

# Improving child protection casework practice

## Learning from child death reviews

The purpose of this Research Note is to present key findings from the Community Services Child Deaths 2010 Annual Report. This is the first report to be published, providing an opportunity for Community Services to share learnings from the review work, to challenge community misconceptions about deaths of children known to Community Services and to provide information about the complexities of child protection work.

This Research Note details the key themes and lessons for improvement that have emerged from Community Services' internal child death reviews in 2010. These were: assessing cumulative and changing risk; assessing risk from new partners or adult household members; working with intergenerational abuse; engagement with parents, caregivers and children; working with risk in early intervention and working with competing priorities.

Community Services has been reviewing the deaths of all children known to Community Services since 2006 to inform and improve practice. It reviews involvement with the families of children and young people where a report was received about the child who died and/or their sibling/s, in the three years preceding the death, or where a child or young person was in care at the time of their death. Reviews are conducted using a rigorous and academically supported methodology by a central team, independent of the Community Services Region which provided services to the child. Reviews make recommendations for practice and system improvement, supporting learning and professional development, both with staff

directly involved in the case and with staff across the Community Services division.

## Enduring challenges in child protection work identified in child death reviews 2006–2010

Child death reviews conducted over the past five years have found that while most deaths are not the result of intentional harm on the part of the parents/carers, some deaths may have been linked to the parents/carers' inability to provide the child with an appropriate level of care. There are a series of 'enduring challenges in child protection practice' identified as part of the child death review work. These themes mirror the experience of child protection systems in other states and nations and also what is reported in the literature. The challenges are:

### Assessing risk holistically

There are challenges for child protection staff in undertaking holistic risk of harm assessments that capture not only the reported incident, but also the child protection history and critical information from child protection interagency partners to get a good understanding of the child's experience.

### 'Asking the hard questions'/engagement

Working with families who do not want or see the need for child protection intervention is difficult. Parents may be reluctant or fearful of intervention from statutory services. While effective engagement is important in working with families, this often comes at a cost of

workers not being honest with parents about child protection concerns. The challenge is in delivering the 'bottom line.'

### **Focusing on the child in assessment, case management and planning**

Child protection workers can easily focus on the parent's issues and experiences and the child becomes the secondary focus in assessments, case plans and decision making. Developing a case plan to address identified risks takes time and relies on good risk assessment.

### **Developing cultural competence**

Child protection workers find it challenging to balance safety concerns for Aboriginal children with cultural concerns. The legacies of historic experiences of trauma, dispossession and forced removal of children mean that many Aboriginal people experience significant disadvantage. Understanding this history can impact on child protection workers' level of confidence around knowing when and how to intervene with Aboriginal families.

### **Prioritising professional supervision**

Supervision of caseworkers is an essential tool to reflect on judgements and guard against predictable errors in child protection work. Holistic professional supervision critically supports every aspect of child protection work and the capacity of caseworkers to address the challenges effectively. Reviews have identified that supervision may focus on one function of supervision at the expense of others, or the use of informal supervision that is not complemented by the more formal approach. In crisis driven environments supervision may not be given the priority it needs. The opportunity can be missed to challenge judgements, guard against over-identification or over-optimism and to ensure the history is considered.

### **Key practice themes emerging from the 2010 child death reviews**

In analysing the practice issues emerging from the death reviews undertaken in 2010, six broad themes were identified. The key learnings are:

1. Assessing Cumulative and Changing Risk
2. Assessing Risk from New Partners or Adult Household Members
3. Working with Intergenerational Abuse
4. Engaging Parents, Caregivers and Children
5. Working with Competing Priorities
6. Working with Risk in Early Intervention.

#### **1. Assessing cumulative and changing risk**

Undertaking risk assessments is an integral part of Community Services' child protection work as the assessment informs decision making about a child's safety.

#### **Practice and systemic issues**

##### *The importance of assessing cumulative harm*

There is a tendency for the response to reports to be based on the most recently reported incident. This focus on recent incidents can obscure historical information and undermine the capacity to think holistically. It also means that the cumulative harm to children can remain undetected. This is exacerbated by a lack of direct contact with children or those who can help us understand their experience, namely interagency partners and extended family.

##### *The need to revise judgements and decisions in light of new information*

Revising judgements and decisions when new information is received is a practice issue that has been extensively discussed in Community Services' review work over the past five years. The tendency not to revise judgements in light of new information is noted as one of the predictable errors of child protection reasoning.

##### *The need to maintain a child focus*

Seeing children as early and as often as possible enables caseworkers to build a more accurate picture of the child's day-to-day experiences and to develop a better understanding of what life is like for the child in their family and community.

**What helps: Strategies to assist**

Observations of the child, their interactions with parents and siblings, whether they are meeting their developmental milestones and information from agencies or others closely involved with children will support more accurate assessment of the level of risk or safety and the need for protective intervention for the child.

## 2. Assessing risk from new partners or adult household members

Research highlights a risk posed by non-biological parents, particularly the male partner of a child's mother. Step-parents, generally step-fathers, are twice as likely to kill a child as the birth parent. The research also shows that children who were fatally assaulted experienced at least one previous violent episode prior to their deaths. Nevertheless, the vast majority of step-parents do not kill their children.

**Practice and systemic issues****Including information about new adult household members in risk assessment**

Recent child death reviews have highlighted the risks that can emerge when new partners join a household. Of particular concern are cases where the new partner has a history of perpetrating serious domestic violence or a record of other violent or anti-social behaviours. Community Services may not always receive information about new partners or household members. However when it does, it is critical that risk assessments consider the history of the new partner or household member to identify any patterns of violence or other factors that may pose a risk to children.

**Assessing risk when information is withheld about new adult household members**

Reviews found that despite efforts by Community Services staff to gather information about the structure of households in which children and young people were living, information was not always accurate or forthcoming. These cases, such as the one described below, highlight the significance of

information obtained about a history of violent behaviour by a household member, usually the partner of a birth parent.

**Case study**

A young child was living in a household where the new partner of the child's carer had a history of extremely violent behaviour toward a previous partner. This behaviour and the perpetrator's history of other antisocial behaviour posed a significant risk to children in the past and to this child. Staff repeatedly acted on information that the perpetrator was living in the household but were met with outright denial and hostility by the carer. This was coupled with attempts by the carer to conceal the involvement of the perpetrator in the household. The review found that:

**....a more objective and thorough assessment would have resulted in consideration of the source of the evidence and review of Community Services and Police records. This would have provided an opportunity to challenge the carer with evidence about the involvement of the perpetrator in the household and to deliver the 'bottom line' that it was unacceptable for the child to continue living in the same household....**

**What helps: Strategies to assist**

Make every effort to gather and consider the known history of all adult household members or caregivers. This includes a check of records held by Community Services and Police and engaging family (and extended family) in the assessment process to capture the wealth of information they can provide.

To establish a better knowledge of the family/household structure, some questions to focus on may include:

- What experience has the new partner had with children?
- What might this mean for the child?
- What information do we know about the partner? Is there a history of violence to partners or children?

- What information do we need to know?
- Is there a history of violence towards partners or children?

### 3. Working with intergenerational abuse

Undertaking comprehensive assessments of families who have been known to the child protection system for several generations presents significant challenges in child protection casework. Child death reviews have found that such families often present with complex dynamics and a consistent range of risk factors across successive generations. Community Services' reviews have found children in these family environments often experience instability in their living and care arrangements. Thus these families become known to several CSCs, further complicating the assessment and intervention process.

#### Practice and systemic issues

##### *Challenges for casework intervention with families with complex histories*

In the context of staffing and workload pressures within CSCs, Managers Casework know that allocation of cases involving families with complex histories can be resource intensive and lengthy purely in terms of the sheer volume of history which often run into hundreds of pages. This comes at the cost of not allocating other multiple, less complex but nevertheless urgent cases. In addition, when a chronic pattern of multiple risk factors is apparent across generations, practitioners may form the view that these families have a certain level of dysfunction that may not be possible to change despite intensive casework.

##### *Conducting a clear analysis of the underlying issues*

Brandon et al<sup>1</sup> describe the concept of the 'Start Again Syndrome' as a common feature of practice for families with complex inter-generational abuse and neglect. They suggest

that casework intervention tends to be focused on the 'here and now' and any historical intervention that may have occurred with the family is ignored. Evidence of the 'start again syndrome' in casework includes responding in an overly optimistic way to a new pregnancy, a new baby or a new report. Starting again can include referrals to support services or parenting skill development when evidence in the family's history indicates that the parents failed to attend or engage with such services when previously referred. Reviewing casework files for these families is a significant task, however, without a comprehensive file review, it is difficult to identify what intervention occurred historically and how the family responded to this intervention. This contributes to an understanding of the real level of risk facing the child.

Community Services' reviews of families with complex histories find that the cases are often allocated only for short periods of intervention. Again, this is common across jurisdictions, with Brandon et al referring to this approach as 'displacement practice'. Family 'symptoms' are treated rather than conducting a clear analysis of the underlying problems and cases can be closed despite evidence of increasing risk.

##### *What helps: Strategies to assist*

It is difficult for managers to advocate to a busy caseworker the importance of reading volumes of files. However it is a good investment of time to examine the history to understand the complex dynamics in these families. It can help avoid the 'start again' syndrome.

A good discussion in supervision or case review about the family history and what intervention has or hasn't worked in the past will help in the development of more effective case planning tailored to the needs of the individual family.

Discussion about the underlying risk issues in the family is critical. It is important to consider the case plan and discuss whether it is addressing the underlying risk issues or just symptoms.

### 4. Engaging parents, caregivers and children

Many parents and caregivers engage well with caseworkers, but some respond with

<sup>1</sup> Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D. & Dodsworth, J. (2008). The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect. *Child Abuse Review*, 17, 313-330 (p.324).



fear, hostility, aggression or reluctance. Family members may unintentionally or deliberately withhold critical information about risks to children. Individual child death reviews have identified that in an attempt to engage one or both parents, or with the wider family, caseworkers can sometimes lose focus on the experience of the child. Reviews have also identified a tendency for caseworkers to focus their assessment and intervention on the mother, unintentionally missing the key role of the father. This is very problematic in cases where risk factors are largely related to the father's behaviour, for example his violence or substance misuse.

## Practice and systemic issues

### *Engaging fathers in casework*

Overlooking the father or partner in the risk assessment process or case planning has been identified as an ongoing issue in child protection. Community Services' reviews have found that this is of particular concern where there is domestic violence in which the father or male partner was the alleged perpetrator. The intervention often just focuses on mother and asks them to protect the children, failing to acknowledge and address either the power imbalance in the relationship or the fathers' equal responsibility to parent their child. We can also miss the opportunity to engage them in taking responsibility for their actions and understanding the impact on the child/ren.

It is important also to acknowledge that a perpetrator's violent or intimidating behaviour can result in caseworkers feeling reluctant to engage or challenge men in these situations. However, effective engagement provides valuable opportunities for casework staff to gather critical information about the family and invite the father to take responsibility for his violent behaviour and its impact on his child. It also enables the caseworker to advise the father of the potential consequences for the family, including the removal of the child.

### *Engaging reluctant families*

Obtaining a clear picture of what life is like for a child can be a significant challenge in child protection work when there are difficulties

engaging with a family. Understanding the reasons why parents or other family members may be reluctant to engage with caseworkers is a key first step to addressing this.

### *A case study*

Two young children were reported to Community Services on a number of occasions because of the mother's alcohol abuse and concerns that she may have been physically harming the children. During one home visit, the mother became verbally aggressive towards caseworkers when they raised the allegations. After several unsuccessful attempts to investigate the reported concerns, caseworkers made contact with the mother when a report was received about her deteriorating mental health. She agreed to remain in contact with the CSC and for the children to be involved with support services. Despite her statements, the mother did not comply with any aspects of the agreed case plan. The parents were separated because of a history of domestic violence.

The review found that:

***....the mother's continued avoidance of Community Services' attempts to monitor her parenting and her inconsistent use of support services should have amplified rather than allayed concerns about the children. The mother seemed to be quite adept at keeping services at a distance through a range of strategies. A sustained and assertive intervention designed around ensuring the children's immediate safety was needed rather than around what the parent was prepared to tolerate.***

A key feature observed in this and other reviews was poor understanding of the concept of 'disguised compliance'. The authority of the caseworker is 'neutralised' by apparent cooperation from the family and apparent cooperation and engagement can reduce or end Community Services involvement.

Community Services has found in previous reviews that the challenge of trying to engage a reluctant parent or carer can lead to caseworkers losing focus on the child. In the face of competing demands, merely superficial

engagement with a case plan may be missed. Caseworkers need to challenge pre-existing ideas of the cause of parents' or other family members' reluctance to engage. Supervision is essential to keep perspective and to reflect on how the parents' or carers' behaviour can affect the way that a caseworker works with the family and whether risk to the child is reducing.

### *Working with extended family members*

In order to support children to remain with their family where possible, Community Services is required to work closely and collaboratively with extended family members to develop and implement safety plans for children. However this is often difficult when these family members are also reluctant or unwilling to engage with caseworkers. This is particularly significant when there are chronic child protection issues that span several generations, which can lead to negative perceptions of the agency.

When engaging with extended family members, particularly when they are being assessed as potential carers for children, the reviews found that it is essential to have direct or 'bottom line' conversations with them to clearly communicate the risks to the child, as well as what is and is not negotiable in relation to the care of a child. If extended family members do not agree with Community Services' assessment, then Community Services must decide if it can ensure the children's safety when in their care.

It has also been observed that in some cases, concerns raised by family members have not been treated with the same level of 'credibility' as reports from mandatory reporters. In one case where a child died following a serious assault, the grandmother had attempted to report very serious concerns about parental drug use and care of the children. She was consistently told that "there was nothing that Community Services could do".

### *What helps: Strategies to assist*

Casework practice topics, research papers and training modules for caseworkers and managers are some of the strategies that have been developed to support caseworkers in their work.

Caseworkers can access comprehensive information on domestic violence on Community

Services' intranet. The site provides information and practice tips on working with families affected by violence. Exploring how confident caseworkers feel about engaging the father in assessment or intervention can be a good way of opening up a discussion about possible feelings of reluctance or anxiety about working with violent men. It is important to then reflect on what this means for the child and strategies for engagement.

In October 2011 training commenced for caseworkers on 'Working with men who use violence in the home'. The training aims to assist caseworkers develop new strategies for establishing effective conversations and respectful relationships with men who use violence in the home, while holding them accountable for their actions to ensure the safety of children, young people and women.

Community Services' Clinical Issues Unit (CIU) provides clinical advice on domestic violence, drugs and alcohol and mental health concerns to frontline staff working with complex, high risk families. A consultation can help to unpack the complexities of a case where there are multiple problems, provide advice about how to engage with families and the best sequence of interventions. The Clinical Issues Unit have recently finalised a Practice Tool 'New Partners and New Household Members' to assist Caseworkers specifically in assessing the safety of children when the composition of adult members of the household changes. The link is: [http://cwp.docsonline.dcs.gov.au/Documents/resources/new\\_partners\\_practice\\_tool.pdf](http://cwp.docsonline.dcs.gov.au/Documents/resources/new_partners_practice_tool.pdf).

It has been noted that family members may unintentionally or deliberately withhold critical information about risks to children. In order to support children to remain with their family where possible, work with extended family members needs to be done well. Clearly, ways of engaging with families that can encourage them to share vital information about the safety of children need to be identified.

## **5. Working with competing priorities**

Working with competing priorities continues to be a major challenge in child protection work. Reports received for the child and/or their

sibling/s are closed without an assessment due to prioritisation of other cases where risk seems more immediate. It is often not possible, on the basis of the available information, to identify those children who may be at risk of serious or even fatal outcomes. Casework staff interviewed for child death reviews, often state that the reports received for the child prior to the death did not stand out over and above many other high risk cases. This is consistent with international research and most commentators conclude that it is not possible to predict accurately which parent will kill their child .

Child death reviews commonly reveal issues about the difficulties in prioritising day-to-day tasks within the context of a constantly shifting work environment. The dynamic nature of child protection work means that in addition to new, more urgent reports being received on a daily basis, crises in allocated cases continue to occur. An immediate response is required for these cases, which often diverts caseworkers' attention away from the completion of planned tasks. In 2010, seven reviews noted that effective, child focused case plans were established for a family after a risk assessment, but tasks were not followed up as planned.

## 6. Working with risk in early intervention

In 2010 early intervention services were delivered through the Brighter Futures program which provided voluntary targeted support tailored to meet the needs of vulnerable families. In 14 cases where children died in 2010, the case had been streamed to Brighter Futures but was determined to be ineligible and referred back to child protection teams due to risk. In nine of these cases, the family did not receive a service from child protection as other cases had a higher priority. For many of the families where the risks were too high for Brighter Futures, the risk issues did not meet the criteria for a child protection response.

From January 2012, the Government introduced changes aimed at reducing this service gap between Brighter Futures and child protection, and to better support families with more complex issues. Community Services' early intervention

teams were renamed 'Strengthening Families'. These teams are working with families with needs complex enough to put them above the ROSH threshold.

Additionally, the Intensive Family Preservation (IFP) service, Community Services' highest-intensity early intervention program, uses a holistic approach to addressing families' needs over a 12 month period. The service is targeted at children and young people who are at imminent risk of removal from their families, but where an assessment is made that there is a reasonable prospect of improvement within the family with the right kind of targeted support.

## Conclusion

The purpose of this Research Note is to summarise the key findings from the Community Services Child Deaths 2010 Annual Report. Child death reviews provide a critical feedback loop to inform policy and practice improvements. It was found that many of the themes identified in this work mirror the experience of child protection systems in other states and nations and what is reported in the literature. The review work undertaken also helps us to understand the complexities of child protection work and what factors can assist or impede frontline staff when working with families.

## Further reading

Child Deaths 2010 Annual Report. Community Services, Department of Family and Community Services, 2011.  
<http://docsonline.dcs.gov.au/resources-and-publications/corporate-publications.html>

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