values the interagency approach and promotes cooperative professional relationships with relevant state and nongovernment agencies and services supporting each family (Scott 1993; Morrison 1996). This interagency approach is important at three stages of the Montrose assessment:

- At Referral.

A community agency or service may initially make the notification to DoCS that leads to a referral to Montrose. Information from notifications and from agencies' reports, assists with setting the goals for Montrose assessment.

- During Assessment.

Local agencies and services can assist with problem definition and identifying family strengths, and they can comment on the current functioning of the family, on their concerns about risk factors, on family needs. They can also report on patterns of family functioning, whether the current issues are transient or chronic, and whether the family has been different in the past or with other supports in place.

- After the assessment.

Community agencies are crucial to the implementation of the recommendations of the Montrose assessment. Services can remain engaged with the family after the assessment is finished, monitoring progress and alerting the child protection service if problems re-emerge.

In line with other research findings (DePanfilis and Zuravin 2002), this study found that the families with the best child protection outcomes are those who engaged successfully with relevant interagency supports. This result includes

a number of the Comparison Group families who were rated as Improved three years after referral.

9.4.2.2 Respectful Engagement of Family Members in the Assessment Process.

Research has indicated that "…actively engaging families in a helping alliance and helping them to accept and receive services may reduce the likelihood of future maltreatment." (De Panfilis and Zuravin 2002, p187). In the research cited, *attendance* at services, rather than the type of services offered, was the critical factor for predicting recurrence of child abuse and neglect. Daro et al (2005) cite the advantages of successful engagement of parents: "Families who believe …their relationship with their worker involved more active participation in the case-planning process may …. feel more responsibility to engage in services." (p.3). Campbell (1998) expresses a similar sentiment: "When services are brought to them, when their pain is witnessed as it occurs, clients have been willing to get involved." (p88).

Family engagement is a major factor associated with the success of the Montrose model. The Montrose assessment team concentrates on engaging family members, and building trust between the family and the team, to put family members at ease in what is an unusual, intrusive and potentially threatening situation. Family members, especially parents, are actively involved in the process of identifying the family's difficulties, and developing a caseplan to address those issues. Accurately matching the family's needs to appropriate resources increases the likelihood that they will stay engaged with the intervention, maximising the chance of a positive child protection outcome.

9.4.2.3 The Montrose Report, Recommendations and Caseplan.

Writing the Report, sharing its contents with the parents, discussing and documenting feedback from them and using its recommendations to inform caseplanning are tools for linking the assessment with recommended interventions.

- *The Report writing Process*

The Report is built around the original goals of the assessment and must be accurate, accessible and non-judgemental. It focuses on *patterns* of behaviour observed, rather than on single incidents. It often uses the family's own words and phrases, which adds to the authenticity for the family. Opinions and recommendations are supported by observed behaviour, and wherever possible, corroborated by professional reports, support services or other valid sources. Accuracy in the Report assists with parental acceptance of the content and recommendations.

- *Parent Access to the Montrose Report prior to the Case Conference.*

Because parents are supplied with the Report at least 24 hours before the Case Conference they have time to read and discuss it. If required, parents can have a support person or an interpreter to assist them to fully understand the Report and its implications. They are then fully informed of the results of the assessment *before* the decision-making meeting, and are then likely to be less anxious and more able to engage with planning around the recommended interventions.

Meeting with the assessing team in the hour before the Case Conference, to give feedback about the Report allows them to express their initial reaction, which is documented, and to correct details (spelling, dates, etc). There is not usually any significant level of challenge to the body of the Report, probably due to the Montrose practice of using of discussing the strengths, concerns and proposed recommendations with the parents at the end of the assessment week.

Feedback from parents indicates that reading the Montrose Report is one of the most powerful aspects of the intervention. They comment on how revealing and powerful it is for them to see a description of their family lifestyle and daily routines 'in black and white'. For many parents it is a sobering experience. It is very confronting for them to read their children's description of life at home, and many surprised how perceptive even very

young children are about the family situation and how clearly they can describe daily life and relationships, and adapting their behaviour in order to cope with life at home. For others, there is a sense of relief that other people can see and appreciate the constant challenges they are facing, and how hard they are trying to do the best they can for their children.

In follow-up questionnaires routinely administered to participants after a Montrose assessment, many parents comment positively on the fact that the Report is available for them to read, formally respond to, and to keep. Many families are accustomed to being interviewed and assessed and having reports written about them, but often the reports are not available to them, unless formally requested under Freedom of Information legislation, or as part of Court documentation.

- *Parent Participation in the Case Conference.*

While inviting parents' (and children's) participation in Case Conferences is a principle of the NSW *Children and Young People (Care and Protection) Act 1998*, and is also recommended Departmental practice, parents often report feeling disempowered and overwhelmed by this situation. To assist with addressing this power imbalance, families who participate in a Montrose assessment are routinely invited to have a support person with them during the Case Conference. Parents have their response to the Montrose assessment as a whole and each of the recommendations recorded in the minutes.

Parents are encouraged participate in negotiating how the recommendations might best be put into action, and how support services might best meet their needs. This is designed to engage parents with the intervention, in the hope that they will remain engaged for the duration of the caseplan. It also avoids situations where parents are asked to be involved in so many concurrent interventions that it is disruptive to their normal family life and becomes impossible for them to comply.

- *Clear Definition of Roles and Responsibilities*

Many of the families referred to Montrose have had a high level of service provision, but there are frequently problems with the family's attendance or compliance with services. Lack of co-ordination of multiple service providers can mean a less effective result. For 73% of the Assessed Group families in this study, one of the Montrose recommendations was that the support services be coordinated by the DoCS Case Manager, through caseplanning meetings and reviews, for a specific period of time.

The Montrose process establishes clarity around all stages of the assessment. The Case Conference designates the specific roles and responsibilities of each party in implementing the Montrose recommendations – the Department, parents, children and support services – in terms of activities, frequency and funding. Clarity of roles and responsibilities prevents over-servicing or gaps in service and is essential for monitoring accountability and making changes if the caseplan does not proceed as expected. Regular review periods are set at the original Case Conference, with the expectation that progress will be formally reviewed according to these timelines.

The advantages of interagency collaboration in assisting families are well documented (Morrison 1997; Scott 1993). Montrose assessed families are more likely to receive the benefits of co-ordinated service support from community agencies and services, in accordance with the Montrose recommendations and the agreed caseplan.

On the other hand, Assessed Group families with an interagency caseplan also come under increased scrutiny, and are more likely to be reported by the support services if child protection concerns emerge. Under these circumstances, unless positive family change is occurring, there would be an expectation of increased, rather than decreased, child protection notifications. However, the results of this study indicate that the increased level of agency scrutiny did not produce a higher rate of notifications in the Assessed Group than the Comparison Group in the three years after referral,

and in fact re-notifications decreased at a greater rate for Assessed Group families than Comparison Group families.

9.4.2.4. Training and Supervision of Montrose Staff.

Positive casework results are more likely to occur when interventions are planned and delivered by skilled and experienced staff.. Research has demonstrated that: "… effective casework relationships are more likely to occur in organizations where caseworkers agree on their roles, are satisfied with their jobs, cooperate with each other and personalize their work." (Glisson and Hemmelgarn 1998, p.404). Adequate orientation, ongoing training and regular supervision of staff are integral to staff retention in the Montrose team and contribute to improved outcomes for families.

As with other child protection services, "Successful outcomes require caseworkers to be responsive to unexpected problems and individualized needs, tenacious in navigating the complex bureaucratic maze of … regulations and able to form personal relationships of trust and confidence with a variety of children and families." (Glisson and Hemmelgarn 1998, p.404). However, training staff for a statewide program where the Manager cannot directly supervise their casework comes with its own set of challenges.

Orientation is an integral part of the training process. New team members are familiarised with all aspects of the Montrose assessment process before they participate in an assessment. After office–based orientation, the new staff member accompanies a team on at least one assessment before taking on a full assessment role with an experienced co-worker. They observe all aspects of the intake, assessment (including the different roles of the parent's worker and the children's worker), agency visits, the Report writing process, the parents' feedback session and the Case Conference. In this way, the process and the philosophy of the program are demonstrated to the new worker in practice, and they are acquainted with the challenges of home based assessment.

New workers have weekly supervision with the Montrose Manager, in order to debrief and to gain supplementary information where required, and also to set learning goals for the following week.

Ongoing training in child protection and family assessment is essential for Montrose staff, and is accessed through team peer education sessions, DoCS learning and development programs and external training and conferences. Continuing external professional development is also encouraged.

Supervision is a key component in staff training and development, as well as in maintaining team cohesion. The Montrose Manager has individual supervision with every staff member, with frequency being based on their level of experience. As far as possible, the Manager has an 'open door' policy in order to address practice issues and team issues as they arise.

A debriefing session takes place with the Manager and the team on the first day after the assessment week. Debriefing with the team Manager - an impartial third party without first hand knowledge of the family members - provides a means of synthesising all the information collected into a comprehensive review of all the child protection issues for the assessed family, and the most effective ways of dealing with them. The debriefing session is also very important in helping the assessing caseworkers to take a step back from their emotional connection with the family, so that they can write a Report that is clear and objective.

9.4.2.5. An Organisational Climate that Supports Individualised Assessment and Caseplanning for High Risk Families.

The final contributing factor to the success of the Montrose Program is the DoCS organisational culture during the period of the study. Positive organisational climate (low conflict, cooperation, role clarity and

personalisation) has been demonstrated to be a primary predictor for service quality and positive outcomes (Glisson and Hemmelgarn 1998).

The fact that the Montrose program operates within a large state bureaucratic structure with a statutory child protection role has positive and negative features. The positives include legislative and statutory authority, uniform policy direction, and access to resources - staff, training, technology, administration, transport, and co-ordination. The negative aspects, or threats to the program, involve managing the need for the program to work in a very *individual* way, albeit within the legislative and policy framework applicable to the rest of the Department.

To date, the DoCS organisational climate has been able to accept the unique approach of the Montrose program, and provide organisational support for it for over a decade. However, small and/or 'non-conventional' programs are always at risk within large bureaucratic structures, where there is a preference for standardised approaches and organisational consistency. Positive outcome evaluation, feedback from families, from CSCs and from service providers have reinforced the benefits of DoCS' support for the Montrose program to date and provide encouragement for Montrose to continue to be innovative in its approach and meet complex families' needs in a specialised, individual way.

9.5 Parent, Child and Child Protection Service-Related Factors Associated With Child Protection Outcomes.

The Secondary Research Questions for this study seek to determine the factors most significantly associated with Outcomes for high risk families referred to child protection services. The questions specifically relate to whether there are particular demographic or family factors, or factors related to families' contact with child protection services, that are associated with outcome in families at high risk for child removal.

The Main Effects Models for the seven child protection Outcome variables used in this study demonstrate that the strongest factors in predicting child protection outcome are *combinations* of child factors, parent factors and factors that relate to the family's history with child protection services. None of the Main Effects Models for child protection outcome is comprised of variables that come only from one type of factor (child/parent/child protection service related). Child protection outcome depends on a complex *interaction* of factors that come from all three groups.

A summary of the Main Effects Models for all child protection Outcome variables in this study follows (Fig. 9.3).

Figure 9.3: Main Effects Models for Child Protection Outcome, Three Years after Family Referral for Montrose Assessment.

FAMILY OUTCOME	
MODEL 1	**MODEL 2**
1. Montrose Assessed Group vs Comparison Group. 2. Number of Male Children per family. 3. Number of Confirmed Notifications per family at time of referral. 4. Current Domestic Violence in Family at time of referral.	1. Montrose Assessed Group vs Comparison Group. 2. Number of Male Children per family. 3. Number of Confirmed Notifications per family at time of referral. 4. Child/ren diagnosed with ADD/HD.
CHILDREN'S OUTCOME	
1. Montrose Assessment vs Comparison Group. 2. Number of Confirmed Notifications per family at Referral. 3. Male Carer's* Past or Current Substance Abuse.	
LEGAL STATUS PER FAMILY	
1. Montrose Assessed Group vs Comparison Group. 2. Legal Orders per family before Referral. 3. Mother's* Past or Current Substance Abuse.	
CHILDREN'S PLACEMENT	
MODEL 1	**MODEL 2**
1. Children's Placement History Before Referral. 2. Age of Primary Carer at Referral. 3. Male Carer's Past or Current Substance Abuse.	1. Children's Placement History Before Referral. 2. Age of Primary Carer at Referral. 3. Mother's Past or Current Substance Abuse.
NUMBER of NOTIFICATIONS PER FAMILY	
1. Number of Notifications per Family at Referral. 2. Age of Primary Carer at Referral. 3. Child/ren diagnosed with ADD/HD	
NUMBER of CONFIRMED NOTIFICATIONS PER FAMILY	
1. Number of Notifications per Family at Referral. 2. Mother's Past or Current Substance Abuse. 3. Number of Male Children per Family.	
ABUSE TYPE PER FAMILY	
1. Number of Notifications per Family at Referral. 2. Age of Primary Carer at Referral.	

* Father; or mother's partner (past or current).

* Mother or female caregiver (past or current).

The results of this study indicate that a number of specific parent, child and child protection service related factors are significantly associated with child protection Outcome models, and should always be considered by Caseworkers assessing families with high risk or chronic child protection concerns (Fig. 9.4).

Fig. 9.4: Factors Most Strongly Associated with Predictive Models for Child Protection Outcome.

FACTORS MOST STRONGLY ASSOCIATED WITH CHILD PROTECTION OUTCOME IN PREDICTIVE MODELS IN THIS STUDY.

1. Past or Current Substance Abuse by Mother / female carer.
2. Past or Current Substance Abuse by Father / male carer.
3. Current Domestic Violence.
4. Younger age group of parents (15-34 years).
5. Three or more male children born to a family.
6. Any child/ren in family diagnosed with ADD/HD*.
7. Families with three or more Child Protection Notifications.
8. Families with five or more substantiated Child Protection Notifications.
9. Families where there has been any previous Children's Court legal order.
10. Families where one or more child has ever been placed in Out of Home Care (especially if placement was not with extended family).

* Attention Deficit /Hyperactivity Disorder

9.6 Main Research Messages from This Study.

The main research messages from this study support ecological systems theory (Bronfenbrenner 1979; Belsky 1980, 1993), on which the Montrose program was predicated (Fig. 9.5).

Fig. 9.5: Main Research Messages from this Study.

MAIN RESEARCH MESSAGES.

1. Child Protection Outcomes are determined by a complex *interaction* of child factors, parent factors and factors related to the family's interaction with the child protection system.

2. Children's individual characteristics interact with, and are affected by, the families in which they live.

3. Each family is uniquely defined by the complex interaction of the personalities, histories and behaviour of both current and past caregivers with those of the children, and the positive and negative influences of the extended family and local community.

4. A family's history of interaction with the child protection system is a very strong predictor of its future relationship with the system.

5. Comprehensive, home-based family assessment can make a significant positive difference in child protection outcomes for high risk tertiary level families where children's placement in the home is in jeopardy.

The research messages illustrate that in child protection matters, family assessment must give due weight to the unique history of each particular family, including persons that are no longer part of the family, in addition to assessing the concerns observed or reported in the current family configuration.

This result has implications for actuarial and self-report risk assessment tools, where a checklist approach may fail to take the investigation of family

and community factors to a sufficient level of current and historical detail. For many families who come to the attention of child protection services, current family presentation may be the legacy of one or more earlier family configurations. The effects of earlier physical, sexual or emotional abuse, serious neglect, domestic violence or substance abuse may affect family functioning long after the person responsible has left the family.

The most important historical factors related to child protection issues are often complex, sensitive and emotional, and they may be obscured by the more recent chaotic family presentation that they gave rise to years earlier. Comprehensive family history taking is an essential first step to understanding the reasons behind current behaviour and values. This study provides strong support for the value of comprehensive home based family assessment in increasing the likelihood of improved child protection outcomes for families, three years after referral.

9.7 Implications of the Findings of this Study for Child Protection Policy and Practice.

Over the last decade, the number of child protection reports has increased exponentially in Australia and many other western countries, for a number of reasons. These include increased public awareness of the serious effects of child abuse and neglect, mandatory reporting of suspected maltreatment being extended to include a wider range of reporters, and a broader definition of the behaviours and situations which require a child protection notification. Many reported families also have complex social issues compounding the child protection concerns.

There has been mounting criticism, from the media and from public instrumentalities such as the Ombudsman, of child protection agencies' inability to meet this increase in referrals. Because of the child protection system's inability to respond to all families at risk, many recent initiatives in Australia and internationally are driven by the desire for 'evidence-based practice', underpinned by sound research, that will determine the most effective way of prioritising cases for intervention, within finite budgetary constraints.

The conclusions of this study are that child protection risks are dependent on a complex interactive process that involves factors associated with the child, the family, their community and the child protection intervention process. Clearly, some of the factors that this study found to be highly predictive of poor child protection outcome cannot be changed, e.g. the number of male children in a family and younger age of parents when reported to a child protection service. Some factors are able to be addressed for some families, e.g. parental history of substance abuse and history of relationships involving domestic violence, but often not until the child protection risks are sufficient for a child protection service to be involved with the family.

The major issues that are highly associated with child protection outcome and are also amenable to child protection intervention, are those related to child protection service interactions with the family, i.e. interventions following child protection reports, legal orders, out of home care placement.

This study demonstrates that for some families, a Montrose home-based family assessment can make a difference to child protection outcome. It may be that other families could benefit similarly from this comprehensive family assessment process that takes account of the positive and negative factors in the family's immediate social environment, as well as relevant cultural factors.

While child protection investigative assessment continues to take a primarily incident-based approach, it remains at risk of gaining only a recent and superficial picture of the family. A broader approach to assessment, that places the child in the context of the family (and its history) and the family in the context of its community, is more likely to determine the causal factors and also the local resources available to the family. However, families' willingness to participate in such an assessment and to fully engage with the recommended interventions is a critical factor in determining a successful child protection outcome.

9.6.1 Community Influences on Child Abuse and Neglect.

In recent years, an adage that is often quoted in the context of child protection is that: "It takes a village to raise a child."* Yet, public housing policy or economic circumstances result in many disadvantaged families living in a 'village' or neighbourhood which contains numerous other families who are also struggling with issues of economic and social disadvantage, unemployment, social dislocation, and in some cases, antisocial behaviour, substance abuse and family violence. There are numerous examples of the association between the characteristics of the family's 'ecological niche', i.e.

* This phrase is widely attributed to African culture, but the actual source is unknown.

the local community or neighbourhood, and child protection risks or protective factors (Garbarino and Sherman 1980; Coulton et al 1995; Crittenden 2000).

While poverty is often associated with increased child protection risk (Pelton 1981; Gil 1981; Berger 2004), many studies highlight the fact that, even in socially deprived neighbourhoods where economic disadvantage predominates, the link between poverty and child maltreatment is complex rather than simple and direct. English (1998) states: "The effects of poverty appear to interact with other risk factors such as unrealistic expectations, depression, isolation, substance abuse and domestic violence to increase the likelihood of maltreatment." (p.47). Waldfogel (2000) also suggests that the relationship between low income status and child maltreatment involves other factors including increased parental stress, increased family visibility, and other factors associated with both poverty and child maltreatment (e.g. substance abuse).

Studies that look more deeply into the effects of socially disadvantaged environments on childrearing note that a sense of social cohesiveness is a major factor in determining whether those communities are rated by residents and services as good places to raise children. Coulton et al (1995) report that parents associate certain factors with a neighbourhood environment that assists them to raise their children. These factors include feelings of *safety* for themselves and their property, *trust* in neighbours and not feeling exploited by them, and *connectedness* to neighbours and the wider community. Residents who are concerned about their own safety and welfare have fewer personal resources to assist vulnerable neighbours who may be overwhelmed by their child care responsibilities.

Garbarino (1981) conducted social mapping exercises which demonstrate that high rates of child maltreatment may co-occur with other indicators of social and economic disadvantage. Garbarino described this as "personally impoverished families clustered in socially impoverished neighbourhoods."

(Garbarino 1981, p.237). In a similar exercise, and following up on an earlier study (Vinson and Homel 1975), Vinson (1999) reports on the co-occurrence of social disadvantage indicators, including low income households, long term unemployment, use of emergency assistance, court convictions and child abuse, in certain postcode localities in the Australian states of NSW and Victoria. Interestingly, in another study on clustering of child abuse in a local community, Vinson and Baldry (1999) determined that two similar localities in metropolitan Sydney had different rates of child abuse reports and substantiation, despite similar levels of social disadvantage and similar public/private housing distribution. This finding demonstrates the complex relationship between social disadvantage and child maltreatment.

Controlling for socio-economic factors, these studies collectively allude to specific factors that contributed to feelings of lack of safety in communities. These include: domestic violence and other types of violence, substance abuse, criminality, unsociability, high child to adult ratio, child neglect and high concentrations of female headed households. Residents of communities dominated by these factors are less likely to become involved in assisting others with child care or supervision, or to place appropriate social boundaries on the behaviour of other residents' children, either because they are overburdened by their own needs, or for fear of reprisal from the child or his/her parent. The cycle of lack of community support and care for families and children is perpetuated in these socially stressed environments (Coulton, Korbin and Su 1999; Slee2006).

Garbarino (1981) suggests that the reason socially impoverished and violence-prone families tend to be clustered together is not a matter of 'likes attracting likes', but a matter of *social policy* (p.258). Two decades ago he vehemently recommended that social planners be encouraged by child advocates and others to avoid public housing policy that concentrates "families with high needs and low resources." He instead proposed scattered site housing, a principle that has been echoed in Australia (Vinson 1999; 2005). Yet, rather than placing vulnerable families within more highly

functioning communities, current public housing policy continues to place them together. Families at high risk for social problems, including child maltreatment, are clustered in public housing estates, or in public housing blocks in neighbourhoods already marked by social disadvantage (with or without economic disadvantage). As well as being socially isolated, they are often geographically isolated, on the periphery of suburbs and cities, and with inadequate public transport systems, so that residents without their own transport find it difficult to access the often limited employment opportunities and support services available. Increasingly, families who are not subject to public housing policy, but who may be working for minimal wages, are constrained by the cost of housing in larger Australian cities and are being forced towards lower cost neighbourhoods where the factors associated with social disadvantage are more likely to be present.

In both these circumstances, the housing situation limits parents' opportunities for support from the local community, and also denies children access to a choice of role models who represent a broader span of age groups, employment experience and backgrounds, and who may provide a wider range of behavioural and aspirational options and guide children and young people's social development. The Search Institute (2003, 2006) has proposed certain personal and community factors that increase resilience in all children and young people. Through surveys with two million young people in the US and Canada, the Search Institute identified 40 "Developmental Assets" - concrete, positive experiences and qualities applicable to children at different developmental stages, which it believes are essential to raising successful young people. The greater the number of Developmental Assets a young person has, or is exposed to, the more positive and successful the young person’s development is likely to be. The fewer Developmental Assets present, the greater the possibility that children and young people will engage in risky behaviours, e.g. substance abuse, unsafe sex and violence.

The 40 Developmental Assets are divided by the Search Institute into two groups. The *20 Internal Assets* are personal characteristics and behaviours that reflect positive internal growth and development. They are grouped under the categories: *Positive Identity, Positive Values, Social Competencies and Commitment to Learning*. The *20 External Assets* are important roles that families, schools, neighbourhoods, and youth organizations can play in promoting healthy development. They are organised under four major headings: *Support, Empowerment, Boundaries and Expectations, and Constructive Use of Time*.

Children raised in disadvantaged neighbourhoods are adversely affected by the social environment itself. The number and quality of External Assets cited by the Search Institute (2003, 2006) is likely to be diminished in socially disadvantaged communities. In addition, any Internal Assets that the child has are less likely to be fostered, because of the limited time and capacity of family, neighbours and formal and informal community resources already overwhelmed by the social environment and personal factors.

In disadvantaged communities, there are likely to be fewer adult role models who encourage positive work and family life. Because of the over-representation of female-headed single parent households among economically disadvantaged populations, there will be fewer positive male role models living in the families. Educational and vocational achievement is often undervalued, and substance abuse is likely to be more common. Fewer adults are connected to their neighbourhood in a positive way that assists them to share in the community responsibility for childrearing in its broadest terms and fewer are able to resolve conflict without resorting to aggression. Many of the adults who might fulfil a positive role are dissatisfied with their own future options in such communities and understandably move out at the first opportunity. This drift adds to local transience, further compromising social cohesiveness.

The results of this study demonstrate the importance of access at the local community level to pro-social role models (especially males) for children (especially boys) whose family environment may be impacted by violence, substance abuse, criminality or other antisocial lifestyles and behaviour. In this study, the children came from 200 families with the following child protection risk factors and associated social disadvantage:

- 78% of families with a history of domestic violence
- 45% of families with past or current substance abuse by the mother/female carer and 42% with substance abuse by the father/male carer
- 16% where the male carer and 9% where the female carer had a history of incarceration through juvenile justice or jail, or both
- 24% where the female carer and 16% where the male carer had educational disadvantage (less than year 8 level).

Given these findings and the associated local and international research, there is a clear need to re-evaluate current housing policy, to ensure that vulnerable families, dependent on low cost or subsidised accommodation, are not clustered together in localities where shared formal and informal social resources are already overburdened. Vinson (1999) expresses the view: "Any serious effort to increase life opportunities for society's most disadvantaged groups cannot ignore such evidence of persistent localised inequalities. It cannot be assumed that social initiatives taken at the state or national level can override extreme degrees of local cumulative disadvantage. Indeed if the residents of such localities and their children are to break free from this web of disadvantage which limits their life opportunities, intensive help in the form of educational, health, family support, housing, justice and other needed community services is required, in combination with supported community-building endeavours to sustain the benefits of assistance rendered. …in no sense can the residents be held responsible for the flawed planning and neglect that produced the concentrations of social need documented in this report." (Vinson 1999, p.45).

9.6.2 Targeting Child Protection Intervention for More Effective Results.

Where should child protection services intervene to be most effective in changing the outcomes for the children who are at highest risk for child maltreatment and/or placement in out of home care? Some possible intervention options occur within primary, secondary and tertiary prevention strategies.

9.6.2.1 Effective Early Intervention and Prevention.

Primary Prevention refers to universal, general programs which educate and inform the public, with the aim of preventing child protection problems before they become a major issue. These may include education programs for young people, before they have children, aimed at developing a realistic sense of the demands and responsibilities associated with child rearing. Alternatively, they may relate to strategies aimed at assisting young people to develop positive attitudes towards children and confidence about the prospect of parenting. Other primary prevention initiatives may take the form of public education campaigns aimed at parents, e.g. 'Don't Shake the Baby', 'Don't Leave Children Unattended in Cars', and 'Don't Smoke around Children'. Other approaches may include time-limited universal family support services or parenting training for all new parents, or for young parents, particularly with their first child.

Based on the results of this study, these public education programs aimed at young parents are addressing an identified child protection risk factor associated with younger parents. However, there is also a pressing need for strong public education programs regarding the serious and long term damage to children who are exposed to domestic violence, and the significant elevation of child protection risk in families where there is parental substance abuse.

Secondary Prevention in child protection targets families where serious child protection issues have not yet been identified, but who have been identified as having factors associated with elevated child protection risk, e.g. substance abuse, low income, younger parental age and single parents.

Specific parent education classes can be developed to meet the needs of these families, and may be supplemented by services such as family support, home visiting programs for new parents, and access to quality childcare or respite care. In addition, where appropriate, parents may be referred to specialist services such as drug and alcohol intervention or counselling, or domestic violence counselling or support services.

The results of this study and other research (English et al 1999) indicate that previous involvement with the child protection system is a very strong predictor of future involvement. This highlights the need to identify families at risk of entering the child protection system, and intervene to alleviate the identified risk factors *before* the family commences involvement with the statutory system.

Tertiary Prevention refers to services targeting to families who have already been identified as having child protection concerns, via confirmed or unconfirmed child protection reports. Despite declarations of support for the philosophy of 'early intervention' to address child protection problems before they become serious, current resource pressures on child protection services affect the range of service options available for non-urgent cases. Incoming child protection reports are often managed by a centralised intake system with a 'triage' process for allocating cases for action, based on the *type* and *severity* of abuse reported. Child protection response - assessment, investigation, intervention or referral to support agencies – is allocated to the most serious *types* of abuse or neglect, (typically physical or sexual abuse), or to families with very young children or high level immediate risk factors (Cicchetti 2004, p.736). While families at highest perceived risk are prioritised for immediate response, limited resources for child protection

intervention means that families who are reported for issues regarded as 'lower risk,' without any signs of intentional child harm, e.g. global neglect, are placed well down the priority list for investigation or intervention, regardless of the number of previous similar child protection reports.

Historically, chronic 'low level' risk families, especially those where neglect is the main issue, have been prioritised as non-urgent response, or no response, and have usually received little or no child protection intervention, despite often having large numbers of previous child protection reports. Children in these families may suffer years of inadequate physical care and/or low level physical abuse, with or without emotional abuse. Alternatively, these families continue to be notified, with escalating levels of risk or harm, until the presenting problem meets the risk threshold for intervention by the child protection service. In many cases, this may take years.

One such case is a family declined by Montrose for assessment because the children were regarded as being at high risk and in need of immediate placement. The family had over 170 child protection notifications on three pre-adolescent children, dating from a few months after the birth of each child. One child had 78 notifications. The presenting problem for most of the notifications in the family was minor physical abuse, verbal abuse and the (single) mother's prescription drug abuse and mental health issues. Interestingly, the eldest child had been made a state ward and had been placed out of the family a number of times, for periods of up to two years. The only notifications on this child during those periods occurred when he had overnight contact with the mother and when he was restored to her care at the end of each period of wardship. Clearly, although there was no single incident of extreme violence or harm, the lifelong pattern of sustained, low level physical and emotional abuse and neglect has significant long-term impact for these children, and very possibly for any children they may have.

While the need to prioritise child protection reports is understandable, the findings of this study and others (English et al 1999) indicate that in terms of renotification rate, the *number* of child protection notifications is more significant than the *reason* for the notification. In addition, this study supports the findings of other studies which report that repeated abuse is often multiple type rather than single type, and that higher numbers of notifications are associated with increasing types of abuse (Ney, Fung and Wickett 1994; Higgins and McCabe 2000).

Given that for a large proportion of investigated reports, child protection risk or harm are *not* substantiated,* the effectiveness of the current system of prioritising cases for allocation must be open to question. With finite resources, child protection intake services clearly need to prioritise responses. However, this should be based on a more thorough assessment of the past and present family situation, and all risk factors, including the length of the child protection history and the number of previous child protection notifications, rather than solely on the gravity of one or two major reported presenting problems, which may or may not be substantiated on investigation.

Comprehensive family assessment, including, but not limited to, risk and safety assessment, is essential for families who accumulate a number of notifications. This type of assessment, like the Montrose assessment, is not focused on any one incident or piece of behaviour, but is aimed at achieving a clear determination of the family's overall situation, strengths, needs and vulnerabilities, and then linking family members, through a formal caseplan, with the support services necessary to initiate and sustain family change.

The findings of this study indicate that more vulnerable parents, e.g. younger parents, and those with intellectual disability or mental illness, require skilled assessment and early intervention services at the *first* indication that they are

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* Substantiation rates ranged from 39%-74% across all Australian states in 2003-04 and 38%-74% in 2004-05 (Australian Institute for Health and Welfare 2005; 2006).

not coping with their children, and well before the problem warrants child protection action. However, in an economic climate of restricted budgets, there will always be tension between allocating staff and resources to urgent, high risk child protection matters rather than offering preventative family assistance services that may reduce both child protection risk and the need for more serious future intervention. One response to this dilemma in a number of countries and some Australian states is the *'Dual Track'* or *'Differential Response'* system for prioritising child protection services.

9.6.2.3 Differential Response to Child Protection Referrals.

Many child protection services are now adopting a 'differential response', 'dual track', or 'flexible approach' model to the intake of child protection reports. In this approach, families with child protection reports deemed to involve low level safety risks are streamed into a *supportive* rather than an *investigative* approach. This second 'track' is usually provided by non-government services, leaving the statutory child protection services to focus on interventions with families with higher levels of risk.

As mentioned previously, parents with social and educational disadvantage may find themselves living in disadvantaged neighbourhoods or communities. In an ecological sense, children in these families are potentially at increased child protection risk because of the combination of parental and community factors, which may also be negatively impacted by broader cultural issues or social policies related to housing, child care, education or employment. Families from such communities may be especially suited for a differential response model, which allows their current living situation to be enriched with services to counteract their earlier experiences of social disadvantage or maltreatment. Families receiving a differential response via an ‘Early Intervention’ system, i.e. a supportive rather than investigative approach, can still be assessed for child safety or risk factors, as well as for family strengths, and also to determine local supports that may be available to the family. This process allows a supportive program to be tailored to the specific situation of each family and to be delivered by local services, which

can both support and monitor the family's progress, ensuring that any child protection issues are detected and reported to the statutory service.

Promising results have been reported by the Minnesota Department of Human Services in terms of family engagement and child protection outcomes using their *Alternative Response System* for child protection reports (Johnson 2005). The St Louis, Missouri, Division of Family Services has also reported very promising results of the work being undertaken by the St Louis Neighbourhood Network in its *Doing Business Differently* Report (Zimmerman 2003). This approach works through a collaborative partnership between the statutory child protection service and local networks of residents, parents and representatives of public, private and community agencies. This network is able to detect vulnerable families at an early stage, and work with them in a multisystemic way to address risk factors for their children, to support and enhance the parents' skills with their children, and to provide integrated community level supports for the whole family. The co-ordinated interagency approach allows for more successful referral of families across systems and also more thorough tracking of families, to avoid them falling between services.

Where there are lower level child protection concerns and few notifications, vulnerable families with younger parents and/or those where the parent/caregivers have mental illness or intellectual disability may benefit from this alternative type of supportive intervention, rather than an investigative child protection response. The model provides comprehensive assessment of the specific strengths, difficulties and needs of the parents and children, linked with interventions that provide both education and support. Intervening early by providing training and support for these parents may establish successful parenting strategies that will assist with the current children, and also with future children.

An Early Intervention approach has been piloted in NSW (NSW DoCS 2005; Liddell et al 2005), and is being progressively implemented in a number of

Australian states. The NSW Department of Community Services will provide almost $150m in funding to Early Intervention services between 2003-2008, building on existing service networks of family support services, playgroups and parenting programs to provide "targeted support to vulnerable children and families to prevent them from entering or escalating in the child protection system." (DoCS 2005, Early Intervention Factsheet).

The NSW service model initially targets vulnerable parents who are expecting a child or who have children under eight years of age, and where there are other designated factors associated with child protection risk. It provides referral to funded support services which may avert child protection intervention in many families associated with ongoing lower level child protection risks. However, for the program to be successful, it is critical that such interventions are sufficiently funded to stay involved with these families for as long as it takes to establish that the parents are linked with community resources and there are no ongoing risks to the children.

9.6.3 Gaps in Current Child Protection Intervention.

9.6.3.1 Services for non-voluntary tertiary level families.

The types of early intervention programs described above have obvious value as secondary prevention strategies, to avoid or minimise some vulnerable families' contact with the statutory child protection system. However, early intervention programs tend to either be generic or universal in approach, or to target a specific group of families, i.e. those where parents are younger. In the latter case, the children are also more likely to be young and the families smaller. Such families tend not to have long histories with child protection services and are less entrenched in the welfare system. By virtue of these characteristics, they have a better prognosis for improved child protection outcomes after an early intervention program.

By comparison, families with chronic or high risk child protection problems are not so amenable to early intervention strategies. In terms of obvious

service gaps for high risk families with serious or longstanding child protection concerns, the most pressing questions raised by this study relate to what is the best way to intervene with these families and who should do this work.

- *What is the best way to intervene with tertiary level families identified as having serious and/or chronic child protection issues?*

Some of this group of families may appear to be lower level risk cases if they are rated on the basis of any single report to child protection services. However, in general, they are families where parents and children are somewhat older, families are often larger, with more complex structures and relationships, and the child protection history and problems tend to be more entrenched. They therefore do not meet the intake criteria for early intervention services.

These are also families that have traditionally been difficult to engage, resistant to intervention and often have multigenerational histories of child maltreatment. They have patterns of behaviour requiring interventions that are more sustained than Intensive Family Based Service models, and may be resource intensive for many years. They are often characterised by the risk factors that this study has demonstrated to be strongly associated with poor child protection outcomes, i.e. parental substance abuse, domestic violence, multiple notifications, previous Children's Court legal action and previous placement of at least one of the children. These families include many of the re-reported families that are currently overwhelming the child protection system, but are continually prioritised for lowest level or no response (English et al 1999).

A number of these families will continue to present in the same way for years, without substantial child protection intervention, but with poor developmental and relationship outcomes for the children. In other families, lack of child protection intervention results in escalation of the risks, until a crisis occurs or

the child's placement in the family becomes untenable, at which stage child removal appears to be the only option.

Many of the families referred to Montrose have previously been threatened with child removal if there is no parental change to lower the risk factors. However, frequently the threats of action do not materialise, or child removal occurs in a crisis situation, even though the families have been known to the child protection service for some time. When children are placed in crisis circumstances, there is often no clear caseplan for restoration and there is risk of 'drift in care'. Yet, the number of families where the parents have themselves spent time in out of home care suggests that simply removing children from maltreating families is not the answer to breaking the cycle of child abuse and neglect.

In this study, both the Assessed Group and the Comparison Group contain many families with the characteristics outlined above, including histories of placement of some of the children. The difference in the Family Outcome and Children's Outcome for those families who participated in a Montrose assessment and those who did not has been clearly demonstrated. The impact of the assessment was sufficient to change the child welfare career path of a substantial number of the Assessed Group families and reduce the risk factors associated with future child protection concerns.

In order to deal with these high risk families, a new strategy is required. This researcher believes that a proportion of the families can be assisted by home-based family assessment if they choose to participate. The current Montrose assessment process is voluntary, and parents must agree in writing to participate. However, many parents report to the Montrose assessment team that they participated in the assessment only because they had been advised by the referring caseworker, directly or indirectly, that Children's Court action was the alternative choice. In this sense, then, the Assessed Group was not necessarily comprised only of parents who were receptive to the assessment process (at least initially) or motivated for change. Despite

this fact, once assessment commenced, the rate of incomplete assessments is negligible, meaning that in most cases the assessment team was able to work with parents to overcome initial resistance and engage them sufficiently to complete the assessment process.

It appears then that the Montrose assessment *can* be successfully applied with parents who are initially unwilling, or at best ambivalent, and that successful completion of the assessment is significantly associated with improved child and family outcomes. Is it therefore time to consider *non-voluntary* home-based assessment? This strategy would require Children's Court intervention, to involve families at high child protection risk in a comprehensive, locally based assessment to develop a specific interagency caseplan, co-ordinated by a government or non-government lead agency, sustained over time and regularly reviewed.

- **Who should work with high risk, non-voluntary families?**

Given the non-voluntary nature of this proposed new assessment strategy, it would need to be authorised by Children's Court action. The NSW Children's Court currently has an assessment clinic, The Children's Court Clinic, which may be asked by Children's Court Magistrates to conduct child and family assessments in order to assist the Court in its deliberations. Currently, to meet demand, the Clinic has contracted staff whose work is co-ordinated by a small group of permanent Clinic staff. Across NSW, sessional psychiatrists, psychologists, social workers and other approved locally based professionals conduct family assessments and furnish reports to the Court, via the Children's Court Clinic.

An advantage of this system is that the assessing staff are deemed to be independent and able to give an unbiased view of the family. A disadvantage is that there is a wide range of assessors, working from a number of different professional and theoretical perspectives, rather than from a consistent assessment model. In addition, most families are expected to travel to the assessor, even if s/he is locally based, and home-based assessment is rare.

In practice, the assessment may involve a considerable journey for the family, followed by a number of hours of individual and family interviews and/or observations in the assessing professional's rooms. Results could be affected by the fact that children are tired from an early rise and travel, and parents may be additionally stressed by the need to prepare and supervise the children travelling to the assessment, often by public transport. Most importantly, however, the family is out of its normal environment, and family members assessed in a clinician's office for one to two hours will not behave as they would in their own home.

It is the contention of this researcher that the limited resources available for assessing this most complex and challenging group of families may be being used inefficiently. In the context of an ecological model, assessment of families in the clinician's office provides some observed or self-reported information about the microsystem of the child within the family. However, office-based assessment often lacks information about the local community within which the family exists and with which it interacts. As Garbarino (1981) puts it: "…the special contribution of an ecological perspective…is first and foremost an appreciation of *place***.** Human ecology is based on the proposition that behaviour and development arise out of a mutual adaptation of person and environment within an 'ecological niche'.….Without demeaning the importance of other perspectives and with the full recognition that each case has its own special etiology, I believe that it is essential that we understand this ecological proposition and incorporate it into our thinking about causation, prevention and intervention." (p.229).

Tertiary level families are frequently assessed by numerous professionals, using many assessment tools and approaches, often over years of presentation to child protection services and the Children's Court. Yet most of these assessments lack a first hand account of everyday life in the family. In addition to the general state of the house and the wellbeing of the children, home-based assessment provides information about family routines, in practice rather than as reported. Home based assessment quickly detects

the amount and nutritional quality of food available for the children and the regularity of meals. Assessing caseworkers can observe health and safety hazards in the home or yard (e.g. cockroach or mice plagues; animals causing hygiene problems in the house; electrical wiring and other dangerous objects; unsecured fences, doors or gates; and pools, ponds or baths or tubs with water accessible to young children). Home-based assessment also provides opportunities to more fully assess the nature of family relationships, interaction and incidents, as they occur, including the precursors, precipitants and after-effects.

In addition, the assessing team can observe the *strengths* of the family, which may not be visible in an office-based context where the family members are under stress because they are out of their own familiar space and routines, and for the reasons associated with travel described earlier. In these stressed circumstances, family members are less likely to display some of their positive attributes, e.g. spontaneous physical or verbal affection or praise, or co-operative activity.

If the home-based assessment extends over a number of days, the positive or negative impact of extended family, neighbours and visitors can also be observed and assessed in a way that is not possible in an office based assessment. For instance, during one Montrose assessment, the caseworker was engaging the children by going for a walk in the local street. She was advised by the six year old that they needed to hide behind a tree from the mother’s drug supplier who was owed money and had threatened the family. On another assessment, members of a motor cycle gang dropped in for a drink with the parents during the assessment, and in another case the team noted that a neighbouring family regularly ate meals with the assessed family, considerably depleting the family's budget. In another family, neighbours were clearly providing the primary physical care for the children, including supplying their meals and doing their laundry. The assessed family's stove, provided by the Department some months before, had never

been used. Such neighbourhood environmental affects could never be detected in office-based assessment.

Working in a team of two assessors allows the team to gain both the parents' and the children's perspectives and balance these. In a community-based family assessment, unique insights can be gained from speaking to the children's teachers, preschool staff, child health workers or other family support services within the family's local area. The Montrose assessment teams have found that agency staff are often more willing to share their concerns about the family in a face-to-face interview, than they are in a subpoenaed report for the Children's Court. Other sources of information that may not come to light in office based assessment are the extended family or concerned neighbours, who are often keen to present their perspectives on the family, and/or offer assistance, if they are part of the home based assessment process.

A specialist home-based assessment team, based on the Montrose model, has much to commend it in providing comprehensive assessment of families with long-term complex child protection risks. When underpinned by the authority of the Children's Court, there are potential advantages for the children, the family and the Court. The assessment assists to provide a clear picture of the family situation, the range of local intervention options, and the services that the family is likely to engage with. While it may not be possible to achieve the same degree of parental insight into the family situation with non-voluntary families, as mentioned earlier, a number of the Montrose assessed families disclosed that they were not entirely voluntary participants, yet most were able to be engaged in the assessment process. There is reason to believe that a specifically trained and experienced team would be able to overcome initial resistance and engage a non-voluntary, Court-referred family sufficiently to complete a home based assessment. Should this not occur, the existing resources are still available to the Children's Court to order other types of assessment.

The obvious exception to the application of the home-based family assessment model to non-voluntary clients is where there is a risk to the workers, due to family violence, substance abuse or serious mental health issues. In such families, the risk factors for workers are also likely to be impacting the safety of the children, and their removal to a place of safety is the most appropriate action.

9.6.3.2 Working with Families with Substance Abuse and/or Domestic Violence.

- **Parental Substance Abuse.**

In this study, results indicate that of all the factors measured, parental substance abuse, past or present, has the most negative effects on child protection outcomes for the children, including increased likelihood of placement of all children in the family in out of home care.

It has been estimated that 9% of children in the U.S. live with at least one substance abusing parent (Office of Applied Studies 2003; US Dept of Health and Human Services 2003a). It has also been estimated that parental substance abuse is responsible for between 70% and 90% of all child welfare spending in the US (Reid, Machetto and Foster 1999; Myers et al 2002, p.113). While there are no reliable published Australian data for the use of illicit drug use or problems in parents or persons who have the responsibility for children (Mitchell et al 2001, p.17; Drugs in the Family Summit 2005, p.3) the situation in Australia appears to be trending in the same direction, with parental substance abuse presenting a major issue in child protection case management (Tomison 1996a).

Given the significant impact of parental substance abuse and domestic violence on child protection outcome for children and families, these factors must be better assessed and dealt with earlier and more rigorously in child protection intervention. In most cases, verbal undertakings from parents that they will decrease or cease substance use or family violence are essentially

unproductive. There is no real consequence for failure to comply, and valuable time can be lost by giving the parent repeated opportunities to demonstrate change. During this period, the child protection risks to the children continue to be present, and in many cases, increase. Therefore, child protection caseplans for families with parental substance abuse or domestic violence must have formal, written, measurable expectations for parental behaviour change, the treatment that will be undertaken, and clearly stated consequences for non-compliance. The caseplan must be time-limited, regularly reviewed and consequences immediately actioned if progress is not made within the pre-established timelines or if the level of safety, welfare and wellbeing of the child decreases.

There is clear and urgent need for closer professional cooperation between child protection and substance abuse treatment services. Collaboration between by child protection agencies and substance abuse services on child protection matters has traditionally presented difficulties because of the different client focus of the two services.

Substance abuse treatment agencies focus on the adult client, usually employing a 'harm minimisation' strategy. However, the harm minimised is primarily about the adult, and the strategy does not sufficiently address risk to children if parents are focused on trying to obtain drugs or alcohol, or when they are substance affected or going through withdrawal. In relation to child protection, there can be no 'harm minimisation' approach. Risk and harm to children due to parental substance abuse must be eliminated, not minimised. Statutory child protection services and substance abuse treatment services must develop strategies that ensure the *safety and wellbeing* of children while parents address their substance abuse issues.

The parent must be able to put the child's needs ahead of their own and provide adequately for children’s daily physical, emotional and developmental needs before attending to their own alcohol or drug needs. If the children’s safety and welfare cannot be assured, placement must be arranged, either

as part of the parent's treatment caseplan (i.e. in a residential treatment centre where mothers can have their children with them) or as the children's child protection caseplan (out of home care). The results of this study strongly indicate that placement with caring and responsible extended family members, rather than in non-relative substitute care, can increase the likelihood of the children's restoration to the birth family, rather than long term placement in out of home care.

Repeated parental failure to complete substance abuse treatment programs or to make changes in their drug and alcohol usage must be taken very seriously in the child protection caseplan. It is difficult to successfully intervene with cases of serious and longstanding substance abuse, and precious time and developmental opportunities for children are lost if parents only half-heartedly attempt to address the issues, or do so only in compliance with a legal order. In such families, permanent placement of the children, particularly very young children, needs to be considered from early on as a formal part of the time-limited caseplan, and not used as a reaction to a 'last straw' crisis.

It is acknowledged that even substance abusers who eventually have a successful outcome will often relapse a number of times before they become substantially alcohol or drug free. It is also accepted that for persons with substance addictions, there is always a risk of relapse. Children do not have unlimited time to wait for substance abusing parents to repeatedly try to change their lifestyle. Therefore, parallel planning for the option of children's long term placement, preferably with extended family where appropriate, should be undertaken in conjunction with any restoration caseplan.

- **Domestic Violence*.***

The total cost of domestic violence to the Australian economy in 2002-03 was estimated at $8.1billion, including the direct costs of pain and suffering and premature mortality and indirect costs of replacing household items, counselling services, rehousing, moving schools and reduced participation in

the workforce (NSW DoCS 2005a, p.3). A significant proportion of domestic violence relationships involve children, as victims or witnesses to family violence. A closer working relationship is required between child protection services and law enforcement services in order to clearly demonstrate that family violence will not be tolerated, because of its substantial negative impact on children's current and future functioning.

An application for an Apprehended Violence Order against the perpetrator on behalf of the children is one way of allowing the children to remain in the family home, rather than requiring them to move out of the home, with or without the non-offending parent, for their own safety. Apprehended Violence Orders may remove the perpetrator from the home, but they are often difficult to enforce, and a history of family violence raises safety issues for the partner (usually female) and the children. However, the alternative option of removing the mother and children, or just the children, to a place of safety, with relatives, friends or in a refuge, disrupts children's daily routine, and often means a change of schools and loss of contact with their neighbourhood social system. Efforts must be made to employ an interagency intervention that enforces legal restraints on the perpetrator of family violence, while at the same time providing a safe and nurturing living environment for the children in a location that causes the least disruption to their daily lives.

As with families where there is parental substance abuse, interventions aimed at domestic violence must be formal, time-limited, regularly reviewed and the consequences for non-compliance clearly stated at the outset. The longer children remain exposed to family violence, the more extensive the physical and/or emotional damage caused by it. This damage has repercussions for their own health and development, their emotional wellbeing and their future relationships with partners and their own children. Opportunities to witness and practice non-violent conflict resolution may help to address some of the damage done by children's exposure to family violence. If the risk to the safety and wellbeing of the children cannot be

assured because of a parent's inability to meet the requirements of a child safety plan, the option of permanency planning to ensure the children's welfare should be part of the caseplan.

9.6.3.3 Interventions that Include Fathers / Male Caregivers.

Traditionally, child protection intervention has focussed primarily on mothers in high risk families. The results of this study demonstrate the need to also focus interventions on the male partners in households, especially where there is reported substance abuse and/or domestic violence. Lacharite et al (1996) explored the role of mother's partners in families reported for neglect. Their findings indicate the critical role of male partners in increasing maternal stress, and reducing parenting capacity of mothers, especially where domestic violence is present. A change in focus towards working with male household members will require a significant change of perspective for some services that are accustomed to working only with women and children who are victims of abusive males. However, working only with the female victim and children does not address the issue of violence with the perpetrator or prevent the same situation continuing, with this or other families.

Intervention should also involve male children, who are at risk of emulating their father or stepfather's dysfunctional behaviour with their mother and siblings in their own relationships and possibly into the next generation. In delivering child protection services, it is important to work with mothers in families where domestic violence has occurred, to ensure that they do not unintentionally respond to their male children in the same way that they did to their abusive partners, reinforcing the message that male members of the household must have their needs met, at the expense of other family members.

In addition to the substantial literature on the negative role of males who perpetrate family violence, there is a growing body of research into broader and potentially more positive roles of males in families involved with child protection services. Ignoring the role of the non-resident father may mean

that a potential source of either support or risk is not being assessed. A study of child protection (neglect) cases in Quebec, by Mayer et al (2003) highlights the need for further research into the impact of male partners. They hypothesise that because of the complex and shifting relationships found in many families referred to child protection services, and because fathers/male partners do not always live full-time with the family, their role may be overlooked or underestimated. However, separated fathers or non-residential partners of the mother may in fact exert considerable influence on the family because they are frequent, regular visitors to the home or have contact with the children for periods of time in their own homes (after school, or while providing respite for the mother, or on weekend or holiday access).

Marshall, English and Stewart (2001) note that males within the home may be associated with an atmosphere of spousal tension and conflict that negatively impacts on the mother's ability to express affection towards her children. However, they also highlight the *positive* effects of male figures (even when they do not live in the home full-time) in moderating depression and aggression in some children. Their results indicate that where there is positive association with the adult male figure, female caregivers report lower levels of depression, and this is significantly associated with a lower level of physical and verbal aggression in dealing with their children.

Clearly, the role of the father, stepfather or partner of the mother, whether or not they are living in the family home, plays a critical role, for better or for worse, in the atmosphere of the home and in the physical and emotional wellbeing of the children, and it is important for services to acknowledge and incorporate the role of a male carer in any intervention plan.

9.7 Implications of this Study for Social Policy and Child Protection Practice.

9.7.1 Supported Housing Policy.

Child protection risks are increased when vulnerable or dysfunctional families, often headed by single females, are accommodated in clusters, with high concentrations of other disadvantaged families. Whether this occurs in high density apartments or in free-standing housing in public housing estates, it is very frequently accompanied by inadequate infrastructure and limited social resources (Garbarino and Sherman, 1980; Garbarino 1998; Vinson 2005; Slee 2006). To foster resilience in vulnerable children, an enriched, rather than a deprived social environment is required (Search Institute 2003, 2006). For vulnerable families, especially those with young children and/or headed by single females, public housing policy must actively consider the increased child protection risks and decreased opportunities for successful outcomes for children and young people when at-risk families are clustered in socially disadvantaged housing and neighbourhoods.

There is some recognition of this fact in the recent policy move towards subsidising disadvantaged families in private rental accommodation, which locates these families across the general community, rather than in clusters. However, it is essential that social housing policy recognises that vulnerable families must be placed in positive and functional social environments that may mitigate any deficits that the children may have as a result of previous disadvantage. More importantly, children who have suffered child maltreatment or social disadvantage must be exposed to the greatest number of opportunities for their resilience and internal developmental assets to be fostered and enhanced by a local community that is rich in the qualities associated with the external developmental assets identified by the Search Institute (2003; 2006) and described earlier in this chapter.

A change in public housing policy makes sense in terms of enhancing the welfare and wellbeing of maltreated children and socially disadvantaged

families. It makes even more sense in terms of the continuing social and economic costs associated with children and young people who have not been adequately prepared to be engaged in employment, in prosocial activities and in functional relationships.

9.7.2 The Role of Home Based Family Assessment with Non-voluntary High Risk Families.

The results of this study indicate that future child protection risks are substantially reduced by a family's participation in a comprehensive home based family assessment. Holistic assessment can clarify the risk factors associated with the most recently reported child protection issue, but also highlights risks related to the family's overall situation, including past, as well as current family members, and broader social and community factors. Intervention based on thorough assessment and family members' participation in determining their own problems and solutions is both effective and cost efficient, given the substantial financial and emotional cost of the alternative outcomes for families and children where such an assessment is not conducted and child protection outcomes are poor. While standard incident-based risk assessment is still possible in high risk, crisis situations, the findings of this study clearly demonstrate that in a majority of cases, child protection outcomes are worse where high risk families do not also have a more comprehensive family assessment.

An associated policy implication for statutory child protection services is the need to deal with high risk families who are not willing to participate in a comprehensive assessment. One strategy could be to attach a home-based family assessment service to the Children’s Court Clinic, where the Court could enforce assessment of families who are before the Court and who are not prepared to voluntarily participate in an assessment.

9.7.3 Prioritisation Systems for Child Protection Intervention.

This study makes a clear statement about the need to intervene as early as possible in the child protection careers of families reported to child protection services. Implications for child protection policy involve the need to re-evaluate current strategies for prioritising child protection reports at point of intake to the statutory service. This study and other literature (English et al 1999; Marshall and English 1999; Higgins and McCabe 2000) indicate that risk and complexity of child protection matters increases directly with the number of child protection reports. This would indicate support for intake policy that prioritises for intervention based on the *number* of previous child protection notifications, not simply to the *reason* for the current notification.

9.7.4 Interagency Intervention.

A clear message from this study is that an interagency intervention that targets identified needs of *all* family members is likely to have more positive results than an approach that targets only the immediate child protection risks, and only in the identified child or children. Interventions involving a number of agencies may appear to be concentrating valuable resources on a particular family, but the complex issues in tertiary, high risk families are unlikely to respond to less intense intervention, and are also likely to require more prolonged involvement of services. Such intervention is cost-effective compared with the alternative options of court action and out of home care placement.

Attempts to address this issue have been attempted previously in NSW, with the production of a number of versions of the Interagency Guidelines for Child Protection Intervention (NSW Government 1997, 2000, 2005, 2006). These Guidelines have been in operation for a number of years, and have just completed their latest formal revision to refine the roles and responsibilities of the participating agencies. However, the implications of the findings of this study are that current policy supporting interagency intervention in child protection responses requires much stronger practical

application by the range of relevant government and non-government agencies. This includes the statutory child protection agency (in NSW, DoCS), Health Department, Police, Justice, Education, Children's Services (child care), and also Foster Care, Drug and Alcohol Services, Mental Health, Disability Services, and counselling, mentoring or other services required by the family.

For the interagency approach to be successfully applied, it is essential that one agency takes a lead role in co-ordinating the caseplan, and arranging regular progress reviews. Initially, the lead role will be taken by the statutory child protection agency, however, this role may change with the caseplan and the changing needs of the family, and flexibility is required for successful application of the interagency approach.

9.8 Implications for Future Research

At the 10th Australasian Conference on Child Abuse and Neglect, Prof. Dorothy Scott, Director of the Australian Centre for Child Protection, called for the dissemination of new program initiatives, based on: "evidence-informed practice" and properly evaluated programs. She stated that: "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 source for research." (Scott 2006, p.18). This study is an example of such research and the Australian child protection system would benefit greatly from the funding of similar practice-based research into child protection issues and initiatives. Some suggestions for possible research projects follow.

9.8.1 Local Evidence-based Research.

There is an urgent need for more Australian evidence-based outcome research concerning children and families referred to child protection services. Currently Australia relies heavily on overseas research, particularly from the United States and Britain and to some extent from Canada. However, the demographics of these countries are very different from those of Australia, particularly in the case of the US, where there is a substantial over-representation in the research of people from African American and Hispanic backgrounds, especially in research investigating the links between economic disadvantage and child abuse.

Before findings from US and British research are applied to Australian populations, they need to be carefully scrutinised, especially where they relate to specific demographic factors, re-reporting rates and child protection outcomes. While some British child protection research has applicability for Australia, it also needs to be considered carefully, bearing in mind the different context of a small, densely populated, largely urbanised country with local authorities and a population that reflects a particular pattern of

migration. Australia has child protection services that are state-administered and in the larger states are challenged to cover huge areas of sparsely populated land. Australia has particular indigenous population issues that are not present in the UK. Research from some Canadian provinces (e.g. Ontario and British Columbia) appears to have some relevance for Australia in terms of demographics, particularly those associated with migration and indigenous peoples.

9.8.2 Program Evaluation in Child Protection.

Associated with the need for local evidence-based practice and outcome results is the need to include program evaluation as a standard part of all child protection program development. Often this essential component is not factored into the initial or ongoing budget allocation for new child protection program initiatives (Corso and Lutzker 2006, p.735). Practitioners and researchers may have different perspectives on what constitutes a measure of program success, and these perspectives need to be more closely aligned, from the inception of new programs. In this way, the most relevant data is gathered from the start of the program and formative evaluation results can inform the future development of the program and for inclusion in the growing body of Australian child protection research and evaluation.

Implications of this recommendation involve the need to allocate a specific budget for program evaluation separate from service provision funds, and also to encourage clinical and casework practitioners and other service providers to become trained and experienced in research methods for program evaluation.

9.8.3 The Impact of Combinations of Risk Factors on Child Protection Outcome.

The extensive database collated for this study provides a rich source of data for future research into a number of factors associated with child protection outcomes. There is a need to build on the research findings of this study,

conducting a more comprehensive examination of the relationship between combinations of the major risk factors identified in this study and child protection outcomes for families and children. In particular, more extensive investigation of the relationship between parents' histories of childhood abuse and out of home care placements would be useful to determine to what extent they could be antecedents of the substance abuse and family violence issues that so strongly impact on child protection outcomes in this study.

A number of the young people in this study had had their own children by the end of the three year follow-up period. Unfortunately, a number of these children had already become known to the NSW child protection service and some had been placed in short term out of home care. In terms of future research projects, the families from this study could provide a baseline group for a longitudinal study of outcomes for the children of these families. This could include their own child protection history and could also be used for the purposes of intergenerational research. If ethical requirements for ongoing research can be met, this study could form the basis of an invaluable piece of longitudinal and intergenerational child protection research, following the child protection histories of children of the original 744 children and young people in this study, many of whose parents also have well documented child protection histories.

9.8.4 Parental Substance Abuse.

The findings in this study and others (Famularo, Kinscherff and Felton 1992; Ammerman et al 1999) regarding the critical impact of parental substance abuse on child protection outcomes indicate the need for continuing research in Australia into programs to prevent parental substance abuse – both for alcohol and drug abuse. However, in comparing the welfare and child protection research from the US, Canada and Britain with Australia, it is essential to consider the difference in type and distribution of substance abuse across the four countries. Such comparisons raise issues similar to

the demographic considerations discussed earlier in comparing populations and social issues across different countries.

- **Alcohol Abuse**

It would appear from the literature that alcohol is the most prevalent substance abuse issue related to child abuse and neglect in the US, Canada Britain and Australia. Despite the prevalence of alcohol abuse, research and intervention programs tend to focus primarily on illicit drug use. Further research is required into the impact of parental alcohol abuse on child protection outcomes for children, and on programs that successfully intervene in families with both parental alcohol abuse and child protection risk. Research is required into the effects of parental alcohol abuse alone, or in combination with other substances. In addition, some research also identifies the increased child protection risk in families with parental alcohol abuse and mental illness (Grayson 1999a). More detailed research into this combination of factors could usefully inform child protection practice.

- **Drug Abuse**

Evidence would suggest that, unlike the situation in Australia, child protection services in many parts of the US, the UK and in some parts of Canada have been significantly affected by the emergence of the 'crack' form of cocaine as a major issue in child abuse and neglect since the 1990s (Dore, Doris and Wright 1995; Kelley 2002 p.109). This drug is particularly hazardous to children because of its reported popularity with women of child-bearing age and because its relatively low cost and mood altering effect, make it attractive to people who are isolated and disadvantaged. However, its use is also associated with violence, criminality and sexual exploitation of children and adults. It presents increased child protection risks for drug dependent newborns and abused and neglected infants and young children, and is resulting in increasing rates of child removal and long term placement. (Dore, Doris and Wright, p.532)

Despite its well-documented prevalence in North America for over a decade, the use of crack cocaine in Australia is very limited at this point in time, and its impact on the welfare sector negligible. However, based on the previous patterns of substance abuse uptake in Australia, it would be wise to anticipate the potential impact that crack cocaine could have on the Australian health and welfare system. Close monitoring of its uptake, especially in disadvantaged communities, would be useful. Child protection services would benefit from further information about the destructive impact of crack cocaine on the individuals, families and communities associated with its distribution and use.

In contrast to the apparent lack of uptake of crack cocaine, in recent years significant child protection risks have been attributed to a rapid increase in Australia of methamphetamine use and/or production by parents and caregivers. Methamphetamine in its various forms is a highly addictive stimulant which creates direct risks to parental health, and also places children at risk of physical abuse and neglect when parents are 'high' (often for days at a time), because of the increased tendencies to violence and paranoia that accompany use. After use, the parent may sleep for days, leaving the children physically and emotionally neglected and at high risk due to lack of parental supervision (Swetlow 2003). In the US, compared with cocaine users, methamphetamine users are more likely to be female and Caucasian, and female users are more likely to be single parents who live alone with their children (Otero et al 2006), increasing the risk factors for those children. When parents are involved in production of the drug, often produced in home 'laboratories' (often kitchens and laundries), children are at increased risk through exposure to highly toxic substances, and also because of the dangers, including criminal behaviour, dangerous animals and firearms, associated with production and distribution of the substance (Ells, Sturgis, and Wright, 2002; Swetlow 2003; Huddleston 2005). Methamphetamine production related child fatalities have already been reported in Australia, and urgent research is required into its use and the child protection risks it presents, as well as strategies to address the

significant impact it may have on child protection and out of home care services in this country.

9.8.5 Domestic Violence and Interventions with Fathers / Male Caregivers.

One Australian research study (Goddard and Hiller 1993) indicates that domestic violence is present in about 40% of families notified for child sexual abuse and 55% of those reported for physical abuse. Given the significant link between domestic violence and poor child protection outcomes for families in the current study, more research is indicated into strategies with families where domestic violence and child protection issues co-exist.

In particular, there is a need for practice-based research into successful interventions with fathers and male caregivers who have perpetrated domestic violence and are still involved with families referred to child protection services. There is currently very little direct intervention with these men. Instead, intervention tends to focus on removing the children, or assisting the mother to remove herself and the children from the situation. Many of these males are involved in numerous sequential relationships. If there is no intervention to challenge and change the male's behaviour, the destructive influence of his violence may be replicated in a succession of vulnerable families, with a potential for an exponential effect on child protection outcomes, particularly if male children also emulate the violent behaviour.

9.8.6 Supportive Interventions for Families with Higher Numbers of Male Children and / or Children Diagnosed with ADD/HD.

Higher numbers of male children in a family featured as a variable in a number of the Main Effects Models in this study. Further investigation is indicated, to see if the number of male children in a family constitutes a risk factor more generally in families referred to child protection services. Practice-based research is needed into interventions for families with higher

numbers of male children, especially if there has been domestic violence co-occurring with child abuse, and/or there is a single female head of household. A higher rate of diagnosis of ADD/HD in male children has been reported (NSW Dept of Health 2002; 2004), and research is required into the additional stress factors for families with higher numbers of male children as well as one or more child/ren diagnosed with ADD/HD.

9.8.7 Working with Indigenous Families with Child Protection Issues.

Indigenous families have consistently been over-represented in child protection statistics and with out of home care placement in Australia (Butler 1992; Thorpe 1994; Angus and Hall 1996; Australian Institute of Health and Welfare 2005, pxiii and p22). The national figure during the years of this study is cited as 10% of all substantiated cases, from only 3% of the total population (Angus and Hall 1996).

Indigenous families are also over-represented in this study, 10.5% of the families having at least one parent who identifies as Aboriginal or Torres Strait Islander. The 21 families with at least one indigenous parent have significantly poorer child protection outcomes in terms of worse Family Outcome (p=.005); worse Children's Outcome (p=0.029); more serious Legal Status (p=0.072) and higher Numbers of Notifications three years after referral (p=0.005) (Appendix 9.7).

There is no statistically significant difference in this study between indigenous and non-indigenous families in the outcome categories Number of Confirmed Notifications, Type of Abuse or Children's Placement three years after referral. However, compared with non-indigenous families, twice the proportion of families with an indigenous parent had *all* children placed in out of home care three years after referral (Appendix 9.7.7). In addition, 60% of the families with indigenous parent/s had one or more children placed in out of home care, compared with 48% of the non-indigenous families.

These figures are particularly concerning, given that Australian child protection systems are very sensitive to the history of forced separation of indigenous children from their parents under previous Child Welfare legislation (Commonwealth of Australia 1997). The National Aboriginal and Torres Strait Islander Social Survey 2002 reports that in 1994, 10% of indigenous people aged 25 years or over reported that they had been removed from their natural family (Australian Bureau of Statistics 2004, p.3).

NSW child protection legislation (*NSW Children and Young Persons (Care and Protection) Act 1998*) now has strict principles governing the placement of indigenous children if they must be removed from their parents' care. First preference must be given to placement into the child's extended family. If this is not possible, the next most favoured placement is with members of the aboriginal community with whom the child has direct cultural ties.* However, the disruptive impact of removing so many indigenous children from their cultural and family backgrounds has left a tangible effect on the social structure and economic situation of many aboriginal families and communities, which frequently has an impact on their childrearing practices, sometimes leading to child protection concerns for the children in these families.

This study's database would provide a useful starting point for further investigation of the relationship between specific parent, child and child protection system related variables and child protection outcomes for indigenous families. Further research and practice development is also required into child protection interventions that may have successful outcomes for indigenous families.

At a broader level, the issues for the First Nations populations in Canada appear to have some similarities to those faced by Australian indigenous peoples, in terms of the impact of economic and educational disadvantage, and a previous policy of state-enforced family disruption, the 'Stolen

* Aboriginal Placement Principle.

Generations', which has resulted in decades of intervention by respective state and federal welfare systems. Both these cultural groups are over-represented in child protection and out of home care statistics, and both struggle with issues of social disadvantage, substance abuse and domestic violence. Further research would be useful, to investigate the potential shared experience of the two populations, and to explore if any child protection interventions within one group may be successfully adapted to meet the needs of the other.

A major challenge remains for child protection services - how to adapt assessment tools for use and relevance when assessing child protection risk in indigenous families, who may have different family structures and relationship patterns, within the family and between the family and its community. The second challenge is to involve indigenous representatives in developing child protection intervention strategies for use with indigenous families, who may be living in urban, rural or remote localities, with varying degrees of access to any services at all, let alone culturally appropriate services relevant to their needs.

9.8.8 Family-based assessment as a tool for change.

More research is required into the use of comprehensive, family-based assessment as a tool for change in families with high risk child protection concerns. Assessment conducted within the family home can synthesise the other types of assessment - family assessment, needs assessment, and risk/safety assessment. The question for future action research is whether the home-based assessment process can be transferred from a specialist team and incorporated into the training of caseworkers for use as a more general intervention strategy with families, instead of, or at least before, more stringent or intrusive interventions.

9.8.9 Limitations of this study.

This study had to contend with a number of methodological limitations which mean that a degree of caution should be applied when generalising the results to other populations. A number of these limitations have been identified in the body of the thesis, and primarily relate to:

a. Ethical considerations which precluded the random allocation of client families into the Assessed Group and Comparison Group.
b. Reliance on secondary data sources for both historical and follow-up information on children and families.
c. Problems of interpretation related to substantiation of child protection reports
d. Gaps in information regarding some Comparison Group families.

a. Case selection methodology

While the experimental model with randomised groups produces the most robust evaluation research, ethical considerations which preclude this technique in child protection services. Clearly this limits the robustness of the results derived from a Comparison Group rather than a strictly randomised Control Group, and also the confidence with which inferences can be drawn.

This study sought to utilise a research design that complied as far as possible with the major requirements of scientific research methods, while balancing the needs of clients and researcher.

b. Data sources.

Reliance on secondary data sources for analysis presents some limitations for data collection and in interpretation of the recorded information. While the DoCS Client Information System was a rich source of data on many families, the amount and quality of the information in the system relies on the individual caseworkers who enter casenotes on it. This places the researcher at a disadvantage, in terms of information gaps and in interpreting caseworkers' subjective or inconclusive comments. In this study, the specific limitations on data from the CIS were:

- Caseworkers not recording sufficient detail for a judgement to be made about a family's situation at referral or outcome.
- Staff turnover, resulting in inconsistencies in information on the CIS.
- The CIS is a *statewide* database, so events which take place outside NSW are not always able to be tracked. A small number of families who live close to NSW state borders may relocate interstate, especially at times of child protection activity – ie families move interstate to remove themselves from the NSW child protection precinct if serious intervention seems imminent, leaving gaps in information for the researcher. This occurred in only a very small number of such families (n=5) in this study.

To address these limitations of secondary data, where gaps occurred, the researcher sought information directly from the current DoCS case manager, wherever this was possible.

c. Problems of interpretation re child protection reports.

A second methodological limitation, reported elsewhere (English et al 1999) involves the counting of 'confirmed' and 'unconfirmed' incidents of maltreatment as pre-test and outcome measures. In practice, the DoCS Caseworker's substantiation of an allegation of child maltreatment relies on a number of service based factors which can affect the decision as to whether maltreatment has actually occurred:

- Whether any investigation is conducted into the allegation (affected by screening criteria and workload capacity)
- Locating and interviewing witnesses and relevant family members
- Insufficient first hand evidence of abuse (standard of proof).

In order to deal with this limitation, this study counts *all* notifications, both confirmed and not confirmed.

d. Gaps in information regarding some families.

Reliance on secondary data placed some limitations on comparing outcome between some Comparison Group families and the Assessed Group. The researcher cannot say with absolute certainty that the Comparison Group families did not independently access the same level of family assessment, caseplanning and intervention as the families who participated in the Montrose assessment. All that can be said is that no such activities are documented on their CIS files, even though other information about outcome was present in many cases.

Future research using similar data sources and populations would benefit from the opportunity for testing the secondary data against first hand information, for instance in the form of direct contact with the families by way of follow-up survey.

9.9 Conclusion.

The major research goal of this study was to evaluate the Montrose Home-based Family Assessment Program and its unique assessment process by examining the child protection outcomes, three years after referral, for 100 Assessed families and 100 Comparison Group families.

The findings of the study suggest that comprehensive home-based family assessment may assist in maintaining children in their families, by setting in place accurately targeted interventions that enhance family functioning and thereby reduce concerns about the safety, welfare and wellbeing of the children. The positive effects of the assessment are still measurable in a significant number of the Assessed Group families' child protection outcomes three years after assessment, compared to the Comparison Group families' outcomes.

The results indicate that a comprehensive family assessment should be considered to be a standard intervention for families who accumulate a number of child protection notifications, regardless of the reason for the notifications. The assessment should not be limited to investigating any single incident or piece of behaviour, but aimed at achieving a clear determination of the family's overall situation - history, strengths, needs and vulnerabilities. Having conducted the assessment, the intervention can then link the family members, through a formal caseplan, with the support services necessary to initiate and sustain family change, or will address the placement needs of the children in order to ensure their safety, welfare or wellbeing.

There are clear financial advantages for the child protection system as a whole if it is receiving fewer child protections reports, undertaking less investigations and less Children's Court action, and keeping children within their birth family, or at least with relatives rather than in substitute care. More importantly, there is less emotional disruption for the children, and the potential for long-term improvement in the standard of parenting for the

current children, and also for any children who may subsequently become part of the family.

The other research goals of this study related to identifying the major factors that impact on child protection outcomes for families at high risk of child removal because of abuse or neglect. Having analysed a large number of demographic, family and child protection service variables, the study has determined that it is a *combination* of child-related, parent-related and child protection service related factors that significantly impact on child protection outcome categories.

Specifically, the predictive variables identified in this study as significantly associated with one or more of the specific child protection outcome variables* are:

1. Past or Current Substance Abuse by Mother/Female caregiver.
2. Past or Current Substance Abuse by Father/Male Caregiver.
3. Current Domestic Violence.
4. Number of male children per family.
5. Diagnosis of ADD/HD# in one or more children in the family.
6. Number of previous child protection notifications.
7. Number of previous confirmed child protection notifications.
8. Legal status history of the children.
9. Out of home placement history of the children.
10. Family's participation in a Montrose Home-based Family Assessment.

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* Demonstrated by being part of a Main Effects Model. The relationship of each predictive variable to specific Outcome Variables is outlined in detail in Chapter 7.
# Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder.

The implications of the findings of this study are that families reported to statutory child protection services need to be targeted for assessment and intervention services as early as possible after it is established that there are problems that affect the safety, welfare and wellbeing of the children. Intervention should be based on the assessed needs of the family, not on the degree of severity of the reported problem that initially brought the family to the attention of the child protection service.

The findings of this study support the use of an ecological approach in family assessment in child protection. Home based assessment can highlight the various roles of the children and parents/caregivers in the family system, and view the family in interaction with its immediate social system - i.e. extended family, neighbourhood and community. Observing the family members in their "ecological niche" can assist the assessment to place the family in its unique social context in a way that is not possible in less comprehensive assessment models.

Using the results of this study, and the supporting evidence from other research, child protection caseworkers can be more aware during family assessment of specific factors and combinations of factors associated with poor child protection outcomes. Caseworkers can then use comprehensive family assessment (as opposed to investigation of reported incidents) to more adequately assess the level of risk in each family, and put appropriate services and supports into place to prevent the family from progressing to situations of higher risk, requiring more serious levels of child protection intervention.

The Montrose Home-based Family Assessment Model has much to offer the child protection system and the children and families it serves. The goals and philosophy of the program are clear and accessible and the basic procedures are highly transferable. Experienced caseworkers can acquire the basic techniques through a training program and supervised practical experience.

The results of this study suggest strong indications of the value of the comprehensive, home-based family assessment model in making a positive difference in child protection outcomes of families with complex, high level and/or chronic risk. Family engagements and accurately targeted intervention can encourage and support improved parenting, which in turn increases the quality of life for the children and families. This change can help to reduce the likelihood of further abuse or neglect, thereby reducing the need for child protection intervention, Children's Court action and out of home care placement. These results suggest that the home-based family assessment model is a positive, cost-effective child protection intervention that could be replicated in Australia or internationally.

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* "Cultural Affiliation" denoted indigenous Australians of Aboriginal or Torres Strait Island heritage.

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Appendix 4.1

Montrose Intake Form.

Montrose Home Based Assessment Programme

REFERRAL INTAKE INFORMATION

DATE..... MONTROSE WORKER.....

FAMILY NAME.....
ADDRESS..... P/CODE: .....
PH.....

REFERRED BY: D.O…….....
SUPERVISING A.M.....
COMMUNITY SERVICES CENTRE..... PH..... FAX….....

HOW LONG HAS THE D.O. HAD THE CASE?..... IS THE SUPERVISING D.O. LIKELY TO CHANGE?.....

HAS THE FAMILY BEEN TOLD ABOUT THE REFERRAL AND WHAT WAS THEIR RESPONSE?
……
GENOGRAM: (Include whereabouts of family members not living in the family home. Please also include any other persons living in the home)

ALL PERSONS CURRENTLY LIVING IN THE FAMILY HOME:

NAME	Relationship	D.O.B.	C.I.S. no	LEGAL STATUS

(If applicable) NON CUSTODIAL PARENT'S NAME AND ADDRESS:……
..... PHONE.....
PARENT'S OCCUPATION:.....
CULTURAL BACKGROUND: .....
RELIGION IF RELEVANT: .....
FAMILY HISTORY: (Include out of home placements of children, parent drug and alcohol and/or psychiatric history, disabilities, domestic violence)
.....
.....

CURRENT CONCERNS:
.....
CURRENT/IMMINENT COURT PROCEEDINGS/ORDERS:
.....
NOTIFICATIONS: (Names, dates and outcomes)
.....
AGENCIES OR SERVICES INVOLVED WITH FAMILY:
.....
SUMMARY OF CSC ACTION AND OUTCOMES TO DATE:
.....
FAMILY'S RESPONSE TO DOCS ACTION:
.....
REPORTS NOW AVAILABLE ON CHILD/REN AND/OR FAMILY:
.....
CURRENT CASEPLAN: (Apart from Montrose Referral)
.....
PROPOSED GOALS OF MONTROSE ASSESSMENT: (What does the D.O. want from the assessment?)
1. .....
2. .....
3. .....
4. .....

D.O. REFERRAL FORM, PARENT INFO, FAXED TO D.O. (Date) ..... by:.....(Montrose staff)

Appendix 4.2

Referring Caseworker Checklist.

Montrose Home Based Assessment Programme

REFERRING CASEWORKER (D.O.) CHECKLIST

NB: The family must know about and consent to the referral.

Please complete all sections of this form and fax or DX to Montrose with relevant reports.

REFERRED BY (D.O.):.....
APPROVED BY (A.M.):.....
C.S.C:..... Phone.....
Fax.....

FAMILY NAME: .....
Address: .....
…….. P/code ..... Phone.....

GENOGRAM: (Include whereabouts of family members not living in the family home.
Please also include any other persons living in the home).

[Separate page]

DISTRICT OFFICER'S MAIN CONCERNS ABOUT THE FAMILY:
.....
CURRENT AGENCIES OR SERVICES INVOLVED WITH FAMILY:
(Please specify contact names and phone numbers)
.....
AGENCIES/SERVICES INVOLVED WITH THE FAMILY IN THE PAST:
.....
CHILD/REN'S SCHOOL/S: (Including preschools etc):
.....

PLEASE LIST THE REPORTS YOU WILL BE SENDING:
.....
PLEASE LIST ANY OTHER RELEVANT REPORTS AVAILABLE ON FILE:
.....

STRENGTHS OF THE FAMILY (AS IDENTIFIED BY D.O.)
1.....
2.....
3.....

PROPOSED GOALS OF MONTROSE ASSESSMENT (What does the D.O. want from the assessment?)
1. .....
2. .....
3. .....
4. .....

WHAT IS THE FAMILY'S REACTION TO THE PROPOSED ASSESSMENT GOALS?
.....

HAS THE FAMILY CONSENTED TO THE REFERRAL FOR ASSESSMENT AND ARE ALL MEMBERS WILLING TO TAKE PART IF REFERRAL IS ACCEPTED BY MONTROSE?
.....

ANY OTHER RELEVANT INFORMATION OR SIGNIFICANT CHANGES IN THE FAMILY SINCE YOUR LAST CONTACT WITH MONTROSE:
.....

SIGNED……..... (DISTRICT OFFICER)

…… ..... (ASSISTANT MANAGER)

…..... DATE

Appendix 4.3

DoCS CLIENT INFORMATION SYSTEM: EXAMPLE OF EVENT HISTORY

EVENT HISTORY

SMITH, John* D.O.B: 7/12/1987 MALE SYDNEY CSC

DATE	EVENT	DESCRIPTION
25/09/96	CASE PLAN	GOAL HDR - RESOLVE FAMILY CONFLICT
15/08/95	EXIT FROM CARE	REASON:E01 - PLANNED EXIT TO CARE OF PARENT
15/08/95	PLACEMENT EXIT	REASON:L01 - CHILD EXITS FROM CARE SYSTEM
03/08/95	CASE PLAN	GOAL 2 - MAINTAIN CHILD IN/OR RESTORE TO FAMILY
03/08/95	ENTRY INTO CARE	REASON: MO4, PLANNED TERM:, SUBURB A - C
03/08/95	PLACEMENT ENTRY	TYPE: P20 AGENCY FOSTER CARE, PURPOSE: R40
20/05/95	REGISTRATION DECISION	DECISION: 1 - CONFIRMED, REGISTER
03/05/95	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 5
28/04/95	ACTUAL ABUSE	ACTUAL ABUSE: N82 FAILURE TO PROVIDE FOOD
28/04/95	ALLEGED ABUSE	ALLEGED ABUSE: N82 FAILURE TO PROVIDE FOOD
28/04/95	NOTIFICATION	NOTIFIED AT SUBURB 'A' BY SCHOOL: PR 2
03/09/93	REGISTRATION DECISION	DECISION: 2 - CONFIRMED, REFERRED, CLOSED
03/09/93	EXIT FROM CARE	REASON:E01 - PLANNED EXIT TO CARE OF PARENT
03/09/93	PLACEMENT EXIT	REASON:L01 - CHILD EXITS FROM CARE SYSTEM
20/08/93	PLACEMENT ENTRY	TYPE: P01 FOSTER CARE, PURPOSE: R01
20/08/93	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 5
20/08/93	ENTRY INTO CARE	REASON: AO4, PLANNED TERM:, SUBURB A
17/08/93	ACTUAL ABUSE	NO 1 NO ABUSE
17/08/93	ALLEGED ABUSE	ALLEGED ABUSE: P22 REQUEST FOR ASSISTANCE
17/08/93	NOTIFICATION	NOTIFIED AT SUBURB 'A' BY PARENT 3
18/02/92	REGISTRATION CLOSURE	CLOSURE: 1 - CHILD NO LONGER AT RISK.
21/05/91	REGISTRATION DECISION	DECISION: 1 - CONFIRMED, REGISTER
17/05/91	ACTUAL ABUSE	N99 OTHER NEGLECT
17/05/91	ALLEGED ABUSE	ALLEGED ABUSE: N99 OTHER NEGLECT
17/05/91	NOTIFICATION	NOTIFIED AT SUBURB 'B' BY POLICE- 0- 1
25/02/91	REGISTRATION DECISION	DECISION: 6 - NOT CONFIRMED, CLOSED
22/02/91	ACTUAL ABUSE	NO 1 NO ABUSE
17/05/91	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 4
22/02/91	ALLEGED ABUSE	ALLEGED ABUSE: P03 FACIAL/HEAD BRUISING
22/02/91	NOTIFICATION	NOTIFIED AT SUBURB 'B' BY PRESCHOOL 1
22/02/91	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 3
22/02/91	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 3
07/01/91	EXIT FROM CARE	REASON:E01 - PLANNED EXIT TO CARE OF PARENT
07/01/91	PLACEMENT EXIT	REASON: L01 - CHILD EXITS FROM CARE SYSTEM
31/12/90	ENTRY INTO CARE	REASON: MO4, PLANNED TERM:, SUBURB B
31/12/90	PLACEMENT ENTRY	TYPE: P01 DEPT FOSTER CARE, PURPOSE: R40
12/10/90	REGISTRATION DECISION	DECISION: 6 - NOT CONFIRMED, CLOSED
09/10/90	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 2
20/09/90	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 2
19/09/90	RECORDS TRANSFER	TRANSFER FROM UNIT 123 TO UNIT 789
18/09/90	ACTUAL ABUSE	NO 1 NO ABUSE
18/09/90	ALLEGED ABUSE	ALLEGED ABUSE: FAILURE TO PROVIDE FOOD
18/09/90	NOTIFICATION	NOTIFIED AT SUBURB 'A' BY NEIGHBOUR 3
30/07/90	REGISTRATION DECISION	DECISION: 5 - NOT CONFIRMED, REFERRED, CLOSED
22/07/90	ACTUAL ABUSE	NO 1 NO ABUSE
22/07/90	ALLEGED ABUSE	ALLEGED ABUSE: E70 PARENT'S ALC/DRUG ABU
22/07/90	NOTIFICATION	NOTIFIED AT CHILD PROTECTION BY POLICE 0-1
22/07/90	INVESTIGATIVE INTERVIEW	INTERVIEWED BY DISTRICT OFFICER # 1
18/03/88	REGISTRATION DECISION	TRANSFERRED FROM ROZELLE (INFORMATION PRE-DATES CIS)_
08/02/88	ACTUAL ABUSE	TRANSFERRED FROM ROZELLE-N99 OTHER NEGLECT
08/02/88	ALLEGED ABUSE	TRANSFERRED FROM ROZELLE (INFORMATION PRE-DATES CIS)_
08/02/88	NOTIFICATION	TRANS. FROM ROZELLE (INFORMATION PRE-DATES CIS)_

* All Identifying Information Altered

Appendix 4.4

Parent Information Sheet.

MONTROSE HOME BASED ASSESSMENT PROGRAMME

INFORMATION FOR PARENTS

The Montrose Programme is part of the Department of Community Services. Its aim is to increase the possibility of children remaining in their families, by assessing the family and identifying what assistance is needed to keep the family unit together.

THE ASSESSMENT.
The Montrose assessment is voluntary. If your family is accepted for assessment, you must confirm your agreement on the consent and release of information form.

Two Montrose team members will spend some hours with your family each day over a period of five days. It is essential that all family members who live in the home are available for the assessment. This will mean that working parents / partners will need to arrange at least two days off work (usually Tuesday or Wednesday and always part of Friday), and the children will need to be away from school for at least the Tuesday. Parents will also need to be available for the Case Conference which is usually held on the Friday of the week after the assessment. Your District Officer can assist with letters to employers if necessary.

We will observe and discuss daily routines, and talk to family members about your present situation, your individual and family history and your relationships with each other. This helps us to gain a better understanding of what resources your family needs to ensure a safe, secure environment for each child. This information will be included in an assessment Report. You will be given a copy of the Report before the Case Conference.

The assessment seeks to encourage positive change in the family, and we keep families informed of our impressions during the assessment week. However, if at any time concerns arise which we feel indicate that children are in an unsafe situation, appropriate steps will be taken to ensure their safety. The Montrose Team will talk to your District Officer and the Assistant Manager during the assessment week. The Team will also talk to other Services and professionals who have been involved with your family, or who might be able to offer future assistance. We may also speak to other members of your family.

THE REPORT.
In the week following the assessment, the Team will prepare a Report including your family's strengths and concerns, and making recommendations to the Community Services Centre for future action. These recommendations will already have been discussed with you during the assessment week.

The report will be given to you for comment, and will be discussed with you before being presented at a Case Conference. Your comments will be attached to the Report. There are only three copies of the Report; one for you; one for the file of your local Community Services Centre; and one for Montrose files. It is your right to decide who else may have access to the Report or parts of it.

THE CASE CONFERENCE.
This formal meeting is convened by the Assistant Manager of your local Community Services Centre and includes you, the Montrose Team, and the District Officer. It may also involve staff from other agencies if they are to provide services to your family. At the Case Conference, the Report and recommendations are discussed and the future caseplan for your family is agreed upon.

EVALUATION.
Immediately after the Case Conference and three months later, the Montrose research team will contact your family as part of our Programme evaluation, to ask for your comments on the assessment.

THIS INFORMATION SHEET IS TO BE FULLY DISCUSSED WITH PARENTS BY THE SUPERVISING DISTRICT OFFICER BEFORE THE PARENT CONSENT FORM IS SIGNED.

Appendix 4.5

Parent Consent Form.

MONTROSE
Home Based Assessment Programme

AGREEMENT TO ASSESSMENT AND CONSENT FOR RELEASE OF INFORMATION

This form must be signed and returned to Montrose before the assessment can take place.

I/We .....**(Parent)**
.....**(Parent/Partner)**

1. understand that the assessment is **voluntary** and will not proceed unless I/We agree to the following conditions and sign this form.

2. have read and understood the attached **Programme Information** and discussed it with the District Officer and **agree that my family will participate in a Montrose Assessment.**

3. understand that the **Montrose assessment and Report** will focus on, and address, the following **goals,** which were negotiated between the referring District Officer and Montrose:-

1. …….
2. ……..
3. ……..

4. understand that the Montrose team visits the family for **five days**. I / we agree that the child/ren's **primary caregiver / mother will be available for a substantial part of every day of the assessment**, and that any other parent/ partner who lives with the family will be available for **at least two full days** *(Usually Tuesday and Friday, to be negotiated with the Montrose Team on the first day of the assessment week).*

5. I / we understand and agree that **the child/ren will need to be absent from school/ preschool for at least one day,** (usually Tuesday) and that the assessment will include and **early morning** (breakfast) and **an evening** (dinnertime) with the family. *(The team does not eat with the family, but observes normal family routines)*

6. I / we consent to **the Montrose staff having contact with and seeking information from relevant schools, services, agencies and relevant family members of the child/ren's extended family.**

7. I / we understand that at the end of the assessment week, the Montrose Team will write a **Report**, based on the goals of the assessment, and making recommendations for future action. Issues to be raised in the Report will be discussed with me during the week of the assessment.

8. I / we understand that I / we will be given a copy of the Report and have an opportunity to discuss it with the Montrose staff in the hour before the **Case Conference**, held in the week following the assessment. I understand that parents are invited to attend the Case Conference and may bring a support person, and that the Case Conference may also involve other relevant agencies and services.

Signed:.....**(Parent / Primary Caregiver)**

Signed:.....**(Parent / Partner)**

Signed:.....**(District Officer)**

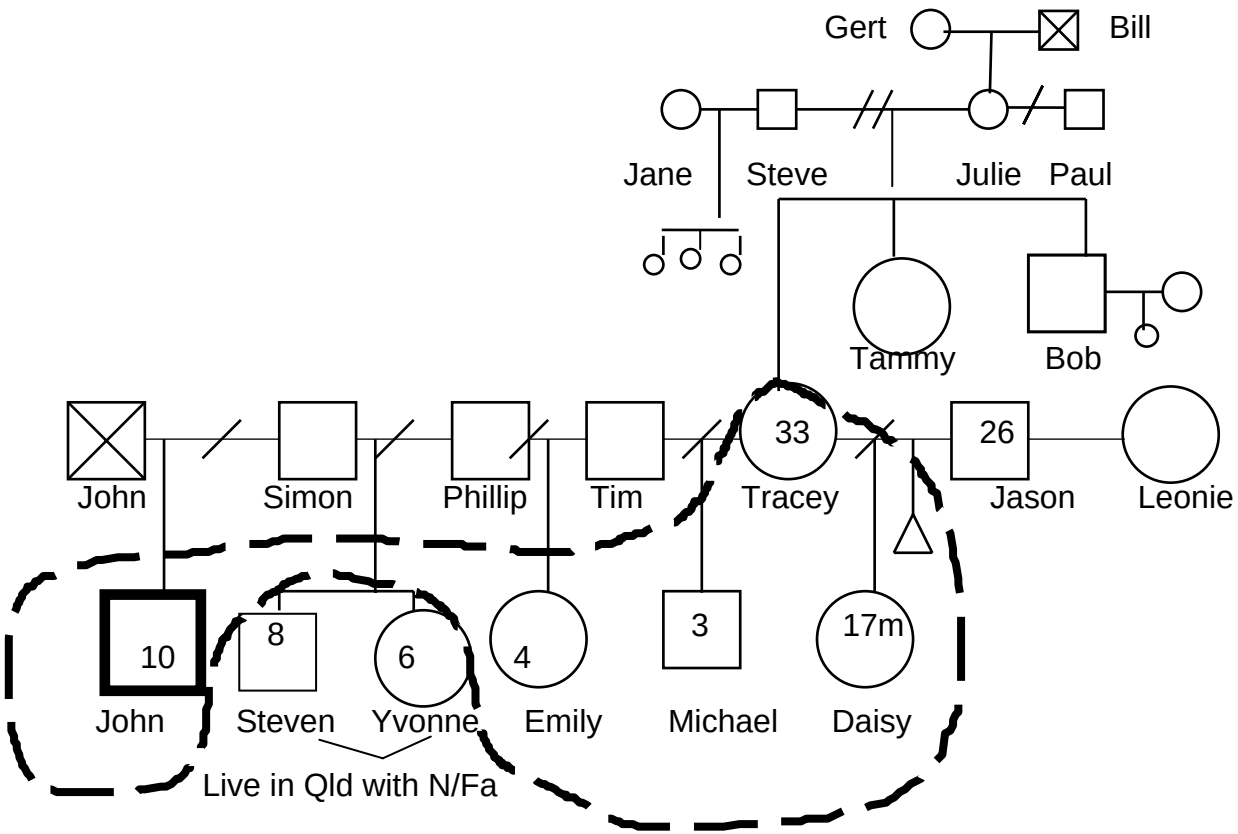
Community Services Centre.....**Date**.....

THE DISTRICT OFFICER WILL GIVE PARENT/S A COPY OF THIS FORM WHEN SIGNED.

Appendix 4.6

SAMPLE GENOGRAM *

SMITH FAMILY GENOGRAM **Date**: …… **Referred By:** ……..…..**CSC**



* All identifying data removed

Appendix 4.7

Most Frequent Recommendations of First 100 Montrose Reports.

MOST FREQUENT RECOMMENDATIONS OF MONTROSE ASSESSMENT REPORTS **January 1993 - Dec 1996** **Total Assessments N = 100**	
RECOMMENDATION	**No. of TIMES RECOMMENDED** + % of 100 Families for whom recommendation was made.
DOCS to Co-ordinate support services and Review progress	**95** (78%)
Family Support Services	**69** (57%)
Individual counselling: parent	**62** (51%)
Individual counselling: child	**47** (38%)
Pre-school / Family day care	**45** (37%)
Respite care	**43** (35%)
Paediatric / Child Development Assessment / Review	**41** (33%)
Parenting classes	**38** (31%)
After school and holiday care	**35** (28%)
Psychological / Psychiatric assessment (Child)	**34** (28%)
Supervision Order with Undertakings (5yr - 3mnth)	**33** (27%)
Psychological / Psychiatric assessment (Parent)	**27** (22%)
Informal / written Undertakings	**23** (19%)
Speech Assessment / Therapy	**18** (14%)
Short term Wardship (1-2yrs)	**16** (13%)
Educational assessment / assistance	**14** (11%)
Appropriate social activities (child)	**13** (10%)

Appendix 4.8

Family Changes in Three Years after Referral.

(1) Crosstab: Family Changes and Effects on Children's Life Situation in 3 Years Following Referral * Assd and Comp Gp. N=196 families. Up to 5 changes/family n=775 changes.

AM CHANGES EFFECT ->CH/N'S LIFE SITN * ASSD vs COMP GP Crosstabulatio

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
FAM CHANGES EFFECT -> CH/N'S LIFE SITN	NEGATIVE	Count	209	298	507
		% within ASSD vs COMP GP	53.5%	77.6%	65.4%
	NEUTRAL	Count	26	28	54
		% within ASSD vs COMP GP	6.6%	7.3%	7.0%
	POSITIVE	Count	156	58	214
		% within ASSD vs COMP GP	39.9%	15.1%	27.6%
Total		Count	391	384	775
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.001

Appendix 4.8 (cont'd)

(2) Crosstab: Family Changes in the Three Years Following Referral * Assessed Group and Comparison Group.

N=200 FAMILIES x UP TO 5 CHANGES PER FAMILY (VALID n = 775 CHANGES)

FAMILY CHANGES	ASSD GP	COMP GP	Total
CH/N REMOVED	24	35	59
CH/N RESTORED	23	19	42
PAR M/HLTH PROBS-VE for CH/N	15	23	38
PAR:D&A ABUS SIGNIF->CH/N W/B	10	26	36
I/AGNCY INT-> +VE OUTCOME	23	8	31
CH/N->MED-L/T A/CARE	15	14	29
MOD IMP in P'S CARE of CHN	23	4	27
SUPERVSN ORDER	15	10	25
PAR:++ SUPPRTS, NO IMP.	6	19	25
FAM. RELOCATED	12	11	23
CH/N->CARE/CUST EXT. FAM	8	14	22
CH/N->TEMPCARE/RESPITE	15	6	21
CH DISCL. CSA PERP. FAM/CARER	10	11	21
PAR:UNDERTAKINGS	11	10	21
PAR NEW REL-> -VE for CH/N	11	9	20
SIGNIF IMP in P'S CARE of CH/N	15	3	18
P REL PROBS->CH/N W/BNG	6	10	16
SLT IMP in P'S CARE of CH/N	13	2	15
CH/N->OTHER PAR.	9	6	15
CH/N MULT. PLACEMNTS	3	11	14
CH:PHYS&EMOT ABUSE	3	11	14
PAR. SEPARATED	8	5	13
JUV JUSTICE ACTION	7	6	13
D.V./AVO	2	9	11
PARENT in JAIL	3	8	11
PAR PSYCHIAT TX ->+ve for CH/N	8	3	11
EDUC SUPPRT PROG	6	3	9
FAM COURT ACTION	5	3	8
P/C NEW REL: +ve for CH/N	6	2	8
CH: DISCLOS.PAST CSA	4	4	8
CH: PERPS SEXL ABUSE	2	6	8
CH - INAPP SEXUAL BEHAV	1	7	8
CH/N to RESI CARE	2	5	7
FAM:MULTIPLE MOVES	2	5	7
FAM: RELOCD INTERSTATE	2	5	7
CH:SPEC SCH PLCT	5	2	7
CH:SEXUAL ABUSE	4	3	7
CH:ALLEG PHYS ABUS in CARE	2	5	7
CARE APPL.N DISM.D by C/CT	3	3	6
SLT IMP IN PAR RELNS	3	2	5
P MULT/TRANS RELS -ve for CH/N	1	4	5
P.S RECONCILED: -ve EFF.on CH/N	4	1	5
PAR. EMPLOYED	5	0	5
YP TO INDEP LIVING	3	2	5
SIGNIF IMP IN PAR RELNS	3	1	4

FAMILY CHANGES	ASSD GP	COMP GP	Total
CH:SIGNIF NON-ACC. INJURY	2	2	4
PAR: DETOX/REHAB	1	3	4
CH: POSS.PSYCHIAT DIS.	3	1	4
PAR: SUIC THRT/ATTEMPT	1	2	3
CH/N:REM.with F/CARER l/t	0	3	3
CH: SER. D&A ISSUES	0	3	3
SHARED CARE	2	1	3
CH DEATH: ACCIDENTAL	2	0	2
OTHER:POSITIVE	1	1	2
PAR. DEATH:SUICIDE	2	0	2
PAR. DEATH:O/DOSE	1	1	2
PAR PSYCH HOS ADMN	2	0	2
YP HAS OWN CHILD	2	0	2
YP in DEFACTO REL.	1	1	2
YP:OWN CH/N-DoCS ACTN	1	1	2
PAR RECONC-FAM SITN IMPVD	2	0	2
CH:ALLEG SEXL AB in CARE	0	2	2
CH ADOPTD by F/CARERS	2	0	2
P'S HLTH->-ve EFF. ON CH W/BNG	0	2	2
CH DEATH:NON-ACCIDENTAL	0	1	1
INFORMAL PLAC. CH/N	0	1	1
CHILD OFF MEDICN	1	0	1
CH:ORIG INJURS BELVD ACCL	1	0	1
CH:SIGNIF ACCDNTL INJURY	1	0	1
YP:OWN CH/N->WARDSHP	1	0	1
NON-ASSD SIB DEC'D-O/D	1	0	1
CH:SIGNIF MALNUTRN	0	1	1
CHRONIC, SER.NEGLECT	0	1	1
W/SHIP EXIPRED. NO MORE NOTNS	0	1	1
Total	**391**	**384**	**775**

Appendix 6.1

Parent/Carer Marital Status and Carer / Partner Relationship to Children in the Referred Family. (N=200 Families).

PARENT MARITAL STATUS + CARER RELATIONSHIP TO CHILDREN

	Freq	Percent	Cumulative Percent
2 PAR MAR; N/PARS OF ALL CHN	36	18.0	18.0
SING. PAR; SEP FR. DEFACTO/S	28	14.0	32.0
SING PAR; PREV MULT. SEQ. PARTNRS	22	11.0	43.0
SING. PAR. SEPD FROM SPOUSE	19	9.5	52.5
2 PAR DEF; DEF ST/PAR. SOME CHN, N/PAR OTHEF	19	9.5	62.0
SING. PAR. - DIVORCED	15	7.5	69.5
2 PAR MAR; SPOUSE ST/P SOME CHN, N/P/OTHER/	12	6.0	75.5
2 PAR DEF. DEF ST/PAR. ALL CHN	8	4.0	79.5
2 PAR DEF.-D/F NOT RELATED TO CH/N	7	3.5	83.0
2 PAR DEF- N/PARS ALL CHN	7	3.5	86.5
DEF ST/PAR ALL CHN- MO MULT.PREV PARTNRS	5	2.5	89.0
SING. PAR; WIDOWED	4	2.0	91.0
SING. PAR. NEVER MARRIED	3	1.5	92.5
2 PAR; SEP, LIVE SAME HOUSE	3	1.5	94.0
OTHER SINGLE PARENT	2	1.0	95.0
SING. PAR- PARTNER IN JAIL	2	1.0	96.0
2 PAR DEF; DIV FR N/PAR OF CHN	2	1.0	97.0
2 PAR MAR; SPOUSE ST/PAR. ALL CHN	1	.5	97.5
OTHER MARRIED	1	.5	98.0
2 PAR MAR; OWN CHN + CHN ON CUST.ORDR"	1	.5	98.5
SING PAR; PREV L/T SAME SEX REL	1	.5	99.0
2 PAR MAR; FOSTER CARERS	1	.5	99.5
2 PAR MAR; ADOPTIVE PARENTS	1	.5	100.0
Total	200	100.0	

Appendix 6.2

Ages of all children in study (incl. adult children) * Assd and Comp Gp

N=744 Chn. (Assd Gp n = 381; Comp Gp n = 363)

AGE	ASSD GROUP	COMP GROUP	TOTAL	% OF TOTAL GP
<= 6 MNTHS	10	18	28	3.8%
6-12 MNTHS	10	6	16	2.2%
1 YR	14	22	36	4.8%
2 YRS	26	31	57	7.7%
3 YRS	30	23	53	7.1%
4 YRS	20	26	46	6.2%
5 YRS	23	15	38	5.1%
6 YRS	29	17	46	6.2%
7 YRS	28	27	55	7.4%
8 YRS	20	10	30	4.0%
9 YRS	27	23	50	6.7%
10 YRS	19	18	37	5.0%
11 YRS	21	17	38	5.1%
12 YRS	16	9	25	3.4%
13YRS	15	9	24	3.2%
14 YRS	20	18	38	5.1%
15YRS	8	8	16	2.2%
16YRS	4	11	15	2.0%
17YRS	3	1	4	0.5%
18+ yrs	18	25	43	5.8%
DEC. BEF REF	2	1	3	0.4%
BORN AFT REF	18	23	41	5.5%
Age N/stated	0	5	5	0.7%
TOTAL	**381**	**363**	**744**	**100%**

Appendix 6.3

Children Aged Birth-17 Years at Time of Referral * Assd Gp and Comp Gp

N=652 Children (AG n=343; CG n=309)

AGE	ASSD GROUP	COMP GROUP	TOTAL	% OF TOTAL GP
<1YR	20	24	44	6.7%
1 YR	14	22	36	5.5%
2 YRS	26	31	57	8.7%
3 YRS	30	23	53	8.1%
4 YRS	20	26	46	7.1%
5 YRS	23	15	38	5.8%
6 YRS	29	17	46	7.1%
7 YRS	28	27	55	8.4%
8 YRS	20	10	30	4.6%
9 YRS	27	23	50	7.7%
10 YRS	19	18	37	5.7%
11 YRS	21	17	38	5.8%
12 YRS	16	9	25	3.8%
13YRS	15	9	24	3.7%
14 YRS	20	18	38	5.8%
15YRS	8	8	16	2.5%
16YRS	4	11	15	2.3%
17YRS	3	1	4	0.5%
TOTAL	**343**	**309**	**652**	**100%**

FAMILY OUTCOME: APPENDICES.

Appendix 7.1

Crosstab: Family Outcome Three Years After Referral * Assessed Group and Comparison Group.
N=181 Families (Assd Gp n=97; Comp Gp n=84)

FAM OUTCOME 3 YRS AFTER REFERRAL * MONT ASSD vs COMP GP Crosstabulation

			MONT ASSD vs COMP GP		
			MONT ASST(AG)	NOT ASSD (CG)	Total
FAM OUTCOME 3 YRS AFTER REFERRAL	FAM SIT IMPVD	Count	62	12	74
		% within FAM OUTCOME 3 YRS AFTER REFERRAL	83.8%	16.2%	100.0%
	FAM SIT NO DIFF	Count	22	38	60
		% within FAM OUTCOME 3 YRS AFTER REFERRAL	36.7%	63.3%	100.0%
	FAM SIT WORSE	Count	13	34	47
		% within FAM OUTCOME 3 YRS AFTER REFERRAL	27.7%	72.3%	100.0%
Total		Count	97	84	181
		% within FAM OUTCOME 3 YRS AFTER REFERRAL	53.6%	46.4%	100.0%

Pearson Chi-Square p = 0.000

Appendix 7.2

FAMILY OUTCOME: MAIN EFFECTS MODEL 1

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: WORSE)	FAM SIT IMPVD	74	40.9%
	FAM SIT NO DIFF	60	33.1%
	FAM SIT WORSE	47	26.0%
MONT ASSD vs COMP GP	MONT ASST(AG)	97	53.6%
	NOT ASSD (CG)	84	46.4%
(2)No OF MALE CHN/FAM	0-2 MALE CHN/FAM	126	69.6%
	3+ MALE CHN/FAM	55	30.4%
(2) TOTAL CONF NOTS/FAM BEF REF/ASST	0-4 CONF NOTS/FAM	78	43.1%
	5+ CONF NOT/FAM	103	56.9%
CURRENT DV / FAM Y/N	CURR DV (+/- PAST)	77	42.5%
	NO KNOWN CURRENT DV	104	57.5%
Valid		181	100.0%
Missing		19	
Total		200	
Subpopulation		16	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	162.309			
Final	85.749	76.560	8	.000

Pseudo R-Square

Cox and Snell	.345
Nagelkerke	.390
McFadden	.195

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	85.749[a]	.000	0	.
MONTROSE	138.018	52.269	2	.000
MALECH2C	93.753	8.004	2	.018
TB4CNTC2	93.027	7.278	2	.026
CURRNTDV	92.446	6.697	2	.035

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	FAM SIT WRSE	FAM SIT IMPVD	FAM SIT NO DIFF	Percent Correct
FAM SIT WRSE	20	7	20	42.6%
FAM SIT IMPVD	3	54	17	73.0%
FAM SIT NO DIFF	12	15	33	55.0%
Overall Percentage	19.3%	42.0%	38.7%	59.1%

Appendix 7.2: FAMILY OUTCOME: MAIN EFFECTS MODEL 1 (cont'd)

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: WORSE)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT IMPVD	Intercept	-1.954	.592	10.908	1	.001			
	[MONTROSE=1]	2.896	.500	33.601	1	.000	18.11	6.801	48.2
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	1.023	.510	4.029	1	.045	2.781	1.024	7.55
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	1.158	.473	5.997	1	.014	3.184	1.260	8.05
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	-1.105	.461	5.751	1	.016	.331	.134	.817
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.
FAM SIT NO DIFF	Intercept	.535	.423	1.600	1	.206			
	[MONTROSE=1]	.484	.435	1.243	1	.265	1.623	.693	3.80
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-.233	.417	.312	1	.576	.792	.350	1.79
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	.246	.433	.323	1	.570	1.279	.547	2.99
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	-.802	.403	3.966	1	.046	.448	.204	.987
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: NO DIFF)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT WRSE	Intercept	-.535	.423	1.600	1	.206			
	[MONTROSE=1]	-.484	.435	1.243	1	.265	.616	.263	1.44
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	.233	.417	.312	1	.576	1.26	.558	2.86
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-.246	.433	.323	1	.570	.782	.335	1.83
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	.802	.403	3.966	1	.046	2.23	1.013	4.91
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.
FAM SIT IMPVD	Intercept	-2.489	.550	20.446	1	.000			
	[MONTROSE=1]	2.412	.449	28.872	1	.000	11.2	4.628	26.9
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	1.256	.461	7.429	1	.006	3.51	1.423	8.66
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	.912	.422	4.670	1	.031	2.49	1.089	5.69
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	-.303	.424	.512	1	.474	.739	.322	1.69
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: IMPVD)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT WRSE	Intercept	1.954	.592	10.908	1	.001			
	[MONTROSE=1]	-2.896	.500	33.601	1	.000	.055	.021	.147
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-1.023	.510	4.029	1	.045	.360	.132	.976
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-1.158	.473	5.997	1	.014	.314	.124	.794
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	1.105	.461	5.751	1	.016	3.020	1.22	7.455
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.
FAM SIT NO DIFF	Intercept	2.489	.550	20.446	1	.000			
	[MONTROSE=1]	-2.412	.449	28.872	1	.000	.090	.037	.216
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-1.256	.461	7.429	1	.006	.285	.115	.703
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-.912	.422	4.670	1	.031	.402	.176	.919
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[CURRNTDV=1]	.303	.424	.512	1	.474	1.354	.590	3.107
	[CURRNTDV=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Appendix 7.3

FAMILY OUTCOME: MAIN EFFECTS MODEL 2

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: WORSE)	FAM SIT IMPVD	74	40.9%
	FAM SIT NO DIFF	60	33.1%
	FAM SIT WORSE	47	26.0%
MONT ASSD vs COMP GP	MONT ASST(AG)	97	53.6%
	NOT ASSD (CG)	84	46.4%
(2)ADD/ADHD (DIAGNSD) / FAM	1 OR MORE CH. DIAG. ADD/HD	51	28.2%
	NO CH/N DIAG ADHD.	130	71.8%
(2) TOTAL CONF NOTS/FAM BEF REF/ASST	0-4 CONF NOTS/FAM	78	43.1%
	5+ CONF NOT/FAM	103	56.9%
(2)No OF MALE CHN/FAM	0-2 MALE CHN/FAM	126	69.6%
	3+ MALE CHN/FAM	55	30.4%
Valid		181	100.0%
Missing		19	
Total		200	
Subpopulation		16	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	160.768			
Final	81.490	79.278	8	.000

Pseudo R-Square

Cox and Snell	.355
Nagelkerke	.401
McFadden	.202

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	81.490[a]	.000	0	.
MONTROSE	134.636	53.146	2	.000
ADDHDYN	90.905	9.415	2	.009
TB4CNTC2	90.662	9.172	2	.010
MALECH2C	89.070	7.580	2	.023

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	FAM SIT WRSE	FAM SIT IMPVD	FAM SIT NO DIFF	Percent Correct
FAM SIT WRSE	11	10	26	23.4%
FAM SIT IMPVD	1	62	11	83.8%
FAM SIT NO DIFF	7	20	33	55.0%
Overall Percentage	10.5%	50.8%	38.7%	58.6%

Appendix 7.3 : FAMILY OUTCOME: MAIN EFFECTS MODEL 2 (Cont'd)

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: WORSE)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT IMPVD	Intercept	-2.095	.586	12.786	1	.000			
	[MONTROSE=1]	2.971	.510	33.939	1	.000	19.5	7.2	53.0
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	-1.529	.513	8.867	1	.003	.217	.079	.593
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	1.373	.485	8.026	1	.005	3.949	1.5	10.2
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	.966	.517	3.491	1	.062	2.627	.954	7.23
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
FAM SIT NO DIFF	Intercept	.341	.398	.735	1	.391			
	[MONTROSE=1]	.492	.434	1.281	1	.258	1.635	.698	3.83
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	-.599	.425	1.987	1	.159	.549	.239	1.26
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	.412	.435	.895	1	.344	1.510	.643	3.54
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-.289	.414	.489	1	.484	.749	.333	1.68
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: NO DIFF)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT WRSE	Intercept	-.341	.398	.735	1	.391			
	[MONTROSE=1]	-.492	.434	1.281	1	.258	.612	.261	1.43
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	.599	.425	1.987	1	.159	1.821	.791	4.19
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-.412	.435	.895	1	.344	.662	.282	1.55
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	.289	.414	.489	1	.484	1.336	.594	3.01
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
FAM SIT IMPVD	Intercept	-2.436	.550	19.598	1	.000			
	[MONTROSE=1]	2.480	.458	29.323	1	.000	11.9	4.87	29.3
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	-.929	.482	3.721	1	.054	.395	.154	1.02
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	.962	.431	4.989	1	.026	2.616	1.13	6.08
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	1.255	.469	7.158	1	.007	3.509	1.40	8.80
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Parameter Estimates

FAMILY OUTCOME 3YRS AFT REF/ ASST (REF: IMPVD)		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
FAM SIT WRSE	Intercept	2.095	.586	12.786	1	.000			
	[MONTROSE=1]	-2.971	.510	33.939	1	.000	.051	.019	.139
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	1.529	.513	8.867	1	.003	4.612	1.69	13
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-1.373	.485	8.026	1	.005	.253	.098	.655
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-.966	.517	3.491	1	.062	.381	.138	1.0
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.
FAM SIT NO DIFF	Intercept	2.436	.550	19.598	1	.000			
	[MONTROSE=1]	-2.480	.458	29.323	1	.000	.084	.034	.206
	[MONTROSE=2]	0[a]	.	.	0	.	.	.	.
	[ADDHDYN=1]	.929	.482	3.721	1	.054	2.532	.985	6.5
	[ADDHDYN=2]	0[a]	.	.	0	.	.	.	.
	[TB4CNTC2=1]	-.962	.431	4.989	1	.026	.382	.164	.889
	[TB4CNTC2=2]	0[a]	.	.	0	.	.	.	.
	[MALECH2C=1]	-1.255	.469	7.158	1	.007	.285	.114	.715
	[MALECH2C=2]	0[a]	.	.	0	.	.	.	.

a. This parameter is set to zero because it is redundant.

Appendix 7.4

Crosstab: Number of Families with One or More Children Diagnosed ADD/HD (N= 200 Families.)

ADD/ADHD (DIAGNSD) / FAM n/y * MONT ASSD vs COMP GP
Crosstabulation

Count

		MONT ASSD vs COMP GP		
		MONT ASST(AG)	NOT ASSD (CG)	Total
ADD/ADHD (DIAGNSD) / FAM n/y	NO CH/N DIAG ADHD.	73	71	144
	1 OR MORE CHN ADD/HD	27	29	56
Total		100	100	200

CHILDREN'S OUTCOME: APPENDICES.

Appendix 7.5

CHILDREN'S OUTCOME: MAIN EFFECTS MODEL

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
CH/N'S OUTCOME 3 YRS AFTER REFERRAL - REF: WORSE	CHN SIT IMPVD	68	38.4%
	CHN SIT NO DIFF	9	5.1%
	CHN SIT WRSE	100	56.5%
MONT ASSD vs COMP GP	MONT ASST (AG)	98	55.4%
	NOT ASSD (CG)	79	44.6%
CONF NOTS / FAM BEF REFL (5+;<=4)	5+ CONF NOT/FAM	98	55.4%
	0-4 CONF NOTS/FAM	79	44.6%
(2) FA SUBABUSE: Y/N	AOD ABUSE (ALC +/- DRUGS)	77	43.5%
	NO KNOWN AOD	100	56.5%
Valid		177	100.0%
Missing		23	
Total		200	
Subpopulation		8	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Onl	89.192			
Final	44.572	44.621	6	.000

Pseudo R-Square

Cox and Snell	.223
Nagelkerke	.274
McFadden	.150

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	44.572[a]	.000	0	.
MONTROSE	75.714	31.142	2	.000
RCNTSB4	54.756	10.184	2	.006
FSUBABYN	51.335	6.763	2	.034

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

	Predicted			
Observed	CHN SIT IMPVD	CHN SIT NO DIFF	CHN SIT WRSE	Percent Correct
CHN SIT IMPVD	44	0	24	64.7%
CHN SIT NO DIFF	3	0	6	.0%
CHN SIT WRSE	23	0	77	77.0%
Overall Percentage	39.5%	.0%	60.5%	68.4%

Appendix 7.5: CHILDREN'S OUTCOME: MAIN EFFECTS MODEL (Cont'd)

Parameter Estimates

CH/N'S OUTCOME 3 YRS AFTER REFERRAL - REF: WORSE [a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
CHN SIT IMPVD	Intercept	-.725	.350	4.287	1	.038			
	[MONTROSE=1]	1.987	.397	24.982	1	.000	7.291	3.3	15.9
	[MONTROSE=2]	0[b]	.	.	0	.	.	.	.
	[RCNTSB4=1]	-.992	.358	7.658	1	.006	.371	.184	.749
	[RCNTSB4=2]	0[b]	.	.	0	.	.	.	.
	[FSUBABYN=1]	-.829	.372	4.962	1	.026	.436	.210	.905
	[FSUBABYN=2]	0[b]	.	.	0	.	.	.	.
CHN SIT NO DIFF	Intercept	-2.500	.770	10.552	1	.001			
	[MONTROSE=1]	-.120	.760	.025	1	.874	.887	.200	3.935
	[MONTROSE=2]	0[b]	.	.	0	.	.	.	.
	[RCNTSB4=1]	.797	.836	.908	1	.341	2.218	.431	11.4
	[RCNTSB4=2]	0[b]	.	.	0	.	.	.	.
	[FSUBABYN=1]	-1.226	.845	2.108	1	.147	.293	.056	1.536
	[FSUBABYN=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: CHN SIT WRSE.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CH/N'S OUTCOME 3 YRS AFT REFERRAL- REF : IMPVD [a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
CHN SIT WRSE	Intercept	.725	.350	4.287	1	.038			
	[MONTROSE=1]	-1.987	.397	24.982	1	.000	.137	.063	.299
	[MONTROSE=2]	0[b]	.	.	0	.	.	.	.
	[RCNTSB4=1]	.992	.358	7.658	1	.006	2.697	1.34	5.445
	[RCNTSB4=2]	0[b]	.	.	0	.	.	.	.
	[FSUBABYN=1]	.829	.372	4.962	1	.026	2.292	1.10	4.754
	[FSUBABYN=2]	0[b]	.	.	0	.	.	.	.
CHN SIT NO DIFF	Intercept	-1.775	.797	4.960	1	.026			
	[MONTROSE=1]	-2.107	.800	6.938	1	.008	.122	.025	.583
	[MONTROSE=2]	0[b]	.	.	0	.	.	.	.
	[RCNTSB4=1]	1.789	.861	4.312	1	.038	5.981	1.11	32.4
	[RCNTSB4=2]	0[b]	.	.	0	.	.	.	.
	[FSUBABYN=1]	-.397	.878	.205	1	.651	.672	.120	3.754
	[FSUBABYN=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: CHN SIT IMPVD.

b. This parameter is set to zero because it is redundant.

Appendix 7.6

Children's Outcome Three Years after Referral * No. of Confirmed Notifications / Family at Referral (N=168 Families)

CONF NOTS / FAM BEF REFL * CH/N'S OUTCOME 3 YRS AFT REFERRAL
Crosstabulation

			CH/N'S OUTCOME 3 YRS AFT REFERRAL		
			CHN SIT WRSE	CHN SIT IMPVD	Total
CONF NOTS / FAM BEF REFL	0-4 CONF NOTS / FAM	Count	37	40	77
		% within CH/N'S OUTCOME 3 YRS AFT REF	37.0%	58.8%	45.8%
	5+ CONF NOT/FAM	Count	63	28	91
		% within CH/N'S OUTCOME 3 YRS AFT REF	63.0%	41.2%	54.2%
Total		Count	100	68	168
		% within CH/N'S OUTCOME 3 YRS AFT REF	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.005

Appendix 7.7

Children's Outcome * Confirmed Notifications / Family at Referral * Assd Gp and Comp Gp (N=168 Fams)

CONF NOTS/FAM BEF REFERRAL * CH/N'S OUTCOME 3 YRS AFT REFERRAL * MONT ASSD vs COMP GP
Crosstabulation

MONT ASSD vs COMP GP				CH/N'S OUTCOME 3 YRS AFT REFERRAL-REF : IMPVD		
				CHN SIT WRSE	CHN SIT IMPVD	Total
MONT ASST(AG)	CONF NOTS / FAM BEF REFL	0-4 CONF NOTS/FAM	Count	12	32	44
			% within CH/N'S OUTCOME	29.3%	59.3%	46.3%
		5+ CONF NOT/FAM	Count	29	22	51
			% within CH/N'S OUTCOME	70.7%	40.7%	53.7%
	Total		Count	41	54	95
			% within CH/N'S OUTCOME	100.0%	100.0%	100.0%
NOT ASSD (CG)	CONF NOTS / FAM BEF REFL	0-4 CONF NOTS/FAM	Count	25	8	33
			% within CH/N'S OUTCOME	42.4%	57.1%	45.2%
		5+ CONF NOT/FAM	Count	34	6	40
			% within CH/N'S OUTCOME	57.6%	42.9%	54.8%
	Total		Count	59	14	73
			% within CH/N'S OUTCOME	100.0%	100.0%	100.0%

Pearson Chi-square significance: Assd Gp p=0.004; Comp Gp: N/Signif.

Appendix 7.8

Crosstab: Children's Outcome 3 years after Referral * Male Carer Substance Abuse * Assd Gp and Comp Gp N =168 families.

(2) FA SUBABUSE: Y/N * CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP * ASSD vs COMP GP
Crosstabulation

ASSD vs COMP GP				CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP		
				CHN SIT WRSE	CHN SIT IMPVD	Total
ASSD GP	FA SUBABUSE:	AOD ABUSE (ALC +/- DRUGS)	Count	26	24	50
			% within (2) FA SUBABUSE: Y/N	52.0%	48.0%	100.0%
		NO KNOWN AOD	Count	15	30	45
			% within (2) FA SUBABUSE: Y/N	33.3%	66.7%	100.0%
	Total		Count	41	54	95
			% within (2) FA SUBABUSE: Y/N	43.2%	56.8%	100.0%
COMP GP	FA SUBABUSE:	AOD ABUSE (ALC +/- DRUGS)	Count	23	2	25
			% within (2) FA SUBABUSE: Y/N	92.0%	8.0%	100.0%
		NO KNOWN AOD	Count	36	12	48
			% within (2) FA SUBABUSE: Y/N	75.0%	25.0%	100.0%
	Total		Count	59	14	73
			% within (2) FA SUBABUSE: Y/N	80.8%	19.2%	100.0%

Pearson Chi Square: Assd Gp p= 0.067; Comp Gp p= 0.080

LEGAL STATUS OUTCOME: APPENDICES.

Appendix 7.9

Legal Status / Family 3 Years after Referral (6 Categories) * Assd and Comp Gp. (N = 200 families)

(6)LEG STAT / FAM 3 YRS AFTER REF * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
(6)LEG STAT / FAM 3 YRS AFTER REF	NO LEG ORDS	Count	58	49	107
		% within ASSD vs COMP GP	58.0%	49.0%	53.5%
	SUP ORD	Count	17	6	23
		% within ASSD vs COMP GP	17.0%	6.0%	11.5%
	CUST ORD	Count	6	20	26
		% within ASSD vs COMP GP	6.0%	20.0%	13.0%
	S/T WARD <2YRS	Count	4	1	5
		% within ASSD vs COMP GP	4.0%	1.0%	2.5%
	L/T WARD > 2 YRS	Count	10	12	22
		% within ASSD vs COMP GP	10.0%	12.0%	11.0%
	MULT ORD TYPES	Count	5	12	17
		% within ASSD vs COMP GP	5.0%	12.0%	8.5%
Total		Count	100	100	200
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi Square significance 0.002

Appendix 7.10

Legal Status 3 yrs after Referral (3 Categories) * Assd Gp and Comp Gp. (N= 200 Families)

LEG STAT/FAM 3 YRS AFT REFL * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
LEG STAT / FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	58	49	107
		% within LEG STAT/FAM	54.2%	45.8%	100.0%
		% within A vs C GP	58.0%	49.0%	53.5%
	S/ORDER	Count	17	6	23
		% within LEG STAT/FAM	73.9%	26.1%	100.0%
		% within A vs C GP	17.0%	6.0%	11.5%
	CUST ORD/ WARD / MULT ORDS	Count	25	45	70
		% within LEG STAT/FAM	35.7%	64.3%	100.0%
		% within A vs C GP	25.0%	45.0%	35.0%
Total		Count	100	100	200
		% within LEG STAT/FAM	50.0%	50.0%	100.0%
		% within A vs C GP	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.003

Appendix 7.11

LEGAL STATUS 3 YEARS AFTER REFERRAL: MAIN EFFECTS MODEL

[Although this Model exceeded the minimum number of events per parameter recommended by Hosmer and Lemeshow (2000)[1], those authors do acknowledge that this "rule of ten" should be used as a guideline in conjunction with the context of the total sample[2], and this Model displayed no evidence of numerical problems.]

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
(3)LEG STAT/FAM 3 YRS AFT REFL: REF- NO LEG ORDS	S/ORDER	23	11.5%
	CUST ORD/WARD/MULT ORDS	70	35.0%
	NO LEG.ORDS	107	53.5%
MONT ASSD vs COMP GP	MONT ASST(AG)	100	50.0%
	NOT ASSD (CG)	100	50.0%
NO LEGAL ORDERS/FAM BEF REF	NO LEGAL ORDERS	107	53.5%
	LEGAL ORDER/S	93	46.5%
(2) MO SUBABUSE : Y/N	MO: AoD ABUSE	89	44.5%
	NO REP. AoD ABUSE	111	55.5%
Valid		200	100.0%
Missing		0	
Total		200	
Subpopulation		8	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	84.709			
Final	51.537	33.172	6	.000

Pseudo R-Square

Cox and Snell	.153
Nagelkerke	.180
McFadden	.087

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	51.537[a]	.000	0	.
montrose	64.874	13.337	2	.001
nolegord	65.264	13.727	2	.001
msubabyn	58.276	6.739	2	.034

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	S/ORDER	CUST ORD/WARD/ MULT ORDS	NO LEG.ORDS	Percent Correct
S/ORDER	0	4	19	.0%
CUST ORD/WARD/MULT ORDS	0	26	44	37.1%
NO LEG.ORDS	0	17	90	84.1%
Overall Percentage	.0%	23.5%	76.5%	58.0%

[1] Hosmer D W and Lemeshow S (2000): Applied Logistic regression. 2nd Ed John Wiley& Sons NY pp.346-347. i.e. a minimum ratio of 1:10 (1 parameter of the independent variable for 10 events of the smallest number of occurrences of the reference group).
[2] Hosmer and Lemeshow (2000): op cit p347

Appendix 7.11 Legal Status 3 Years After Referral: Main Effects Model (Cont'd)

Parameter Estimates

(3)LEG STAT/FAM 3 YRS AFT REFL: REF- NO LEG STAT[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
S/ORDER	Intercept	-1.163	.496	5.505	1	.019			
	[montrose=1]	.940	.529	3.153	1	.076	2.559	.907	7.22
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	-1.435	.504	8.105	1	.004	.238	.089	.639
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-.845	.531	2.532	1	.112	.430	.152	1.22
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
CUST ORD/WARD/MULT ORDS	Intercept	.202	.307	.432	1	.511			
	[montrose=1]	-.815	.329	6.144	1	.013	.443	.232	.843
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	-.905	.322	7.868	1	.005	.405	.215	.761
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	.486	.326	2.229	1	.135	1.626	.859	3.08
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: NO LEG.ORDS .

b. This parameter is set to zero because it is redundant.

Parameter Estimates

LEG STAT/FAM 3 YRS AFT REFL: REF- CUST/ WARD / MULT ORDS[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO LEG.ORDS	Intercept	-.202	.307	.432	1	.511			
	[montrose=1]	.815	.329	6.144	1	.013	2.260	1.186	4.305
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	.905	.322	7.868	1	.005	2.471	1.313	4.649
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-.486	.326	2.229	1	.135	.615	.325	1.164
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
S/ORDER	Intercept	-1.365	.498	7.503	1	.006			
	[montrose=1]	1.755	.550	10.163	1	.001	5.782	1.966	17.0
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	-.531	.534	.988	1	.320	.588	.207	1.675
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-1.331	.552	5.803	1	.016	.264	.090	.780
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: CUST ORD/WARD/MULT ORDS.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

LEG STAT/FAM 3 YRS AFT REFL: REF- S/ORD[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO LEG.ORDS	Intercept	1.163	.496	5.505	1	.019			
	[montrose=1]	-.940	.529	3.153	1	.076	.391	.139	1.1
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	1.435	.504	8.105	1	.004	4.200	1.6	11
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	.845	.531	2.532	1	.112	2.327	.822	6.6
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
CUST ORD/WARD /MULT ORDS	Intercept	1.365	.498	7.503	1	.006			
	[montrose=1]	-1.755	.550	10.163	1	.001	.173	.059	.509
	[montrose=2]	0[b]	.	.	0	.	.	.	.
	[nolegord=1]	.531	.534	.988	1	.320	1.700	.597	4.8
	[nolegord=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	1.331	.552	5.803	1	.016	3.784	1.3	11
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: S/ORDER.

b. This parameter is set to zero because it is redundant.

Appendix 7.12

Legal Status per Family at Referral (Legal Orders/No Legal Orders) * Legal Status three years after referral (Legal Orders/No Legal Orders) * Assd and Comp Gp. (N=200 Families).

(2) LEGAL STAT/ FAM BEF REF * (2) LEG STAT/FAM 3YRS AFT REF * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) LEG STAT/FAM 3YRS AFT REF		Total
				NO LEG.ORDS	S/O;CUST WARD;MULT	
ASSD GP	LEGAL STAT / FAM BEF REF	NO LEG ORD	Count	24	13	37
			% within LEGAL STAT/ FAM BEF REF	64.9%	35.1%	100.0%
		S/ORD;CUST; WARD;MULT	Count	34	29	63
			% within LEGAL STAT/ FAM BEF REF	54.0%	46.0%	100.0%
	Total		Count	58	42	100
			% within LEGAL STAT/ FAM BEF REF	58.0%	42.0%	100.0%
COMP GP	LEGAL STAT / FAM BEF REF	NO LEG ORD	Count	27	14	41
			% within LEGAL STAT/ FAM BEF REF	65.9%	34.1%	100.0%
		S/ORD;CUST; WARD;MULT	Count	22	37	59
			% within LEGAL STAT/ FAM BEF REF	37.3%	62.7%	100.0%
	Total		Count	49	51	100
			% within LEGAL STAT/ FAM BEF REF	49.0%	51.0%	100.0%

Pearson Chi Square: Assd Gp Not signif; Comp Gp p= 0.005

Appendix 7.13

Legal Order Type 3 Yrs After Referral (3 categories) * Legal Order Type Per Family Before Referral * Assd Gp and Comp Gp. (N=200 Families)

CH/N'S LEGAL STAT/FAM BEF REF * LEG STAT/FAM 3 YRS AFT REF * MONT ASSD vs COMP GP Crosstabulation

MONT ASSD vs COMP GP				LEG STAT/FAM 3 YRS AFT REF			Total
				NO LEG. ORDS	S / ORDER	CUST ORD / WARD / MULT ORD	
MONT ASST(AG)	CH/N'S LEGAL STAT / FAM BEF REF	NO LEG ORD +/- UTGS	Count	24	3	10	37
			% within LEG STAT / FAM 3 YRS AFT REF	41.4%	17.6%	40.0%	37.0%
		SUPVSN ORD	Count	13	2	1	16
			% within LEG STAT / FAM 3 YRS AFT REF	22.4%	11.8%	4.0%	16.0%
		CUST / WARD / MULT	Count	21	12	14	47
			% within LEG STAT / FAM 3 YRS AFT REF	36.2%	70.6%	56.0%	47.0%
	Total		Count	58	17	25	100
			% within LEG STAT / FAM 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%
NOT ASSD (CG)	CH/N'S LEGAL STAT / FAM BEF REF	NO LEG ORD +/- UTGS	Count	27	2	12	41
			% within LEG STAT / FAM 3 YRS AFT REF	55.1%	33.3%	26.7%	41.0%
		SUPVSN ORD	Count	5		7	12
			% within LEG STAT / FAM 3 YRS AFT REF	10.2%		15.6%	12.0%
		CUST / WARD / MULT	Count	17	4	26	47
			% within LEG STAT / FAM 3 YRS AFT REF	34.7%	66.7%	57.8%	47.0%
	Total		Count	49	6	45	100
			% within LEG STAT / FAM 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%

Pearson Chi-square significance: Assd Gp p=0.041; Comp Gp p=0.056

CHILDREN'S PLACEMENT OUTCOME: APPENDICES.

Appendix 7.14

Children's Placement History Before Referral * Assd Gp and Comp Gp. (N=200 Families)

(4)TOT PLACT TYPES /FAM BEFORE REF * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
(4)TOT PLACT TYPES /FAM BEFORE REF	FAM HOME+/- RESPITE	Count	35	37	72
		% within ASSD vs COMP GP	35.0%	37.0%	36.0%
	FAM + EXTD FAM	Count	12	21	33
		% within ASSD vs COMP GP	12.0%	21.0%	16.5%
	FAM+SUB CARE	Count	49	40	89
		% within ASSD vs COMP GP	49.0%	40.0%	44.5%
	FAM+EXTFAM +SubCARE	Count	4	2	6
		% within ASSD vs COMP GP	4.0%	2.0%	3.0%
Total		Count	100	100	200
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi square: Not significant

Appendix 7.15

Children's Placement Three Years after Referral (Family or Extended family vs Substitute Care) * Assd Gp and Comp Gp. (N=197 families)

(2) CHN'S PLCT 3 YRS AFT REF * MONT ASSD vs COMP GP Crosstabulation

			MONT ASSD vs COMP GP		
			MONT ASST (AG)	NOT ASSD (CG)	Total
(2) CHN'S PLCT 3 YRS AFT REF	ALL CHN FAM OR EXT FAM	Count	75	62	137
		% within (2) CHN'S PLCT 3 YRS AFT REF	54.7%	45.3%	100.0%
		% within MONT ASSD vs COMP GP	75.0%	63.9%	69.5%
	1 OR MORE CHN SUB CARE	Count	25	35	60
		% within (2) CHN'S PLCT 3 YRS AFT REF	41.7%	58.3%	100.0%
		% within MONT ASSD vs COMP GP	25.0%	36.1%	30.5%
Total		Count	100	97	197
		% within (2) CHN'S PLCT 3 YRS AFT REF	50.8%	49.2%	100.0%
		% within MONT ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi-square p=0.091

Appendix 7.16

Children's Placement Three Years after Referral (5 Cats)* Assd Gp and Comp Gp. (N=197 families)

(5)PLCT CHN 3 YRS AFT REF * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
(5)PLCT CHN 3 YRS AFT REF	ALL CHN FAM ONLY	Count	55	46	101
		% within ASSD vs COMP GP	55.0%	47.4%	51.3%
	ALL CHN EXT FAM ONLY	Count	9	6	15
		% within ASSD vs COMP GP	9.0%	6.2%	7.6%
	DIFF CHN: FAM/ EXT FAM	Count	11	10	21
		% within ASSD vs COMP GP	11.0%	10.3%	10.7%
	ALL CHN SUB CARE ONLY	Count	5	10	15
		% within ASSD vs COMP GP	5.0%	10.3%	7.6%
	DIFF CHN: FAM/ SUB CARE	Count	20	25	45
		% within ASSD vs COMP GP	20.0%	25.8%	22.8%
Total		Count	100	97	197
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi Square: N/Sig.

Appendix 7.17

Children's Placement Three Years after Referral: Main Effects Model 1

Nominal Regression:

Case Processing Summary

		N	Marginal Percentage
CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: ALL FAM	ALL CHN OoHC	25	15.0%
	SOME CHN OoHC	53	31.7%
	ALL CHN FAM HOME	89	53.3%
CHNS PLCT BEF REFERRAL	FAM HOME+/- RESPITE	56	33.5%
	FAM + EXTD FAM	28	16.8%
	FAM+SUB CARE	83	49.7%
(2) AGE PRIMARY CARER	15-34 YRS	105	62.9%
	35 YRS+	62	37.1%
(2) FA SUBABUSE: Y/N	AOD ABUSE (ALC +/- DRUGS)	75	44.9%
	NO KNOWN AOD	92	55.1%
Valid		167	100.0%
Missing		33	
Total		200	
Subpopulation		12	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	95.211			
Final	64.981	30.229	8	.000

Pseudo R-Square

Cox and Snell	.166
Nagelkerke	.192
McFadden	.092

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	64.981[a]	.000	0	.
chplcb4r	78.779	13.798	4	.008
fsubabyn	71.580	6.599	2	.037
agep1c2	74.059	9.078	2	.011

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	ALL CHN OoHC	SOME CHN OoHC	ALL CHN FAM HOME	Percent Correct
ALL CHN OoHC	9	0	16	36.0%
SOME CHN OoHC	12	4	37	7.5%
ALL CHN FAM HOME	5	3	81	91.0%
Overall Percentage	15.6%	4.2%	80.2%	56.3%

Chn's Plct Three Years after Referral: Main Effects Model 1 (Cont'd)

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: ALL FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN OoHC	Intercept	-2.276	.645	12.473	1	.000			
	[chplcb4r=1]	-1.701	.618	7.577	1	.006	.182	.054	.613
	[chplcb4r=2]	-2.223	1.086	4.188	1	.041	.108	.013	.910
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	1.169	.505	5.363	1	.021	3.22	1.197	8.662
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	1.602	.615	6.787	1	.009	4.96	1.487	16.6
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
SOME CHN OoHC	Intercept	-.882	.387	5.207	1	.022			
	[chplcb4r=1]	-.685	.405	2.859	1	.091	.504	.228	1.115
	[chplcb4r=2]	-.265	.483	.301	1	.583	.767	.298	1.977
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	.615	.360	2.926	1	.087	1.85	.914	3.745
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	.632	.371	2.895	1	.089	1.88	.908	3.895
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN FAM HOME.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: ALL OoHC[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN FAM HOME	Intercept	2.276	.645	12.473	1	.000			
	[chplcb4r=1]	1.701	.618	7.577	1	.006	5.5	1.63	18
	[chplcb4r=2]	2.223	1.086	4.188	1	.041	9.2	1.10	78
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	-1.169	.505	5.363	1	.021	.311	.115	.836
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-1.602	.615	6.787	1	.009	.202	.060	.673
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
SOME CHN OoHC	Intercept	1.394	.673	4.284	1	.038			
	[chplcb4r=1]	1.016	.641	2.515	1	.113	2.8	.787	9.7
	[chplcb4r=2]	1.958	1.095	3.200	1	.074	7.1	.829	61
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	-.554	.515	1.159	1	.282	.575	.210	1.6
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-.970	.633	2.349	1	.125	.379	.110	1.3
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN IN OoHC .

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: OoHC & FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN FAM HOME	Intercept	.882	.387	5.207	1	.022			
	[chplcb4r=1]	.685	.405	2.859	1	.091	1.984	.897	4.392
	[chplcb4r=2]	.265	.483	.301	1	.583	1.303	.506	3.358
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-.632	.371	2.895	1	.089	.532	.257	1.101
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	-.615	.360	2.926	1	.087	.540	.267	1.094
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.
ALL CHN OoHC	Intercept	-1.394	.673	4.284	1	.038			
	[chplcb4r=1]	-1.016	.641	2.515	1	.113	.362	.103	1.271
	[chplcb4r=2]	-1.958	1.095	3.200	1	.074	.141	.017	1.206
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	.970	.633	2.349	1	.125	2.638	.763	9.121
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[fsubabyn=1]	.554	.515	1.159	1	.282	1.740	.635	4.772
	[fsubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: SOME CHN IN OoHC .

b. This parameter is set to zero because it is redundant.

Appendix 7.18

Children's Placement Three Years after Referral: Main Effects Model 2

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: OoHC & FAM	ALL CHN FAM HOME	89	53.3%
	ALL CHN OoHC	25	15.0%
	SOME CHN IN OoHC	53	31.7%
CHNS PLCT BEF REFERRAL	FAM HOME+/- RESPITE	56	33.5%
	FAM + EXTD FAM	28	16.8%
	FAM+SUB CARE	83	49.7%
(2) AGE PRIMARY CARER	15-34 YRS	105	62.9%
	35 YRS+	62	37.1%
(2) MO SUBABUSE : Y/N	MO: AoD ABUSE	79	47.3%
	NO REP. AoD ABUSE	88	52.7%
Valid		167	100.0%
Missing		33	
Total		200	
Subpopulation		12	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	98.683			
Final	69.022	29.661	8	.000

Pseudo R-Square

Cox and Snell	.163
Nagelkerke	.189
McFadden	.090

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	69.022[a]	.000	0	.
chplcb4r	81.892	12.870	4	.012
agep1c2	75.402	6.380	2	.041
msubabyn	75.053	6.031	2	.049

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	ALL CHN FAM HOME	ALL CHN OoHC	SOME CHN IN OoHC	Percent Correct
ALL CHN FAM HOME	73	12	4	82.0%
ALL CHN OoHC	9	12	4	48.0%
SOME CHN IN OoHC	31	11	11	20.8%
Overall Percentage	67.7%	21.0%	11.4%	57.5%

Chn's Plct Three Years after Referral: Main Effects Model 2 (Cont'd).

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: ALL FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN OoHC	Intercept	-2.143	.637	11.32	1	.001			
	[chplcb4r=1]	-1.590	.614	6.706	1	.010	.204	.061	.679
	[chplcb4r=2]	-2.171	1.084	4.013	1	.045	.114	.014	.954
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	1.264	.617	4.195	1	.041	3.54	1.06	11.9
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	1.110	.546	4.139	1	.042	3.03	1.04	8.843
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
SOME CHN OoHC	Intercept	-.527	.362	2.121	1	.145			
	[chplcb4r=1]	-.720	.403	3.187	1	.074	.487	.221	1.073
	[chplcb4r=2]	-.311	.478	.422	1	.516	.733	.287	1.871
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	.655	.375	3.056	1	.080	1.93	.924	4.016
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-.195	.366	.283	1	.595	.823	.401	1.688
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN FAM HOME.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: ALL OoHC[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN FAM HOME	Intercept	2.143	.637	11.316	1	.001			
	[chplcb4r=1]	1.590	.614	6.706	1	.010	4.906	1.47	16.3
	[chplcb4r=2]	2.171	1.084	4.013	1	.045	8.768	1.05	73.4
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-1.264	.617	4.195	1	.041	.282	.084	.947
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-1.110	.546	4.139	1	.042	.330	.113	.960
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
SOME CHN OoHC	Intercept	1.616	.663	5.945	1	.015			
	[chplcb4r=1]	.870	.648	1.804	1	.179	2.388	.671	8.50
	[chplcb4r=2]	1.860	1.102	2.852	1	.091	6.426	.742	55.7
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-.609	.647	.885	1	.347	.544	.153	1.93
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-1.305	.563	5.365	1	.021	.271	.090	.818
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN IN OoHC .

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CHNS PLCT 3 YRS AFT REF - FAM vs OoHC - REF: OoHC & FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN FAM HOME	Intercept	.527	.362	2.121	1	.145			
	[chplcb4r=1]	.720	.403	3.187	1	.074	2.05	.932	4.53
	[chplcb4r=2]	.311	.478	.422	1	.516	1.36	.534	3.48
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	-.655	.375	3.056	1	.080	.519	.249	1.08
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	.195	.366	.283	1	.595	1.22	.593	2.49
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
ALL CHN OoHC	Intercept	-1.616	.663	5.945	1	.015			
	[chplcb4r=1]	-.870	.648	1.804	1	.179	.419	.118	1.49
	[chplcb4r=2]	-1.860	1.102	2.852	1	.091	.156	.018	1.35
	[chplcb4r=3]	0[b]	.	.	0	.	.	.	.
	[agep1c2=1]	.609	.647	.885	1	.347	1.84	.517	6.54
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	1.305	.563	5.365	1	.021	3.69	1.22	11.1
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: SOME CHN IN OoHC .

b. This parameter is set to zero because it is redundant.

Appendix 7.19

Male Carer Substance Abuse * Assd Gp and Comp Gp. (N = 200 Families.)

(2) FA SUBABUSE: Y/N * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
(2) FA SUB ABUSE: Y/N	AOD ABUSE (ALC +/- DRUGS)	Count	51	33	84
		% within (2) FA SUBABUSE: Y/N	60.7%	39.3%	100.0%
	NO KNOWN AOD	Count	49	67	116
		% within (2) FA SUBABUSE: Y/N	42.2%	57.8%	100.0%
Total		Count	100	100	200
		% within (2) FA SUBABUSE: Y/N	50.0%	50.0%	100.0%

Pearson Chi Square : p=0.010

Appendix 7.20

Chn's Placement Three Years After Referral * Male Carer Substance Abuse * Assd Gp and Comp Gp. N = 197 Families

(2) FA SUBABUSE: Y/N * CHNS PLCT 3 YRS AFT REF * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				CHNS PLCT 3 YRS AFT REF			
				ALL CHN FAM HOME	SOME CHN OoHC	ALL CHN OoHC	Total
ASSD GP	(2) FA SUB ABUSE: Y/N	AOD ABUSE (ALC +/- DRUGS)	Count	24	18	9	51
			% within CHNS PLCT 3 YRS AFT REF	43.6%	58.1%	64.3%	51.0%
		NO KNOWN AOD	Count	31	13	5	49
			% within CHNS PLCT 3 YRS AFT REF	56.4%	41.9%	35.7%	49.0%
	Total		Count	55	31	14	100
			% within CHNS PLCT 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%
COMP GP	(2) FA SUB ABUSE: Y/N	AOD ABUSE (ALC +/- DRUGS)	Count	11	10	10	31
			% within CHNS PLCT 3 YRS AFT REF	23.9%	28.6%	62.5%	32.0%
		NO KNOWN AOD	Count	35	25	6	66
			% within CHNS PLCT 3 YRS AFT REF	76.1%	71.4%	37.5%	68.0%
	Total		Count	46	35	16	97
			% within CHNS PLCT 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%

Pearson Chi Square : Assd Gp: Not signif; Comp Gp p=0.015

Appendix 7.21

Mother's Substance Abuse at Referral * Assd Gp and Comp Gp (N=200 Families)

(2) MO SUBABUSE : Y/N * MONT ASSD vs COMP GP Crosstabulation

			MONT ASSD vs COMP GP		
			MONT ASST (AG)	NOT ASSD (CG)	Total
(2) MO SUB ABUSE : Y/N	MO: AoD ABUSE	Count	49	40	89
		% within MONT ASSD vs COMP GP	49.0%	40.0%	44.5%
	NO REP. AoD ABUSE	Count	51	60	111
		% within MONT ASSD vs COMP GP	51.0%	60.0%	55.5%
Total		Count	100	100	200
		% within MONT ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi Square: Not Signif.

Appendix 7.22

Mother's Substance Abuse * Children's Placement Three Years After Referral * Assd Gp and Comp Gp. (N=197 Families)

(2) MO SUBABUSE : Y/N * CHNS PLCT 3 YRS AFT REF * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				CHNS PLCT 3 YRS AFT REF: ALL CHN FAM HOME	SOME CHN OoHC	ALL CHN OoHC	Total
ASSD GP	MO SUB-ABUSE Y/N	MO: AoD ABUSE	Count	27	12	10	49
			% within MO SUB ABUSE Y/N	55.1%	24.5%	20.4%	100.0%
		NO REP. AoD ABUSE	Count	28	19	4	51
			% within MO SUB ABUSE Y/N	54.9%	37.3%	7.8%	100.0%
	Total		Count	55	31	14	100
			% within MO SUB ABUSE Y/N	55.0%	31.0%	14.0%	100.0%
COMP GP	MO SUB-ABUSE Y/N	MO: AoD ABUSE	Count	14	11	13	38
			% within MO SUB ABUSE Y/N	36.8%	28.9%	34.2%	100.0%
		NO REP. AoD ABUSE	Count	32	24	3	59
			% within MO SUB ABUSE Y/N	54.2%	40.7%	5.1%	100.0%
	Total		Count	46	35	16	97
			% within MO SUB ABUSE Y/N	47.4%	36.1%	16.5%	100.0%

Pearson Chi square significance: Assd Gp- N/s; Comp Gp- p=0.001

Appendix 7.23

Age Group of Primary Carer at Referral * Assd Gp and Comp Gp. (N = 170 Families).

(2) AGE PRIMARY CARER * ASSD vs COMP GP Crosstabulation

Count

		ASSD vs COMP GP: ASSD GP	COMP GP	Total
(2) AGE PRIMARY CARER	15-34 YRS	61	47	108
	35 YRS+	39	23	62
Total		100	70	170

Pearson Chi Square : no signif difference

Appendix 7.24

Chn's Placement Three Years After Referral * Age Group of Primary Carer at Referral * Assd Gp and Comp Gp. (N = 167 Families)

CHNS PLCT 3 YRS AFT REF * (2) AGE PRIMARY CARER * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) AGE PRIMARY CARER: 15-34 YRS	35 YRS+	Total
ASSD GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	30	25	55
			% within CHNS PLCT 3 YRS AFT REF	54.5%	45.5%	100.0%
		SOME CHN OoHC	Count	21	10	31
			% within CHNS PLCT 3 YRS AFT REF	67.7%	32.3%	100.0%
		ALL CHN OoHC	Count	10	4	14
			% within CHNS PLCT 3 YRS AFT REF	71.4%	28.6%	100.0%
	Total		Count	61	39	100
			% within CHNS PLCT 3 YRS AFT REF	61.0%	39.0%	100.0%
COMP GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	18	16	34
			% within CHNS PLCT 3 YRS AFT REF	52.9%	47.1%	100.0%
		SOME CHN OoHC	Count	15	7	22
			% within CHNS PLCT 3 YRS AFT REF	68.2%	31.8%	100.0%
		ALL CHN OoHC	Count	11	0	11
			% within CHNS PLCT 3 YRS AFT REF	100.0%	.0%	100.0%
	Total		Count	44	23	67
			% within CHNS PLCT 3 YRS AFT REF	65.7%	34.3%	100.0%

Pearson Chi Square: Assd Gp: Not Signif; Comp Gp p= 0.016

NOTIFICATIONS AND CONFIRMED NOTIFICATIONS OUTCOME : APPENDICES.

Appendix 7.25

Total Number of Notifications per Family at Referral to Montrose.

Statistics TOTAL N=200 FAMS

		#TOT NOTS - FAM BEF REFERRAL
N	Valid	200
	Missing	0
Sum		2302

Statistics : ASSD GP

		#TOT NOTS / FAM BEF REFERRAL
N	Valid	100
	Missing	0
Mean		11.95
Median		7.00
Mode		3
Minimum		0
Maximum		63
Sum		1195

Statistics: COMP GP

		#TOT NOTS / FAM BEF REFERRAL
N	Valid	100
	Missing	0
Mean		11.07
Median		8.00
Mode		6
Minimum		1
Maximum		46
Sum		1107

Appendix 7.26

Summary: Number of Notifications and Confirmed Notifications Three Years Before and After Referral * Assessed Group and Comparison Group .

Statistics TOTAL : ASSD & COMP GROUPS

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF	# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	200	200	200	200	200	200
	Missing	0	0	0	0	0	0
Mean		7.45	5.07	-2.38	5.04	2.54	-2.50
Median		6.00	3.00	-2.00	4.00	1.00	-2.00
Mode		3	0	-1	3	0	-1
Sum		1490	1014	-476	1007	508	-499

Statistics ASSESSED GROUP

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF	# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100	100	100	100
	Missing	0	0	0	0	0	0
Mean		7.73	4.56	-3.17	5.24	2.24	-3.00
Median		6.00	2.00	-2.00	4.00	1.00	-2.00
Mode		3	0	-1	3	0	0
Sum		773	456	-317	524	224	-300

Statistics COMPARISON GROUP

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF	# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100	100	100	100
	Missing	0	0	0	0	0	0
Mean		7.17	5.58	-1.59	4.83	2.84	-1.99
Median		6.00	3.00	-1.00	3.00	1.00	-1.50
Mode		1[a]	0	0	2	0	-1
Sum		717	558	-159	483	284	-199

a. Multiple modes exist. The smallest value is shown

Appendix 7.27

Notifications/Family in Three years Before & Three Years after Referral.

Notifications in Three years Before Referral* Assessed Group and Comparison Group. N=200 families

(2) NOTS/FAM BEFORE REF (<=2; 3+) * ASSD vs COMP GP Crosstabulation

			ASSD vs COMP GP		
			ASSD GP	COMP GP	Total
(2) NOTS/FAM BEFORE REF (<=2; 3+)	0-2 NOTS/FAM	Count	16	14	30
		% within ASSD vs COMP GP	16.0%	14.0%	15.0%
	3+ NOTS/FAM	Count	84	86	170
		% within ASSD vs COMP GP	84.0%	86.0%	85.0%
Total		Count	100	100	200
		% within ASSD vs COMP GP	100.0%	100.0%	100.0%

Pearson Chi square: Not signif.

Notifications in 3 Yrs Before and 3 Yrs After Referral: Total Group. N=200 Families

Statistics TOTAL GROUP N=200 FAMILIES

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	200	200	200
	Missing	0	0	0
Mean		7.45	5.07	-2.38
Median		6.00	3.00	-2.00
Mode		3	0	-1
Range		53	40	55
Minimum		0	0	-33
Maximum		53	40	22
Sum		1490	1014	-476

Notifications in 3 Yrs Before and 3 Yrs After Referral: Assd Gp. N=100 Fams

Statistics ASSD GP

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100
	Missing	0	0	0
Mean		7.73	4.56	-3.17
Median		6.00	2.00	-2.00
Mode		3	0	-1
Range		53	40	55
Minimum		0	0	-33
Maximum		53	40	22
Sum		773	456	-317

Notifications in 3 Yrs Before and 3 Yrs After Referral: Comp. Gp. N=100 Fams.

Statistics COMP GP

		# NOTS / FAM in 3YRS BEF REF	# NOTS / FAM in 3YRS AFT REF	DIFF BET # NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100
	Missing	0	0	0
Mean		7.17	5.58	-1.59
Median		6.00	3.00	-1.00
Mode		1[a]	0	0
Range		32	28	44
Minimum		0	0	-22
Maximum		32	28	22
Sum		717	558	-159

a. Multiple modes exist. The smallest value is shown

Appendix 7.28

NOTIFICATIONS PER FAMILY 3 YRS AFTER REFERRAL: MAIN EFFECTS MODEL

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
NTILES of FAMRNOT3	0-1 NOT	67	39.4%
	2-4 NOTS	55	32.4%
	5+ NOTS	48	28.2%
(2) AGE PRIMARY CARER	15-34 YRS	108	63.5%
	35 YRS+	62	36.5%
(2) NOTS/FAM BEFORE REF (<=2; 3+)	0-2 NOTS/FAM	25	14.7%
	3+ NOTS/FAM	145	85.3%
ADD/ADHD (DIAGNSD) / FAM n/y	NO CH/N DIAG ADHD.	121	71.2%
	1 OR MORE CHN ADD/HD	49	28.8%
Valid		170	100.0%
Missing		30	
Total		200	
Subpopulation		8	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	74.130			
Final	48.584	25.546	6	.000

Pseudo R-Square

Cox and Snell	.140
Nagelkerke	.157
McFadden	.069

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	48.584[a]	.000	0	.
agep1c2	58.609	10.025	2	.007
tb4not02	60.359	11.775	2	.003
addhdny	55.110	6.526	2	.038

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

	Predicted			
Observed	0-1 NOT	2-4 NOTS	5+ NOTS	Percent Correct
0-1 NOT	42	0	25	62.7%
2-4 NOTS	28	0	27	.0%
5+ NOTS	11	0	37	77.1%
Overall Percentage	47.6%	.0%	52.4%	46.5%

Parameter Estimates

NTILES of FAMRNOT3[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
0-1 NOT	Intercept	.244	.465	.274	1	.600			
	[agep1c2=1]	-1.258	.455	7.648	1	.006	.284	.116	.693
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[tb4not02=1]	2.223	.794	7.844	1	.005	9.231	1.949	43.722
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[addhdny=1]	1.014	.443	5.248	1	.022	2.757	1.158	6.565
	[addhdny=2]	0[b]	.	.	0	.	.	.	.
2-4 NOTS	Intercept	.203	.473	.184	1	.668			
	[agep1c2=1]	-1.229	.461	7.096	1	.008	.293	.119	.723
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[tb4not02=1]	1.446	.842	2.953	1	.086	4.246	.816	22.094
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[addhdny=1]	.969	.451	4.615	1	.032	2.634	1.089	6.374
	[addhdny=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: 5+ NOTS.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

NTILES of FAMRNOT3 - REF:0-1[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
5+ NOTS	Intercept	-.244	.465	.274	1	.600			
	[agep1c2=1]	1.258	.455	7.648	1	.006	3.519	1.443	8.586
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[tb4not02=1]	-2.223	.794	7.844	1	.005	.108	.023	.513
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[addhdny=1]	-1.014	.443	5.248	1	.022	.363	.152	.864
	[addhdny=2]	0[b]	.	.	0	.	.	.	.
2-4 NOTS	Intercept	-.041	.425	.009	1	.923			
	[agep1c2=1]	.030	.379	.006	1	.937	1.030	.490	2.164
	[agep1c2=2]	0[b]	.	.	0	.	.	.	.
	[tb4not02=1]	-.777	.505	2.365	1	.124	.460	.171	1.237
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[addhdny=1]	-.046	.437	.011	1	.917	.955	.406	2.248
	[addhdny=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: 0-1 NOT.

b. This parameter is set to zero because it is redundant.

Appendix 7.29

CONFIRMED NOTIFICATIONS BEFORE AND AFTER REFERRAL

(1) TOTAL STUDY GROUP: Confirmed Notifications Before Referral. N=200 Families.

Statistics TOTAL N=200 FAMS

#TOT CONF NOTS- ALL CHN in FAM BEI		
N	Valid	200
	Missing	0
Sum		1522

Statistics ASSD GP

#TOT CONF NOTS- ALL CHN in FAM BE		
N	Valid	100
	Missing	0
Sum		809

Statistics COMP GP

#TOT CONF NOTS / FAM BEF REI		
N	Valid	100
	Missing	0
Sum		713

(2) TOTAL STUDY GROUP: Confirmed Notifications in 3 Yrs Before and 3 Yrs After Referral. N=200 Families.

Statistics TOTAL GROUP N=200 FAMILIES

		# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	200	200	200
	Missing	0	0	0
Mean		5.04	2.54	-2.50
Median		4.00	1.00	-2.00
Mode		3	0	-1
Range		35	17	37
Minimum		0	0	-25
Maximum		35	17	12
Sum		1007	508	-499

(3a) ASSESSED GROUP: Confirmed Notifications in 3 Yrs Before and 3 Yrs After Referral. n=100 Fams

Statistics ASSD GP

		# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100
	Missing	0	0	0
Mean		5.24	2.24	-3.00
Median		4.00	1.00	-2.00
Mode		3	0	0
Range		35	14	34
Minimum		0	0	-25
Maximum		35	14	9
Sum		524	224	-300

(3b) COMPARISON GP: Confirmed Notifications In 3 Yrs Before and 3 Yrs After Referral. n=100 Fams.

Statistics COMP GP

		# CONF NOTS / FAM in 3YRS BEF REF	# CONF NOTS / FAM in 3YRS AFT REF	DIFF BET # CONF NOTS / FAM: 3YS AFT - 3YS BEF REF
N	Valid	100	100	100
	Missing	0	0	0
Mean		4.83	2.84	-1.99
Median		3.00	1.00	-1.50
Mode		2	0	-1
Range		25	17	32
Minimum		0	0	-20
Maximum		25	17	12
Sum		483	284	-199

Appendix 7.30

CONFIRMED NOTIFICATIONS 3 YRS AFTER REFERRAL: MAIN EFFECTS MODEL

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	NO CONF NOTS	80	40.0%
	1-2 CONF NOTS	51	25.5%
	3+ CONF NOTS	69	34.5%
(2) NOTS/FAM BEFORE REF (<=2; 3+)	0-2 NOTS/FAM	30	15.0%
	3+ NOTS/FAM	170	85.0%
(2) MO SUBABUSE : Y/N	MO: AoD ABUSE	89	44.5%
	NO REP. AoD ABUSE	111	55.5%
(2)No OF MALE CHN/FAM	0-2 MALE CHN/FAM	141	70.5%
	3+ MALE CHN/FAM	59	29.5%
Valid		200	100.0%
Missing		0	
Total		200	
Subpopulation		7	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	75.365			
Final	45.275	30.091	6	.000

Pseudo R-Square

Cox and Snell	.140
Nagelkerke	.158
McFadden	.070

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	45.275[a]	.000	0	.
tb4not02	56.708	11.434	2	.003
msubabyn	54.077	8.802	2	.012
malech2c	52.642	7.367	2	.025

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	NO CONF NOTS	1-2 CONF NOTS	3+ CONF NOTS	Percent Correct
NO CONF NOTS	43	0	37	53.8%
1-2 CONF NOTS	31	0	20	.0%
3+ CONF NOTS	15	0	54	78.3%
Overall Percentage	44.5%	.0%	55.5%	48.5%

Parameter Estimates

NTILES of CFAMRNOT3 REF: 3+ CONF NOTS[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO CONF NOTS	Intercept	-.425	.345	1.520	1	.218			
	[tb4not02=1]	2.016	.773	6.797	1	.009	7.510	1.649	34.2
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-.570	.352	2.626	1	.105	.566	.284	1.13
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
	[malech2c=1]	.969	.382	6.427	1	.011	2.635	1.246	5.57
	[malech2c=2]	0[b]	.	.	0	.	.	.	.
1-2 CONF NOTS	Intercept	-.540	.372	2.109	1	.146			
	[tb4not02=1]	2.005	.803	6.234	1	.013	7.425	1.539	35.8
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-1.177	.408	8.310	1	.004	.308	.138	.686
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
	[malech2c=1]	.823	.428	3.706	1	.054	2.278	.985	5.27
	[malech2c=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: 3+ CONF NOTS.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

NTILES of CFAMRNOT3 REF: 0 CONF NOTS[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
3+ CONF NOTS	Intercept	.425	.345	1.520	1	.218			
	[tb4not02=1]	-2.016	.773	6.797	1	.009	.133	.029	.606
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	.570	.352	2.626	1	.105	1.768	.888	3.52
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
	[malech2c=1]	-.969	.382	6.427	1	.011	.379	.179	.803
	[malech2c=2]	0[b]	.	.	0	.	.	.	.
1-2 CONF NOTS	Intercept	-.115	.389	.087	1	.768			
	[tb4not02=1]	-.011	.443	.001	1	.979	.989	.415	2.36
	[tb4not02=2]	0[b]	.	.	0	.	.	.	.
	[msubabyn=1]	-.608	.385	2.489	1	.115	.545	.256	1.16
	[msubabyn=2]	0[b]	.	.	0	.	.	.	.
	[malech2c=1]	-.146	.429	.116	1	.734	.864	.373	2.00
	[malech2c=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: NO CONF NOTS.

b. This parameter is set to zero because it is redundant.

Appendix 7.31

Notifications / Family Three Years after Referral * No. Chn per Family Diagnosed ADD/HD * Assessed Group and Comparison Group. (N=200 Families)

ADD/ADHD (DIAGNSD) / FAM n/y * NTILES of FAMRNOT3 - REF:5+ NOTS * MONT ASSD vs COMP GP Crosstabulation

MONT ASSD vs COMP GP				NTILES of FAMRNOT3 0-1 NOT	2-4 NOTS	5+ NOTS	Total
MONT ASST (AG)	ADD/HD / FAM	NO CH/N DIAG ADHD.	Count	30	26	17	73
			% within ADD/HD / FAM	41.1%	35.6%	23.3%	100.0%
		1 OR MORE CHN ADD/HD	Count	10	8	9	27
			% within ADD/HD / FAM	37.0%	29.6%	33.3%	100.0%
	Total		Count	40	34	26	100
			% within ADD/HD / FAM	40.0%	34.0%	26.0%	100.0%
NOT ASSD (CG)	ADD/HD / FAM	NO CH/N DIAG ADHD.	Count	27	24	20	71
			% within ADD/HD / FAM	38.0%	33.8%	28.2%	100.0%
		1 OR MORE CHN ADD/HD	Count	7	6	16	29
			% within ADD/HD / FAM	24.1%	20.7%	55.2%	100.0%
	Total		Count	34	30	36	100
			% within ADD/HD / FAM	34.0%	30.0%	36.0%	100.0%

Pearson Chi Square: Assd Gp Not Signif ; Comp Gp p= 0.038

Appendix 7.32

No. of Conf Notifications per Family Three Years after Referral * History of Maternal Substance Abuse * Assessed Group and Comparison Group. N=200 Families.

NTILES of CFAMRNOT3 REF: 3+ CONF NOTS * (2) MO SUBABUSE : Y/N * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) MO SUBABUSE : Y/N MO: AoD ABUSE	NO REP. AoD ABUSE	Total
ASSD GP	NTILES of CONF NOTS / FAM 3 YS AFT REF	NO CONF NOTS	Count	22	22	44
			% within NTILES of CFAMRNOT3	50.0%	50.0%	100.0%
		1-2 CONF NOTS	Count	9	16	25
			% within NTILES of CFAMRNOT3	36.0%	64.0%	100.0%
		3+ CONF NOTS	Count	18	13	31
			% within NTILES of CFAMRNOT3	58.1%	41.9%	100.0%
	Total		Count	49	51	100
			% within NTILES of CFAMRNOT3	49.0%	51.0%	100.0%
COMP GP	NTILES of CONF NOTS / FAM 3 YS AFT REF	NO CONF NOTS	Count	13	23	36
			% within NTILES of CFAMRNOT3	36.1%	63.9%	100.0%
		1-2 CONF NOTS	Count	6	20	26
			% within NTILES of CFAMRNOT3	23.1%	76.9%	100.0%
		3+ CONF NOTS	Count	21	17	38
			% within NTILES of CFAMRNOT3	55.3%	44.7%	100.0%
	Total		Count	40	60	100
			% within NTILES of CFAMRNOT3	40.0%	60.0%	100.0%

Pearson Chi Square: Assd Gp Not signif ; Comp Gp p= 0.030

Appendix 7.33

No. of Conf. Notifications per Family Three Years after Referral * No. Male Children / Family * Assd and Comp Gp. N=200 Fams

(2)No OF MALE CHN/FAM * NTILES of CFAMRNOT3 REF: 3+ CONF NOTS * MONT ASSD vs COMP GP Crosstabulation

MONT ASSD vs COMP GP				NTILES of CFAMRNOT3 REF: 3+ CONF NOTS			Total
				NO CONF NOTS	1-2 CONF NOTS	3+ CONF NOTS	
MONT ASST (AG)	(2)No OF MALE CHN/FAM	0-2 MALE CHN/FAM	Count	32	21	19	72
			% within No. MALE CHN/FAM	44.4%	29.2%	26.4%	100.0%
		3+ MALE CHN/FAM	Count	12	4	12	28
			% within No. MALE CHN/FAM	42.9%	14.3%	42.9%	100.0%
	Total		Count	44	25	31	100
			% within No. MALE CHN/FAM	44.0%	25.0%	31.0%	100.0%
NOT ASSD (CG)	(2)No OF MALE CHN/FAM	0-2 MALE CHN/FAM	Count	31	17	21	69
			% within No. MALE CHN/FAM	44.9%	24.6%	30.4%	100.0%
		3+ MALE CHN/FAM	Count	5	9	17	31
			% within No. MALE CHN/FAM	16.1%	29.0%	54.8%	100.0%
	Total		Count	36	26	38	100
			% within No. MALE CHN/FAM	36.0%	26.0%	38.0%	100.0%

Pearson Chi Square: Assd Gp Not sign ; Comp Gp p= 0.015

ABUSE TYPES OUTCOME : APPENDICES.

Appendix 7.34

ABUSE TYPE 3 YEARS AFTER REFERRAL: MAIN EFFECTS MODEL

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
ABUS / FAM 3 YRS AFT REF	NO ABUSE	52	30.6%
	SINGLE TYPE ABUSE	45	26.5%
	MULT ABUSE TYPES	73	42.9%
(2) NOTS/FAM BEFORE REF (<=2; 3+)	0-2 NOTS/FAM	25	14.7%
	3+ NOTS/FAM	145	85.3%
(2) AGE PRIMARY CARER	15-34 YRS	108	63.5%
	35 YRS+	62	36.5%
Valid		170	100.0%
Missing		30	
Total		200	
Subpopulation		4	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	54.319			
Final	36.831	17.487	4	.002

Pseudo R-Square

Cox and Snell	.098
Nagelkerke	.111
McFadden	.048

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	36.831[a]	.000	0	.
TB4NOT02	48.304	11.473	2	.003
AGEP1C2	43.957	7.126	2	.028

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	NO ABUSE	SINGLE TYPE ABUSE	MULT ABUSE TYPES	Percent Correct
NO ABUSE	13	0	39	25.0%
SINGLE TYPE ABUSE	8	0	37	.0%
MULT ABUSE TYPES	4	0	69	94.5%
Overall Percentage	14.7%	.0%	85.3%	48.2%

Parameter Estimates

ABUS / FAM 3 YRS AFT REF[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO ABUSE	Intercept	-.290	.329	.779	1	.377			
	[TB4NOT02=1	1.820	.611	8.862	1	.003	6.17	1.862	20.4
	[TB4NOT02=2	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	-.427	.401	1.131	1	.288	.653	.297	1.43
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.
SINGLE TYPE ABUSE	Intercept	-.004	.307	.000	1	.989			
	[TB4NOT02=1	1.515	.659	5.277	1	.022	4.55	1.249	16.6
	[TB4NOT02=2	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	-1.065	.404	6.956	1	.008	.345	.156	.761
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: MULT ABUSE TYPES.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

ABUS / FAM 3 YRS AFT REF[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
SINGLE TYPE ABUSE	Intercept	.286	.323	.785	1	.376			
	[TB4NOT02=1]	-.305	.516	.350	1	.554	.737	.268	2.03
	[TB4NOT02=2]	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	-.638	.423	2.278	1	.131	.528	.231	1.21
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.
MULT ABUSE TYPES	Intercept	.290	.329	.779	1	.377			
	[TB4NOT02=1]	-1.820	.611	8.862	1	.003	.162	.049	.537
	[TB4NOT02=2]	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	.427	.401	1.131	1	.288	1.532	.698	3.36
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: NO ABUSE.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

ABUS / FAM 3 YRS AFT REF[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
MULT ABUSE TYPES	Intercept	.004	.307	.000	1	.989			
	[TB4NOT02=1]	-1.515	.659	5.277	1	.022	.220	.060	.801
	[TB4NOT02=2]	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	1.065	.404	6.956	1	.008	2.901	1.31	6.401
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.
NO ABUSE	Intercept	-.286	.323	.785	1	.376			
	[TB4NOT02=1]	.305	.516	.350	1	.554	1.356	.494	3.727
	[TB4NOT02=2]	0[b]	.	.	0	.	.	.	.
	[AGEP1C2=1]	.638	.423	2.278	1	.131	1.893	.826	4.338
	[AGEP1C2=2]	0[b]	.	.	0	.	.	.	.

a. The reference category is: SINGLE TYPE ABUSE.

b. This parameter is set to zero because it is redundant.

Appendix 7.35

Notifications / Family Before Referral * Abuse Type Three Years After Referral * Assd and Comp Gp. (N = 200 Families)

(2) NOTS/FAM BEFORE REF (<=2; 3+) * ABUS / FAM 3 YRS AFT REF * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				ABUS / FAM 3 YRS AFT REF: NO ABUSE	SINGLE TYPE ABUSE	MULT ABUSE TYPES	Total
ASSD GP	NOTS / FAM BEF REF	0-2 NOTS / FAM	Count	9	3	4	16
			% within ABUS / FAM 3 YRS AFT REF	29.0%	10.7%	9.8%	16.0%
		3+ NOTS / FAM	Count	22	25	37	84
			% within ABUS / FAM 3 YRS AFT REF	71.0%	89.3%	90.2%	84.0%
	Total		Count	31	28	41	100
			% within ABUS / FAM 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%
COMP GP	NOTS / FAM BEF REF	0-2 NOTS / FAM	Count	7	7	0	14
			% within ABUS / FAM 3 YRS AFT REF	25.0%	31.8%	.0%	14.0%
		3+ NOTS / FAM	Count	21	15	50	86
			% within ABUS / FAM 3 YRS AFT REF	75.0%	68.2%	100.0%	86.0%
	Total		Count	28	22	50	100
			% within ABUS / FAM 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%

Pearson Chi Square: Assd Gp p=0.058 ; Comp Gp p= 0.000

Appendix 7.36

Abuse Type per Family 3 Years After Referral * Age group of Primary Carer. (N=170 Families)

(2) AGE PRIMARY CARER * ABUS / FAM 3 YRS AFT REF Crosstabulation

			ABUS / FAM 3 YRS AFT REF: NO ABUSE	SINGLE TYPE ABUSE	MULT ABUSE TYPES	Total
(2) AGE PRIMARY CARER	15-34 YRS	Count	34	22	52	108
		% within (2) AGE PRIMARY CARER	31.5%	20.4%	48.1%	100.0%
	35 YRS+	Count	18	23	21	62
		% within (2) AGE PRIMARY CARER	29.0%	37.1%	33.9%	100.0%
Total		Count	52	45	73	170
		% within (2) AGE PRIMARY CARER	30.6%	26.5%	42.9%	100.0%

Pearson Chi Square: p=0.047

Appendix 7.37

Relationship Between Abuse Type and Other Outcome Variables.

1. Abuse Type per Family 3 Years After Referral * Family Outcome 3 Years After Referral (N=181 Families)

Crosstab

			FAM OUTCOME 3 YRS AFT REF			Total
			FAM SIT IMPVD	FAM SIT NO DIFF	FAM SIT WORSE	
ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	35	6	5	46
		% within FAM OUTCOME 3 YRS AFT REF	47.3%	10.0%	10.6%	25.4%
	SINGLE TYPE ABUSE	Count	25	12	7	44
		% within FAM OUTCOME 3 YRS AFT REF	33.8%	20.0%	14.9%	24.3%
	MULT TYPE ABUSE	Count	14	42	35	91
		% within FAM OUTCOME 3 YRS AFT REF	18.9%	70.0%	74.5%	50.3%
Total		Count	74	60	47	181
		% within FAM OUTCOME 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%

Pearson Chi Square: p= 0.000

2. Abuse Type Per Family 3 Years After Referral * Ch/n's Outcome 3 Yrs After Referral (N=177 Families)

Crosstab

			CH/N'S OUTCOME 3 YRS AFT REF			Total
			CHN SIT IMPVD	CHN SIT NO DIFF	CHN SIT WRSE	
ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	34	1	12	47
		% within CH/N'S OUTCOME 3 YRS AFT REF	50.0%	11.1%	12.0%	26.6%
	SINGLE TYPE ABUSE	Count	22	3	20	45
		% within CH/N'S OUTCOME 3 YRS AFT REF	32.4%	33.3%	20.0%	25.4%
	MULT TYPE ABUSE	Count	12	5	68	85
		% within CH/N'S OUTCOME 3 YRS AFT REF	17.6%	55.6%	68.0%	48.0%
Total		Count	68	9	100	177
		% within CH/N'S OUTCOME 3 YRS AFT REF	100.0%	100.0%	100.0%	100.0%

Pearson Chi Square: p= 0.000

3. Abuse Type Per Family 3 Years After Referral * Legal Status 3 Yrs After Referral. (N=200 Families)

Crosstab

			LEG STAT/FAM 3 YRS AFT REFL			
			NO LEG. ORDS	S / ORDER	CUST ORD / WARD / MULT ORDS	Total
ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	40	7	12	59
		% within LEG STAT/FAM 3 YRS AFT REFL	37.4%	30.4%	17.1%	29.5%
	SINGLE TYPE ABUSE	Count	31	3	16	50
		% within LEG STAT/FAM 3 YRS AFT REFL	29.0%	13.0%	22.9%	25.0%
	MULT TYPE ABUSE	Count	36	13	42	91
		% within LEG STAT/FAM 3 YRS AFT REFL	33.6%	56.5%	60.0%	45.5%
Total		Count	107	23	70	200
		% within LEG STAT/FAM 3 YRS AFT REFL	100.0%	100.0%	100.0%	100%

Pearson Chi Square: p= 0.004

4. Abuse Type Per Family 3 Years After Referral * Children's Placement 3 Years After Referral (N=197 Fams)

Crosstab

			CHNS PLCT 3 YRS AFT REF			
			ALL CHN FAM HOME	SOME CHN OoHC	ALL CHN OoHC	Total
ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	38	13	8	59
		% within CHNS PLCT 3 YRS AFT REF	37.6%	19.7%	26.7%	29.9%
	SINGLE TYPE ABUSE	Count	26	18	4	48
		% within CHNS PLCT 3 YRS AFT REF	25.7%	27.3%	13.3%	24.4%
	MULT TYPE ABUSE	Count	37	35	18	90
		% within CHNS PLCT 3 YRS AFT REF	36.6%	53.0%	60.0%	45.7%
Total		Count	101	66	30	197
		% within CHNS PLCT 3 YRS AFT REF	100.0%	100.0%	100%	100%

Pearson Chi Square: p= 0.038

Appendix 7.38

"*PARENTAL SUBSTANCE ABUSE, MENTAL HEATH ISSUES, DEVELOPMENTAL DISABILITY OR DUAL DIAGNOSIS*": OUTCOME MODELS

1. Main Effects Model For Dependent Variable: Children's Placement Three Years after Referral and Independent Variable: *Parental Substance Abuse, Mental Heath Issues, Developmental Disability or Dual Diagnosis.*
(N=197 Families)

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
CH/NS PLCT 3 YRS AFT REFERRAL- FAM vs OoHC - REF: ALL OoHC	ALL CHN IN FAM HOME	101	51.3%
	SOME CHN IN OoHC (EXT FAM/SUB CARE)	66	33.5%
	ALL CHN IN OoHC (EXT FAM/SUB CARE)	30	15.2%
(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	P. D&A ISSUES	36	18.3%
	P. MENTAL HEALTH ISSUES	44	22.3%
	P. DEVELOPMENTAL DISABILITY	15	7.6%
	DUAL DIAG -D&A+/-DD+/-MHLTH	22	11.2%
	NO P. D&A, MENTAL HLTH OR DD ISSUES	80	40.6%
Valid		197	100.0%
Missing		3	
Total		200	
Subpopulation		5	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	62.804			
Final	34.606	28.198	8	.000

Pseudo R-Square

Cox and Snell	.133
Nagelkerke	.154
McFadden	.072

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	34.606[a]	.000	0	.
RPDAMHDD	62.804	28.198	8	.000

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted			
	ALL CHN IN FAM HOME	SOME CHN IN OoHC (EXT FAM/SUB CARE)	ALL CHN IN OoHC (EXT FAM/SUB CARE)	Percent Correct
ALL CHN IN FAM HOME	89	12	0	88.1%
SOME CHN IN OoHC (EXT FAM/SUB CARE)	53	13	0	19.7%
ALL CHN IN OoHC (EXT FAM/SUB CARE)	19	11	0	.0%
Overall Percentage	81.7%	18.3%	.0%	51.8%

Parameter Estimates

CH/NS PLCT 3 YRS AFT REFERRAL-FAM vs OoHC - REF: ALL FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN IN OoHC (EXT FAM/SUB CARE)	Intercept	-3.135	.722	18.8	1	.000			
	[RPDAMHDD=1]	3.048	.834	13.4	1	.000	21.08	4.110	108
	[RPDAMHDD=2]	1.708	.853	4.007	1	.045	5.520	1.036	29.4
	[RPDAMHDD=3]	2.442	.947	6.652	1	.010	11.50	1.797	73.6
	[RPDAMHDD=4]	2.779	.874	10.1	1	.001	16.10	2.901	89.4
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
SOME CHN IN OoHC (EXT FAM/SUB CARE)	Intercept	-.363	.230	2.485	1	.115			
	[RPDAMHDD=1]	.443	.462	.920	1	.337	1.557	.630	3.850
	[RPDAMHDD=2]	-.291	.412	.498	1	.480	.748	.333	1.677
	[RPDAMHDD=3]	-.618	.715	.747	1	.388	.539	.133	2.189
	[RPDAMHDD=4]	-.330	.594	.309	1	.578	.719	.224	2.303
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN IN FAM HOME.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CH/NS PLCT 3 YRS AFT REFERRAL-FAM vs OoHC - REF: ALL OoHC[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN IN FAM HOME	Intercept	3.135	.722	18.84	1	.000			
	[RPDAMHDD=1]	-3.048	.834	13.35	1	.000	.047	.009	.243
	[RPDAMHDD=2]	-1.708	.853	4.007	1	.045	.181	.034	.965
	[RPDAMHDD=3]	-2.442	.947	6.652	1	.010	.087	.014	.556
	[RPDAMHDD=4]	-2.779	.874	10.10	1	.001	.062	.011	.345
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
SOME CHN IN OoHC (EXT FAM/SUB CARE)	Intercept	2.773	.729	14.47	1	.000			
	[RPDAMHDD=1]	-2.606	.836	9.711	1	.002	.074	.014	.380
	[RPDAMHDD=2]	-1.999	.880	5.159	1	.023	.135	.024	.760
	[RPDAMHDD=3]	-3.060	1.056	8.402	1	.004	.047	.006	.371
	[RPDAMHDD=4]	-3.109	.935	11.06	1	.001	.045	.007	.279
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: ALL CHN IN OoHC (EXT FAM/SUB CARE).

b. This parameter is set to zero because it is redundant.

Parameter Estimates

CH/NS PLCT 3 YRS AFT REFERRAL-REF : SOME OoHC/SOME FAM[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
ALL CHN IN FAM HOME	Intercept	.363	.230	2.485	1	.115			
	[RPDAMHDD=1]	-.443	.462	.920	1	.337	.642	.260	1.59
	[RPDAMHDD=2]	.291	.412	.498	1	.480	1.338	.596	3.00
	[RPDAMHDD=3]	.618	.715	.747	1	.388	1.855	.457	7.53
	[RPDAMHDD=4]	.330	.594	.309	1	.578	1.391	.434	4.46
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
ALL CHN IN OoHC (EXT FAM/SUB CARE)	Intercept	-2.773	.729	14.5	1	.000			
	[RPDAMHDD=1]	2.606	.836	9.711	1	.002	13.5	2.63	69.7
	[RPDAMHDD=2]	1.999	.880	5.159	1	.023	7.385	1.32	41.5
	[RPDAMHDD=3]	3.060	1.056	8.402	1	.004	21.3	2.69	169
	[RPDAMHDD=4]	3.109	.935	11.1	1	.001	22.4	3.58	140
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: SOME CHN IN OoHC (EXT FAM/SUB CARE).

b. This parameter is set to zero because it is redundant.

2. Main Effects Model For Dependent Variable: Children's Legal Status Three Years After Referral and Independent Variable: *Parental Substance Abuse, Mental Heath Issues, Developmental Disability Or Dual Diagnosis*[*].

Nominal Regression

Case Processing Summary

		N	Marginal Percentage
(4) LEG STAT 3 YRS AFT REFL-REF:MULT ORDS	NO LEG.ORDS	107	53.5%
	S/ORDER	23	11.5%
	CUST ORD / WARD	53	26.5%
	MULT ORDR TYPES	17	8.5%
(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	P. D&A ISSUES	38	19.0%
	P. MENTAL HEALTH ISSUES	44	22.0%
	P. DEVELOPMENTAL DISABILITY	15	7.5%
	DUAL DIAG -D&A+/-DD+/-MHLTH	22	11.0%
	NO P. D&A, MENTAL HLTH OR DD ISSUES	81	40.5%
Valid		200	100.0%
Missing		0	
Total		200	
Subpopulation		5	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	69.252			
Final	46.897	22.354	12	.034

Pseudo R-Square

Cox and Snell	.106
Nagelkerke	.118
McFadden	.049

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	46.897[a]	.000	0	.
RPDAMHDD	69.252	22.354	12	.034

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Classification

Observed	Predicted				
	NO LEG.ORDS	S/ORDER	CUST ORD / WARD	MULT ORDR TYPES	Percent Correct
NO LEG.ORDS	107	0	0	0	100.0%
S/ORDER	23	0	0	0	.0%
CUST ORD / WARD	53	0	0	0	.0%
MULT ORDR TYPES	17	0	0	0	.0%
Overall Percentage	100.0%	.0%	.0%	.0%	53.5%

[*] Dual Diagnosis in this context refers to the presence of any two or more of the parental issues in this variable.

Parameter Estimates

(4) LEGSTAT 3YRS AFTER REFL- REF: NO ORDERS [a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
S/ORDER	Intercept	-1.852	.380	23.73	1	.000			
	[RPDAMHDD=1]	.312	.741	.177	1	.674	1.37	.320	5.84
	[RPDAMHDD=2]	.713	.556	1.642	1	.200	2.04	.685	6.07
	[RPDAMHDD=3]	1.159	.803	2.085	1	.149	3.19	.661	15.4
	[RPDAMHDD=4]	-.546	1.112	.241	1	.624	.580	.066	5.12
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
CUST ORD / WARD	Intercept	-.987	.269	13.50	1	.000			
	[RPDAMHDD=1]	.833	.476	3.058	1	.080	2.30	.904	5.85
	[RPDAMHDD=2]	-.152	.487	.097	1	.755	.859	.331	2.23
	[RPDAMHDD=3]	.805	.662	1.477	1	.224	2.24	.611	8.20
	[RPDAMHDD=4]	.787	.524	2.257	1	.133	2.20	.787	6.13
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
MULT ORDR TYPES	Intercept	-2.833	.594	22.74	1	.000			
	[RPDAMHDD=1]	2.391	.732	10.68	1	.001	10.9	2.60	45.9
	[RPDAMHDD=2]	.713	.852	.700	1	.403	2.04	.384	10.8
	[RPDAMHDD=3]	1.041	1.233	.714	1	.398	2.83	.253	31.7
	[RPDAMHDD=4]	.435	1.202	.131	1	.717	1.55	.147	16.3
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: NO LEG.ORDS .

b. This parameter is set to zero because it is redundant.

Parameter Estimates

(4) LEG STAT 3 YRS AFT REFL - REF:CUST / WARD[a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO LEG.ORDS	Intercept	.987	.269	13.496	1	.000			
	[RPDAMHDD=1]	-.833	.476	3.058	1	.080	.435	.171	1.11
	[RPDAMHDD=2]	.152	.487	.097	1	.755	1.16	.448	3.02
	[RPDAMHDD=3]	-.805	.662	1.477	1	.224	.447	.122	1.64
	[RPDAMHDD=4]	-.787	.524	2.257	1	.133	.455	.163	1.27
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
S/ORDER	Intercept	-.865	.421	4.212	1	.040			
	[RPDAMHDD=1]	-.521	.771	.457	1	.499	.594	.131	2.69
	[RPDAMHDD=2]	.865	.654	1.750	1	.186	2.38	.659	8.56
	[RPDAMHDD=3]	.354	.843	.176	1	.674	1.42	.273	7.44
	[RPDAMHDD=4]	-1.332	1.135	1.377	1	.241	.264	.029	2.44
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
MULT ORDR TYPES	Intercept	-1.846	.621	8.827	1	.003			
	[RPDAMHDD=1]	1.558	.762	4.183	1	.041	4.75	1.1	21.1
	[RPDAMHDD=2]	.865	.919	.886	1	.347	2.37	.392	14.4
	[RPDAMHDD=3]	.236	1.259	.035	1	.851	1.27	.107	14.9
	[RPDAMHDD=4]	-.351	1.224	.082	1	.774	.704	.064	7.74
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: CUST ORD / WARD.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

(4) LEG STAT 3 YRS AFT REFL-REF: MULT ORDS [a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO LEG.ORDS	Intercept	2.833	.594	22.74	1	.000			
	[RPDAMHDD=1]	-2.391	.732	10.68	1	.001	.092	.022	.384
	[RPDAMHDD=2]	-.713	.852	.700	1	.403	.490	.092	2.605
	[RPDAMHDD=3]	-1.041	1.233	.714	1	.398	.353	.032	3.954
	[RPDAMHDD=4]	-.435	1.202	.131	1	.717	.647	.061	6.819
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
S/ORDER	Intercept	.981	.677	2.099	1	.147			
	[RPDAMHDD=1]	-2.079	.950	4.790	1	.029	.125	.019	.805
	[RPDAMHDD=2]	.000	.957	.000	1	1.00	1.000	.153	6.531
	[RPDAMHDD=3]	.118	1.339	.008	1	.930	1.125	.082	15.506
	[RPDAMHDD=4]	-.981	1.568	.391	1	.532	.375	.017	8.103
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
CUST ORD / WARD	Intercept	1.846	.621	8.827	1	.003			
	[RPDAMHDD=1]	-1.558	.762	4.183	1	.041	.211	.047	.937
	[RPDAMHDD=2]	-.865	.919	.886	1	.347	.421	.070	2.550
	[RPDAMHDD=3]	-.236	1.259	.035	1	.851	.789	.067	9.317
	[RPDAMHDD=4]	.351	1.224	.082	1	.774	1.421	.129	15.635
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: MULT ORDR TYPES.

b. This parameter is set to zero because it is redundant.

Parameter Estimates

(4) LEG STAT 3 YRS AFT REFL - REF:SUP ORD [a]		B	Std. Error	Wald	df	Sig.	Exp (B)	95% Confidence Interval for Exp(B) Lower Bound	Upper Bound
NO LEG. ORDS	Intercept	1.852	.380	23.728	1	.000			
	[RPDAMHDD=1]	-.312	.741	.177	1	.674	.732	.171	3.13
	[RPDAMHDD=2]	-.713	.556	1.642	1	.200	.490	.165	1.46
	[RPDAMHDD=3]	-1.159	.803	2.085	1	.149	.314	.065	1.51
	[RPDAMHDD=4]	.546	1.112	.241	1	.624	1.725	.195	15.2
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
CUST ORD WRD	Intercept	.865	.421	4.212	1	.040			
	[RPDAMHDD=1]	.521	.771	.457	1	.499	1.684	.372	7.63
	[RPDAMHDD=2]	-.865	.654	1.750	1	.186	.421	.117	1.52
	[RPDAMHDD=3]	-.354	.843	.176	1	.674	.702	.134	3.66
	[RPDAMHDD=4]	1.332	1.135	1.377	1	.241	3.789	.410	35.1
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.
MULT ORDR TYPES	Intercept	-.981	.677	2.099	1	.147			
	[RPDAMHDD=1]	2.079	.950	4.790	1	.029	8.000	1.2	51.5
	[RPDAMHDD=2]	.000	.957	.000	1	1.000	1.000	.153	6.53
	[RPDAMHDD=3]	-.118	1.339	.008	1	.930	.889	.064	12.3
	[RPDAMHDD=4]	.981	1.568	.391	1	.532	2.667	.123	57.6
	[RPDAMHDD=5]	0[b]	.	.	0	.	.	.	.

a. The reference category is: S/ORDER.

b. This parameter is set to zero because it is redundant.

Appendix 8.1

8. IMPACT OF MONTROSE ASSESSMENT ON FAMILIES WITH FACTORS ASSOCIATED WITH POOR CHILD PROTECTION OUTCOME.

1. Family Outcome * No. of Male Children per Family * Assd Group and Comp. Group. (N=181 Fams.) (Assd Gp n =97; Comp Gp n =84.

FAM OUTCOME 3 YRS AFT REF * (2)No OF MALE CHN/FAM * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2)No OF MALE CHN/FAM		Total
				0-2 MALE CHN/FAM	3+ MALE CHN/FAM	
ASSD GP	FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	6	7	13
			% within (2)No OF MALE CHN/FAM	8.7%	25.0%	13.4%
		FAM SIT NO DIFF	Count	12	10	22
			% within (2)No OF MALE CHN/FAM	17.4%	35.7%	22.7%
		FAM SIT IMPVD	Count	51	11	62
			% within (2)No OF MALE CHN/FAM	73.9%	39.3%	63.9%
	Total		Count	69	28	97
			% within (2)No OF MALE CHN/FAM	100.0%	100.0%	100.0%
COMP GP	FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	24	10	34
			% within (2)No OF MALE CHN/FAM	42.1%	37.0%	40.5%
		FAM SIT NO DIFF	Count	23	15	38
			% within (2)No OF MALE CHN/FAM	40.4%	55.6%	45.2%
		FAM SIT IMPVD	Count	10	2	12
			% within (2)No OF MALE CHN/FAM	17.5%	7.4%	14.3%
	Total		Count	57	27	84
			% within (2)No OF MALE CHN/FAM	100.0%	100.0%	100.0%

Pearson Chi-square: Mont Assd Gp: p = 0.005; Comp Gp not signif.

2. Family Outcome * No. Confirmed Notifications per Family * Assd Group and Comp Gp. (N=181 families).

FAM OUTCOME 3 YRS AFT REF * CONF NOTS / FAM BEF REFL (<=4;5+) * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				CONF NOTS / FAM BEF REFL (<=4;5+)		Total
				0-4 CONF NOTS/FAM	5+ CONF NOT/FAM	
ASSD GP	FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	3	10	13
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	6.7%	19.2%	13.4%
		FAM SIT NO DIFF	Count	5	17	22
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	11.1%	32.7%	22.7%
		FAM SIT IMPVD	Count	37	25	62
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	82.2%	48.1%	63.9%
	Total		Count	45	52	97
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	100.0%	100.0%	100.0%
COMP GP	FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	Count	11	23	34
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	33.3%	45.1%	40.5%
		FAM SIT NO DIFF	Count	16	22	38
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	48.5%	43.1%	45.2%
		FAM SIT IMPVD	Count	6	6	12
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	18.2%	11.8%	14.3%
	Total		Count	33	51	84
			% within CONF NOTS / FAM BEF REFL (<=4;5+)	100.0%	100.0%	100.0%

Pearson Chi Square: Assd Gp p= 0. 002; Comp Gp: not signif.

3. Family Outcome * Current DV at Referral * Assessed Group and Comp Group. (N=181 Families)

FAM OUTCOME 3 YRS AFT REF * CURRENT DV / FAM Y/N * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				CURRENT DV / FAM Y/N: CURR DV (+/- PAST)	CURRENT DV / FAM Y/N: NO KNOWN CURRENT DV	Total
ASSD GP	FAM OUT-COME 3 YRS AFT REF	FAM SIT WRSE	Count	7	6	13
			% within CURRENT DV / FAM Y/N	16.7%	10.9%	13.4%
		FAM SIT NO DIFF	Count	11	11	22
			% within CURRENT DV / FAM Y/N	26.2%	20.0%	22.7%
		FAM SIT IMPVD	Count	24	38	62
			% within CURRENT DV / FAM Y/N	57.1%	69.1%	63.9%
	Total		Count	42	55	97
			% within CURRENT DV / FAM Y/N	100.0%	100.0%	100.0%
COMP GP	FAM OUT-COME 3 YRS AFT REF	FAM SIT WRSE	Count	20	14	34
			% within CURRENT DV / FAM Y/N	57.1%	28.6%	40.5%
		FAM SIT NO DIFF	Count	12	26	38
			% within CURRENT DV / FAM Y/N	34.3%	53.1%	45.2%
		FAM SIT IMPVD	Count	3	9	12
			% within CURRENT DV / FAM Y/N	8.6%	18.4%	14.3%
	Total		Count	35	49	84
			% within CURRENT DV / FAM Y/N	100.0%	100.0%	100.0%

Pearson Chi Square: Assd Gp Not signif; Comp Gp p= 0.029

4. Legal Status / family three years after referral * Mother's Substance Abuse, Past or Current * Assd Group and Comp Group. N= 200 Families

LEG STAT/FAM 3 YRS AFT REFL * (2) MO SUBABUSE : Y/N * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) MO SUBABUSE : Y/N: MO: AoD ABUSE	(2) MO SUBABUSE : Y/N: NO REP. AoD ABUSE	Total
ASSD GP	LEG STAT/FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	29	29	58
			% within (2) MO SUBABUSE : Y/N	59.2%	56.9%	58.0%
		S/ORDER	Count	4	13	17
			% within (2) MO SUBABUSE : Y/N	8.2%	25.5%	17.0%
		CUST ORD/ WARD/MULT ORDS	Count	16	9	25
			% within (2) MO SUBABUSE : Y/N	32.7%	17.6%	25.0%
	Total		Count	49	51	100
			% within (2) MO SUBABUSE : Y/N	100.0%	100.0%	100.0%
COMP GP	LEG STAT/FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	17	32	49
			% within (2) MO SUBABUSE : Y/N	42.5%	53.3%	49.0%
		S/ORDER	Count	2	4	6
			% within (2) MO SUBABUSE : Y/N	5.0%	6.7%	6.0%
		CUST ORD/ WARD/MULT ORDS	Count	21	24	45
			% within (2) MO SUBABUSE : Y/N	52.5%	40.0%	45.0%
	Total		Count	40	60	100
			% within (2) MO SUBABUSE : Y/N	100.0%	100.0%	100.0%

Pearson Chi Square: Assd Gp p= 0.035 ; Comp Gp n/s.
Pearson Chi Square: Assd Gp p= 0.035; Comp Gp Not signif.

5. Children's Placement three years after referral * History of Plct at Referral * Assd Gp and Comp Gp. (N=197 Families: AG= 100 fams; CG =97 Fams.)

CHNS PLCT 3 YRS AFT REF * (3) CHNS PLCT BEF REF * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(3) CHNS PLCT BEF REF			Total
				FAM HOME	FAM + EXTD FAM	FAM+SUB CARE	
ASSD GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	23	9	23	55
			% within CHNS PLCT 3 YRS AFT REF	41.8%	16.4%	41.8%	100.0%
		SOME CHN OoHC	Count	11	3	17	31
			% within CHNS PLCT 3 YRS AFT REF	35.5%	9.7%	54.8%	100.0%
		ALL CHN OoHC	Count	1	0	13	14
			% within CHNS PLCT 3 YRS AFT REF	7.1%	.0%	92.9%	100.0%
	Total		Count	35	12	53	100
			% within CHNS PLCT 3 YRS AFT REF	35.0%	12.0%	53.0%	100.0%
COMP GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	20	10	16	46
			% within CHNS PLCT 3 YRS AFT REF	43.5%	21.7%	34.8%	100.0%
		SOME CHN OoHC	Count	10	9	16	35
			% within CHNS PLCT 3 YRS AFT REF	28.6%	25.7%	45.7%	100.0%
		ALL CHN OoHC	Count	5	2	9	16
			% within CHNS PLCT 3 YRS AFT REF	31.3%	12.5%	56.3%	100.0%
	Total		Count	35	21	41	97
			% within CHNS PLCT 3 YRS AFT REF	36.1%	21.6%	42.3%	100.0%

Pearson Chi Square: Assd Gp p= 0.017; Comp Gp N/S.

6. No. of Notifications / Family Three Years after Referral * No. of Notifications / Family before referral (0-2;3+) * Assd Group and Comp Group. N=200 families.

NTILES of FAMRNOT3 - REF:5+ NOTS * (2) NOTS/FAM BEFORE REF (<=2; 3+) * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) NOTS/FAM BEFORE REF (<=2; 3+)		Total
				0-2 NOTS/FAM	3+ NOTS/FAM	
ASSD GP	NTILES of FAMRNOT3 - REF:5+ NOTS	0-1 NOT	Count	10	30	40
			% within NTILES of FAMRNOT3	25.0%	75.0%	100.0%
		2-4 NOTS	Count	5	29	34
			% within NTILES of FAMRNOT3	14.7%	85.3%	100.0%
		5+ NOTS	Count	1	25	26
			% within NTILES of FAMRNOT3	3.8%	96.2%	100.0%
	Total		Count	16	84	100
			% within NTILES of FAMRNOT3	16.0%	84.0%	100.0%
COMP GP	NTILES of FAMRNOT3 - REF:5+ NOTS	0-1 NOT	Count	8	26	34
			% within NTILES of FAMRNOT3	23.5%	76.5%	100.0%
		2-4 NOTS	Count	4	26	30
			% within NTILES of FAMRNOT3	13.3%	86.7%	100.0%
		5+ NOTS	Count	2	34	36
			% within NTILES of FAMRNOT3	5.6%	94.4%	100.0%
	Total		Count	14	86	100
			% within NTILES of FAMRNOT3	14.0%	86.0%	100.0%

Pearson Chi Square: Assd Gp p= 0.070; Comp Gp p= 0.095
Pearson Chi Square: Assd Gp p= 0.070; Comp Gp p= 0.095.

7. No. of Confirmed Notifications / Family Three Years After Referral * No. of Notifications / Family At Referral * Assd Group and Comp Group. N=200 families

NTILES of CFAMRNOT3 REF: 3+ CONF NOTS * (2) NOTS/FAM BEFORE REF (<=2; 3+) * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) NOTS/FAM BEFORE REF (<=2; 3+) 0-2 NOTS/FAM	3+ NOTS/FAM	Total
ASSD GP	NTILES of CONF NOTS 3YA	NO CONF NOTS	Count	10	34	44
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	22.7%	77.3%	100.0%
		1-2 CONF NOTS	Count	5	20	25
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	20.0%	80.0%	100.0%
		3+ CONF NOTS	Count	1	30	31
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	3.2%	96.8%	100.0%
	Total		Count	16	84	100
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	16.0%	84.0%	100.0%
COMP GP	NTILES of CONF NOTS 3YA	NO CONF NOTS	Count	7	29	36
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	19.4%	80.6%	100.0%
		1-2 CONF NOTS	Count	6	20	26
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	23.1%	76.9%	100.0%
		3+ CONF NOTS	Count	1	37	38
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	2.6%	97.4%	100.0%
	Total		Count	14	86	100
			% within NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	14.0%	86.0%	100.0%

Pearson Chi Square: Assd Gp p= 0.063 ; Comp Gp p= 0.034

8. Type of Abuse * Age of Primary Caregiver * Assd Group and Comp Group. (N=170 Families: Assessed Group = 100 fams; Comparison Group =70 Fams.)

ABUS / FAM 3 YRS AFT REF * (2) AGE PRIMARY CARER * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				(2) AGE PRIMARY CARER 15-34 YRS	35 YRS+	Total
ASSD GP	ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	21	10	31
			% within ABUS / FAM 3 YRS AFT REF	67.7%	32.3%	100.0%
		SINGLE TYPE ABUSE	Count	13	15	28
			% within ABUS / FAM 3 YRS AFT REF	46.4%	53.6%	100.0%
		MULT ABUSE TYPES	Count	27	14	41
			% within ABUS / FAM 3 YRS AFT REF	65.9%	34.1%	100.0%
	Total		Count	61	39	100
			% within ABUS / FAM 3 YRS AFT REF	61.0%	39.0%	100.0%
COMP GP	ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	13	8	21
			% within ABUS / FAM 3 YRS AFT REF	61.9%	38.1%	100.0%
		SINGLE TYPE ABUSE	Count	9	8	17
			% within ABUS / FAM 3 YRS AFT REF	52.9%	47.1%	100.0%
		MULT ABUSE TYPES	Count	25	7	32
			% within ABUS / FAM 3 YRS AFT REF	78.1%	21.9%	100.0%
	Total		Count	47	23	70
			% within ABUS / FAM 3 YRS AFT REF	67.1%	32.9%	100.0%

Pearson Chi Square: N/Sig.

Appendix 8.2

MONTROSE RECOMMENDATIONS FOR THE 100 ASSESSED FAMILIES
(N= 100 Families; n = 800 potential recommendations - up to 8/ family)

CATEGORY LABEL	COUNT	PCT OF INTERVENTION TYPES	PCT OF CASES
Family Support Service: support &/ or training	130	17.9	130.0*
Parent: assessment / counselling	93	12.8	93.0
Docs co-ordinate / review caseplan	73	10.1	73.0
Ch/n: assessment /counselling	73	10.1	73.0
Other recommendation	46	6.3	46.0
Paediatric assessment / review	42	5.8	42.0
Preschool / family day care / playgroup	36	5.0	36.0
Child: educational intervention	31	4.3	31.0
Parent: Undertakings (Informal; or Formal - as part of a Supervision Order)	30	4.1	30.0
After school &/or holiday activities	29	4.0	29.0
Supervision Order	**27**	**3.7**	27.0
Parent & chn: counselling (various types, including mental health, sexual assault)	26	3.6	26.0
DoCS review current legal order if no change in X# (1 / 3 / 6) months	23	3.2	23.0
Other DoCS action required	13	1.8	13.0
Short Term Wardship Order (< 2 yrs)	**12**	**1.7**	12.0
Speech assessment /review	9	1.2	9.0
Alternate placement if no change in X# (1 / 3 / 6) months	7	1.0	7.0
Long Term Wardship Order (2->18 yrs)	**5**	**.7**	5.0
Parent drug & alcohol intervention (Detox; rehab; assessment ; counselling)	5	.7	5.0
Parent: health intervention	5	.7	5.0
Chn: respite care /support worker / mentor	5	.7	5.0
Custody Order (usually to other family member)	**4**	**.6**	4.0
Ch/n: Immediate removal- Care Order to DoCS	**1**	**1**	1.0
Child/young person: D&A intervention	1	.1	1.0
Total responses	**726**	**100.0**	**726.0**

100 valid cases (Assessed Group) ; 100 missing cases (Comparison Group)

∗*Total may exceed 100% as more than one type of Intervention in a category may be recommended per family*

9. DISCUSSION AND CONCLUSIONS

Appendix 9.1

Primary Caregiver Aged 15-34 Years * Number Of Children

NO. CHN IN FAMILY AT REF/ASST

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	18.5	18.5	18.5
	2	33	30.6	30.6	49.1
	3	24	22.2	22.2	71.3
	4	19	17.6	17.6	88.9
	5	5	4.6	4.6	93.5
	6	4	3.7	3.7	97.2
	7	1	.9	.9	98.1
	8	1	.9	.9	99.1
	9	1	.9	.9	100.0
	Total	108	100.0	100.0	

Appendix 9.2

Parental Developmental Disability * Outcome Categories

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
FAM OUTCOME 3 YRS AFT REF	FAM SIT WRSE	4	4
	FAM SIT NO DIFF	7	7
	FAM SIT IMPVD	4	4
Total		15	15

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
CH/N'S OUTCOME 3 YRS AFT REF	CHN SIT WRSE	8	8
	CHN SIT NO DIFF	2	2
	CHN SIT IMPVD	4	4
Total		14	14

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
LEG STAT/FAM 3 YRS AFT REFL	S/ORDER	3	3
	CUST ORD/WARD/MULT ORDS	6	6
	NO LEG.ORDS	6	6
Total		15	15

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
CHNS PLCT 3 YRS AFT REF	ALL CHN OoHC	4	4
	SOME CHN OoHC	3	3
	ALL CHN FAM HOME	8	8
Total		15	15

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
NTILES of FAMRNOT3 - REF:0-1 NOTS	5+ NOTS	8	8
	2-4 NOTS	6	6
	0-1 NOT	1	1
Total		15	15

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
NTILES of CFAMRNOT3 REF: 0 CONF NOTS	3+ CONF NOTS	7	7
	1-2 CONF NOTS	4	4
	NO CONF NOTS	4	4
Total		15	15

Crosstab

Count

		(R) PAR D&A/M HLTH/DEV DIS/DUAL DIAG	
		P. DEVELOPMENTAL DISABILITY	Total
ABUS / FAM 3 YRS AFT REF	SINGLE TYPE ABUSE	3	3
	MULT ABUSE TYPES	11	11
	NO ABUSE	1	1
Total		15	15

Appendix 9.3

Primary Presenting Problem * Legal Orders Three Years After Referral

PRIM. PRES PROBLEM * LEG STAT/FAM 3 YRS AFT REFL Crosstabulation

			LEG STAT/FAM 3 YRS AFT REFL			
			NO LEG.ORDS	S/ORDER	CUST ORD/WARD/ MULT ORDS	Total
PRIM. PRES PROBLEM	P NOT MANAGE CH/N BEH.	Count	49	3	17	69
		% within PRIM. PRES PROBLEM	71.0%	4.3%	24.6%	100.0%
	CHRON/SEV. NEGLECT	Count	14	5	13	32
		% within PRIM. PRES PROBLEM	43.8%	15.6%	40.6%	100.0%
	SEVERE PHYS ABUS	Count	8	4	7	19
		% within PRIM. PRES PROBLEM	42.1%	21.1%	36.8%	100.0%
	P MHlth->Ch SFTY/W/BNG	Count	13	5	6	24
		% within PRIM. PRES PROBLEM	54.2%	20.8%	25.0%	100.0%
	P D&A ->Ch SFTY/W/BNG	Count	6	2	8	16
		% within PRIM. PRES PROBLEM	37.5%	12.5%	50.0%	100.0%
	CH/N SEXUAL ABUSE	Count	0	2	3	5
		% within PRIM. PRES PROBLEM	.0%	40.0%	60.0%	100.0%
	P.DEV DIS->Ch SFTY/ W/B	Count	4	0	5	9
		% within PRIM. PRES PROBLEM	44.4%	.0%	55.6%	100.0%
Total		Count	94	21	59	174
		% within PRIM. PRES PROBLEM	54.0%	12.1%	33.9%	100.0%

Pearson Chi square: p=0.012

Appendix 9.4

Primary Presenting Problem * Placement Three Years After Referral

PRIM. PRES PROBLEM * CHNS PLCT 3 YRS AFT REF Crosstabulation

			CHNS PLCT 3 YRS AFT REF			
			ALL CHN FAM HOME	SOME CHN OoHC	ALL CHN OoHC	Total
PRIM. PRES PROBLEM	P NOT MANAGE CH/N BEH.	Count	37	26	4	67
		% within PRIM. PRES PROBLEM	55.2%	38.8%	6.0%	100.0%
	CHRON/SEV. NEGLECT	Count	15	11	6	32
		% within PRIM. PRES PROBLEM	46.9%	34.4%	18.8%	100.0%
	SEVERE PHYS ABUS	Count	10	8	1	19
		% within PRIM. PRES PROBLEM	52.6%	42.1%	5.3%	100.0%
	P MHlth->Ch SFTY/W/BNG	Count	13	5	6	24
		% within PRIM. PRES PROBLEM	54.2%	20.8%	25.0%	100.0%
	P D&A ->Ch SFTY/W/BNG	Count	6	2	8	16
		% within PRIM. PRES PROBLEM	37.5%	12.5%	50.0%	100.0%
	CH/N SEXUAL ABUSE	Count	2	3	0	5
		% within PRIM. PRES PROBLEM	40.0%	60.0%	.0%	100.0%
	P.DEV DIS->Ch SFTY/ W/B	Count	3	2	4	9
		% within PRIM. PRES PROBLEM	33.3%	22.2%	44.4%	100.0%
Total		Count	86	57	29	172
		% within PRIM. PRES PROBLEM	50.0%	33.1%	16.9%	100.0%

Pearson Chi square p=0.003

Appendix 9.5
Parent's Mental Health * Outcomes * Assessed Group and Comparison Group

Crosstab

Count

ASSD vs COMP GP			FAM OUTCOME 3 YRS AFT REF			Total
			FAM SIT WRSE	FAM SIT NO DIFF	FAM SIT IMPVD	
ASSD GP	PAR MENTAL HEALTH: PRIM/SEC PRES PROB	PAR MENTAL HEALTH	2	7	32	41
		OTHER	11	15	30	56
	Total		13	22	62	97
COMP GP	PAR MENTAL HEALTH: PRIM/SEC PRES PROB	PAR MENTAL HEALTH	11	15	6	32
		OTHER	23	23	6	52
	Total		34	38	12	84

Pearson Chi square Assd Gp p=0.029; Comp Gp: Not sig.

Crosstab

Count

ASSD vs COMP GP			CH/N'S OUTCOME 3 YRS AFT REF			Total
			CHN SIT WRSE	CHN SIT NO DIFF	CHN SIT IMPVD	
ASSD GP	PAR MENTAL HEALTH: PRIM/SEC PRES PROB	PAR MENTAL HEALTH	11	1	29	41
		OTHER	30	2	25	57
	Total		41	3	54	98
COMP GP	PAR MENTAL HEALTH: PRIM/SEC PRES PROB	PAR MENTAL HEALTH	19	3	7	29
		OTHER	40	3	7	50
	Total		59	6	14	79

Pearson Chi square Assd Gp p=0.030; Comp Gp: Not sig.

Appendix 9.6

Relationship between Implementation of Montrose Recommendations and Outcome.

1. Rate of Implementation of Montrose Recommendations for Assessed Families. (n=100 Families)

ASSD FAMS: RECS ALL/MOST IMPLEMNTD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ALL/MST RECS NOT IMPD	16	8.0	16.0	16.0
	ALL/ MOST RECS IMPLD	84	42.0	84.0	100.0
	Total	100	50.0	100.0	
Missing	N/A COMP GP	100	50.0		
Total		200	100.0		

2. Assessed Families with All/Most Recommendations Implemented * Family Outcome Three Years After Referral. (n=97 Families)

Crosstab

			FAM OUTCOME 3 YRS AFT REF			
			FAM SIT WRSE	FAM SIT NO DIFF	FAM SIT IMPVD	Total
ASSD FAMS: RECS ALL/MOST IMPLEMNTD	ALL/MST RECS NOT IMPD	Count	4	6	6	16
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	25.0%	37.5%	37.5%	100.0%
	ALL/ MOST RECS IMPLD	Count	9	16	56	81
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	11.1%	19.8%	69.1%	100.0%
Total		Count	13	22	62	97
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	13.4%	22.7%	63.9%	100.0%

Pearson Chi Square: p= 0.053

3. Assessed Families with All/Most Recommendations Implemented * Children's Outcome Three Years After Referral. (n=95 Families)

SSD FAMS: RECS ALL/MOST IMPLEMNTD * CH/N'S OUTCOME 3 YRS AFT REF - WSE/IM
Crosstabulation

			CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP		
			CHN SIT WRSE	CHN SIT IMPVD	Total
ASSD FAMS: RECS ALL/MOST IMPLEMNTD	ALL/MST RECS NOT IMPD	Count	9	6	15
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	60.0%	40.0%	100.0%
	ALL/ MOST RECS IMPLD	Count	32	48	80
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	40.0%	60.0%	100.0%
Total		Count	41	54	95
		% within ASSD FAMS: RECS ALL/MOST IMPLEMNTD	43.2%	56.8%	100.0%

Pearson Chi Square : Not significant

Appendix 9.7

CHILD PROTECTION OUTCOME FOR FAMILIES OF INDIGENOUS STATUS

1. Indigenous Status * Family Outcome 3 Years After Referral

N=181 Families. Families where at least one parent identifies as Aboriginal n= 19

Crosstab

			PAR/S IDTIFY AS ABORIG.		
			PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
FAM OUTCOME 3 YRS AFT REF	FAM SIT IMPVD	Count	2	72	74
		% within PAR/S IDTIFY AS ABORIG.	10.5%	44.4%	40.9%
	FAM SIT NO DIFF	Count	7	53	60
		% within PAR/S IDTIFY AS ABORIG.	36.8%	32.7%	33.1%
	FAM SIT WORSE	Count	10	37	47
		% within PAR/S IDTIFY AS ABORIG.	52.6%	22.8%	26.0%
Total		Count	19	162	181
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.005

2. Indigenous Status * Family Outcome 3 Years After Referral. (N=181 Families). Assessed Group n=97; Comparison Group n=84.

Families where at least one parent identifies as Aboriginal n= 19

FAM OUTCOME 3 YRS AFT REF * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

				PAR/S IDTIFY AS ABORIG.		
ASSD vs COMP GP				PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	FAM OUT COME 3 YRS AFT REF	FAM SIT IMPVD	Count	2	60	62
			% within PAR/S IDTIFY AS ABORIG.	28.6%	66.7%	63.9%
		FAM SIT NO DIFF	Count	2	20	22
			% within PAR/S IDTIFY AS ABORIG.	28.6%	22.2%	22.7%
		FAM SIT WORSE	Count	3	10	13
			% within PAR/S IDTIFY AS ABORIG.	42.9%	11.1%	13.4%
	Total		Count	7	90	97
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	FAM OUT COME 3 YRS AFT REF	FAM SIT IMPVD	Count	0	12	12
			% within PAR/S IDTIFY AS ABORIG.	.0%	16.7%	14.3%
		FAM SIT NO DIFF	Count	5	33	38
			% within PAR/S IDTIFY AS ABORIG.	41.7%	45.8%	45.2%
		FAM SIT WORSE	Count	7	27	34
			% within PAR/S IDTIFY AS ABORIG.	58.3%	37.5%	40.5%
	Total		Count	12	72	84
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: Assd Gp: p=0.039; Comp Gp: N/signif.

3. Indigenous Status * Children's Outcome 3 Years After Referral.

N=168 Families. Families where at least one parent identifies as Aboriginal n= 18

Crosstab

			PAR/S IDTIFY AS ABORIG.		
			PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMI	CHN SIT WRSE	Count	15	85	100
		% within PAR/S IDTIFY AS ABORIG	83.3%	56.7%	59.5%
	CHN SIT IMPVD	Count	3	65	68
		% within PAR/S IDTIFY AS ABORIG	16.7%	43.3%	40.5%
Total		Count	18	150	168
		% within PAR/S IDTIFY AS ABORIG	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.029

4. Indigenous Status * Children's Outcome 3 Years After Referral (N=168 Families) * Assd Gp (n=95) and Comp Gp (n=73).

CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP	CHN SIT WRSE	Count	5	36	41
			% within PAR/S IDTIFY AS ABORIG.	71.4%	40.9%	43.2%
		CHN SIT IMPVD	Count	2	52	54
			% within PAR/S IDTIFY AS ABORIG.	28.6%	59.1%	56.8%
	Total		Count	7	88	95
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	CH/N'S OUTCOME 3 YRS AFT REF - WSE/IMP	CHN SIT WRSE	Count	10	49	59
			% within PAR/S IDTIFY AS ABORIG.	90.9%	79.0%	80.8%
		CHN SIT IMPVD	Count	1	13	14
			% within PAR/S IDTIFY AS ABORIG.	9.1%	21.0%	19.2%
	Total		Count	11	62	73
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: No signif Diff

5. Indigenous Status * Legal Status 3 Years After Referral

N=200 Families. Families where at least one parent identifies as Aboriginal n= 21

LEG STAT/FAM 3 YRS AFT REFL * PAR/S IDTIFY AS ABORIG. Crosstabulation

			PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
LEG STAT/ FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	8	99	107
		% within PAR/S IDTIFY AS ABORIG.	38.1%	55.3%	53.5%
	S/ORDER	Count	1	22	23
		% within PAR/S IDTIFY AS ABORIG.	4.8%	12.3%	11.5%
	CUST ORD/WARD/ MULT ORDS	Count	12	58	70
		% within PAR/S IDTIFY AS ABORIG.	57.1%	32.4%	35.0%
Total		Count	21	179	200
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.072

6 . Indigenous Status * Legal Status 3 Years After Referral * Assd Gp and Comp Gp. N=200 Families.

LEG STAT/FAM 3 YRS AFT REFL * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	LEG STAT/ FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	4	54	58
			% within PAR/S IDTIFY AS ABORIG.	50.0%	58.7%	58.0%
		S/ORDER	Count	1	16	17
			% within PAR/S IDTIFY AS ABORIG.	12.5%	17.4%	17.0%
		CUST ORD/WARD/ MULT ORDS	Count	3	22	25
			% within PAR/S IDTIFY AS ABORIG.	37.5%	23.9%	25.0%
	Total		Count	8	92	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	LEG STAT/ FAM 3 YRS AFT REFL	NO LEG.ORDS	Count	4	45	49
			% within PAR/S IDTIFY AS ABORIG.	30.8%	51.7%	49.0%
		S/ORDER	Count	0	6	6
			% within PAR/S IDTIFY AS ABORIG.	.0%	6.9%	6.0%
		CUST ORD/WARD/ MULT ORDS	Count	9	36	45
			% within PAR/S IDTIFY AS ABORIG.	69.2%	41.4%	45.0%
	Total		Count	13	87	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi Square: No signif. diff.

7. Indigenous Status * Children's Placement 3 Years After Referral

N=200 Families. Families where at least one parent identifies as Aboriginal n= 20

CHNS PLCT 3 YRS AFT REF * PAR/S IDTIFY AS ABORIG. Crosstabulation

			PAR/S IDTIFY AS ABORIG.		
			PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	8	93	101
		% within PAR/S IDTIFY AS ABORIG.	40.0%	52.5%	51.3%
	SOME CHN OoHC	Count	6	60	66
		% within PAR/S IDTIFY AS ABORIG.	30.0%	33.9%	33.5%
	ALL CHN OoHC	Count	6	24	30
		% within PAR/S IDTIFY AS ABORIG.	30.0%	13.6%	15.2%
Total		Count	20	177	197
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square : No Signif. Difference

8. Indigenous Status * Children's Placement 3 Years After Referral * Assd Gp and Comp Gp.

N=200 Families. Families where at least one parent identifies as Aboriginal n= 20

CHNS PLCT 3 YRS AFT REF * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

				PAR/S IDTIFY AS ABORIG.		
ASSD vs COMP GP				PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	3	52	55
			% within PAR/S IDTIFY AS ABORIG.	37.5%	56.5%	55.0%
		SOME CHN OoHC	Count	2	29	31
			% within PAR/S IDTIFY AS ABORIG.	25.0%	31.5%	31.0%
		ALL CHN OoHC	Count	3	11	14
			% within PAR/S IDTIFY AS ABORIG.	37.5%	12.0%	14.0%
	Total		Count	8	92	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	CHNS PLCT 3 YRS AFT REF	ALL CHN FAM HOME	Count	5	41	46
			% within PAR/S IDTIFY AS ABORIG.	41.7%	48.2%	47.4%
		SOME CHN OoHC	Count	4	31	35
			% within PAR/S IDTIFY AS ABORIG.	33.3%	36.5%	36.1%
		ALL CHN OoHC	Count	3	13	16
			% within PAR/S IDTIFY AS ABORIG.	25.0%	15.3%	16.5%
	Total		Count	12	85	97
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square : No Signif. Difference

9. Indigenous Status * Notifications 3 Years After Referral

N=200 Families. Families where at least one parent identifies as Aboriginal n= 21

Crosstab

			PAR/S IDTIFY AS ABORIG.		
			PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
NTILES of FAMRNOT3 - REF:5+ NOTS	0-1 NOT	Count	5	69	74
		% within PAR/S IDTIFY AS ABORIG.	23.8%	38.5%	37.0%
	2-4 NOTS	Count	3	61	64
		% within PAR/S IDTIFY AS ABORIG.	14.3%	34.1%	32.0%
	5+ NOTS	Count	13	49	62
		% within PAR/S IDTIFY AS ABORIG.	61.9%	27.4%	31.0%
Total		Count	21	179	200
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi Square: p=0.005

10. Indigenous Status * Notifications 3 Years After Referral* Assd Gp and Comp Gp N=200 Families.

Families where at least 1 parent identifies as Aboriginal n= 21

NTILES of FAMRNOT3 - REF:5+ NOTS * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	NTILES of FAMRNOT3 - REF:5+ NOTS	0-1 NOT	Count	2	38	40
			% within PAR/S IDTIFY AS ABORIG.	25.0%	41.3%	40.0%
		2-4 NOTS	Count	2	32	34
			% within PAR/S IDTIFY AS ABORIG.	25.0%	34.8%	34.0%
		5+ NOTS	Count	4	22	26
			% within PAR/S IDTIFY AS ABORIG.	50.0%	23.9%	26.0%
	Total		Count	8	92	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	NTILES of FAMRNOT3 - REF:5+ NOTS	0-1 NOT	Count	3	31	34
			% within PAR/S IDTIFY AS ABORIG.	23.1%	35.6%	34.0%
		2-4 NOTS	Count	1	29	30
			% within PAR/S IDTIFY AS ABORIG.	7.7%	33.3%	30.0%
		5+ NOTS	Count	9	27	36
			% within PAR/S IDTIFY AS ABORIG.	69.2%	31.0%	36.0%
	Total		Count	13	87	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: Assd Gp: N/sig; Comp Gp: p=0.023

11. Indigenous Status * Confirmed Notifications 3 Years After Referral N=200 Families.

NTILES of CFAMRNOT3 REF: 3+ CONF NOTS * PAR/S IDTIFY AS ABORIG. Crosstabulation

			PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
NTILES of CFAMRNOT3 REF: 3+ CONF NOTS	NO CONF NOTS	Count	6	74	80
		% within PAR/S IDTIFY AS ABORIG.	28.6%	41.3%	40.0%
	1-2 CONF NOTS	Count	5	46	51
		% within PAR/S IDTIFY AS ABORIG.	23.8%	25.7%	25.5%
	3+ CONF NOTS	Count	10	59	69
		% within PAR/S IDTIFY AS ABORIG.	47.6%	33.0%	34.5%
Total		Count	21	179	200
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: No signif diff.

12. Indigenous Status * Confirmed Notifications 3 Years After Referral * Assd Gp and Comp Gp N=200 Families.

NTILES of CFAMRNOT3 REF: 3+ CONF NOTS * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

ASSD vs COMP GP				PAR/S IDTIFY AS ABORIG. PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	NTILES of CFAMRNOT 3 REF: 3+ CONF NOTS	NO CONF NOTS	Count	2	42	44
			% within PAR/S IDTIFY AS ABORIG.	25.0%	45.7%	44.0%
		1-2 CONF NOTS	Count	3	22	25
			% within PAR/S IDTIFY AS ABORIG.	37.5%	23.9%	25.0%
		3+ CONF NOTS	Count	3	28	31
			% within PAR/S IDTIFY AS ABORIG.	37.5%	30.4%	31.0%
	Total		Count	8	92	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	NTILES of CFAMRNOT 3 REF: 3+ CONF NOTS	NO CONF NOTS	Count	4	32	36
			% within PAR/S IDTIFY AS ABORIG.	30.8%	36.8%	36.0%
		1-2 CONF NOTS	Count	2	24	26
			% within PAR/S IDTIFY AS ABORIG.	15.4%	27.6%	26.0%
		3+ CONF NOTS	Count	7	31	38
			% within PAR/S IDTIFY AS ABORIG.	53.8%	35.6%	38.0%
	Total		Count	13	87	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: No signif diff.

13. Indigenous Status * Type of Abuse Three Years after Referral N=200 Families.

ABUS / FAM 3 YRS AFT REF * PAR/S IDTIFY AS ABORIG. Crosstabulation

			PAR/S IDTIFY AS ABORIG.		
			PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	5	54	59
		% within PAR/S IDTIFY AS ABORIG.	23.8%	30.2%	29.5%
	SINGLE TYPE ABUSE	Count	4	46	50
		% within PAR/S IDTIFY AS ABORIG.	19.0%	25.7%	25.0%
	MULT ABUSE TYPES	Count	12	79	91
		% within PAR/S IDTIFY AS ABORIG.	57.1%	44.1%	45.5%
Total		Count	21	179	200
		% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: No signif diff.

14. Indigenous Status * Type of Abuse Three Years after Referral * Assd Gp and Comp Gp. N=200 Families.

ABUS / FAM 3 YRS AFT REF * PAR/S IDTIFY AS ABORIG. * ASSD vs COMP GP Crosstabulation

				PAR/S IDTIFY AS ABORIG.		
ASSD vs COMP GP				PAR/S IDNTFY AS ABORIGINAL	OTHER	Total
ASSD GP	ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	2	29	31
			% within PAR/S IDTIFY AS ABORIG.	25.0%	31.5%	31.0%
		SINGLE TYPE ABUSE	Count	2	26	28
			% within PAR/S IDTIFY AS ABORIG.	25.0%	28.3%	28.0%
		MULT ABUSE TYPES	Count	4	37	41
			% within PAR/S IDTIFY AS ABORIG.	50.0%	40.2%	41.0%
	Total		Count	8	92	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%
COMP GP	ABUS / FAM 3 YRS AFT REF	NO ABUSE	Count	3	25	28
			% within PAR/S IDTIFY AS ABORIG.	23.1%	28.7%	28.0%
		SINGLE TYPE ABUSE	Count	2	20	22
			% within PAR/S IDTIFY AS ABORIG.	15.4%	23.0%	22.0%
		MULT ABUSE TYPES	Count	8	42	50
			% within PAR/S IDTIFY AS ABORIG.	61.5%	48.3%	50.0%
	Total		Count	13	87	100
			% within PAR/S IDTIFY AS ABORIG.	100.0%	100.0%	100.0%

Pearson Chi square: No signif diff.

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