

Are we meeting family needs in Australia?¹

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During the final decades of the twentieth century in Australia, as in other post-industrial countries, the general social and economic context in which families existed changed radically (McGurk 1997). Australia, like many other countries of the western world, made significant progress in enhancing the health and wellbeing of its citizens. For example, there was a lowering of infant mortality rates, increased participation in education and health programs, and a reduction in the levels of physical and intellectual disability.

Given that families are dynamic and complex entities, responsive to economic and social change in their wider environment, it is perhaps not surprising then, that families themselves experienced significant changes to their structure (McGurk 1997). The 'changing patterns of family structure and formation - [such as] the formation of marriage-like relationships, changes in childbearing and fertility patterns, revisited gender roles, the intrusion of work into family life and family breakdown' (McGurk 1997:v) have been interpreted as evidence of both the decline of the family 'as we know it', and alternatively, as evidence of the ability of families to adapt to changing circumstances. With regard to the latter, it is the family's 'durability and adaptability' that are seen as evidence that families (albeit different sorts of families) will continue to remain as the basic social unit of society (McGurk 1997).

Clearly, not all changes to families and the wider society have been positive. Australia and other post-industrial countries have had to contend with an increase in the incidence of a number of social problems (such as generally higher levels of unemployment and poverty). Further, the social benefits thought to accrue through strong economic growth do not appear to have been realised. Despite periods of strong economic performance, relatively high levels of violence, poverty and unemployment are occurring in a society where an increasing number of its members being marginalised and excluded.

For example, Australia has been recognised as one of the richest countries per head of population in the world, however the Australian community appears to be becoming more and more economically polarised, with one per cent of the population holding 20 per cent of the country's wealth, and with the least wealthy holding no net wealth at all (Dallaire et al. 1995). Thus, rather than becoming more evenly distributed, the gap between the 'haves' and the 'have nots' is widening.

In addition, families, services and governments have had to cope with the recognition or discovery of a variety of new issues or problems that may impact on families and communities (the societal 'discovery' of child abuse and the drug abuse epidemic; would seem to be two prime examples).

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In the 1990s, encapsulating the situation nicely, the eminent American psychologist, James Garbarino (1995), was arguing that there was a 'toxicity' of the social environment similar to the toxicity of the physical environment, and that the contemporary social environment was particularly toxic for children. Garbarino's toxic factors included: violence in all its forms, poverty, unemployment, poor housing and an under-resourced education system. He argues that the management of socially toxic environments needed to be similar to the management of the physically toxic environment – receiving a similar, if not greater, level of perceived urgency by the public.

CHANGING NATURE OF FAMILY SUPPORT

The increasing expansion and identification of social ills or issues (e.g. child abuse and parenting problems, youth suicide, bullying, domestic violence, substance abuse, relationship breakdown etc.), combined with a greater focus on the quality of family life, and the health and wellbeing of family members, has produced significant demand for assistance as families and communities seek external support to assist them in achieving and maintaining a 'reasonable' standard of living, health and wellbeing. This has occurred as traditional forms of support provided by extended family and/or friends and neighbours have been decreasing.

As a consequence, families have turned to governments and a range of professional supports to assist them to deal with the changing nature of society and the specific issues they may face. The last decade has seen a re-investment in a rapidly changing family support sector, and the growing recognition of the need to work strategically to produce to ensure the best response for families and improved societal health and wellbeing.

Which leads to the question: are we meeting families needs in Australia?

ARE WE MEETING FAMILIES NEEDS IN AUSTRALIA?

More specifically, is the family support system meeting the needs of Australian families? Do our current approaches work? And if so, how do we know? What is good practice in supporting families?

Perhaps the two areas where there is the clearest evidence that societal intervention can make a difference are youth suicide and HIV/AIDS. Following significant investment in national strategies designed to educate the community and support families and communities, the prevalence of each issue has been reduced or restricted. There have also been some 'successes' in reducing or preventing some forms of crime; and recently it has been argued that the prevalence of child sexual abuse in the community may be stabilising or actually dropping, after years of community education and prevention initiatives. Yet overall, there do not appear to be significant changes in overall rates of a variety of social problems and/or social phenomena (e.g. the divorce rates; drug abuse; violence and bullying etc.).

One of the substantial problems in determining if 'support' is successful is that in general the service sector and policymakers lack good evidence of the interventions that can produce a significant change in family or community health and wellbeing. That is, we don't really know what interventions or programs work, under what circumstances and for whom.

Therefore, in answering the question: are we meeting families' needs, the answer is that while we're probably on the right track, we currently lack the information required to make an accurate determination, or to enhance our service response.

What I will do therefore, is attempt to provide an overview of some of the current trends in service provision that have been developed to meet identified needs. To outline recent changes, some of the key facets of service provision and some promising areas that would benefit from further exploration. Note that I will talk predominantly in terms of child welfare-family support and associated 'skilling' programs, the sector with which I have the most familiarity.

But first, what do we know about what works - what is the current evidence base.

Evidence-based practice

A key facet of any attempt to enhance family support for the future is to develop the evidence-base to better inform practice. Evidence-based practice can be defined as:

'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals' (Sackett, Richardson, Rosenberg & Haynes 1997:2).

More specifically, it involves:

'integrating individual practice expertise with the best available external evidence from systematic research as well as considering the values and expectations of clients' (Gambrill 1999:346).

That is, evidence based practice involves the creation of a body of quality research in order to make policy and practice decisions informed by a *critical appraisal* of the best evidence available rather than merely 'accepting famous ideas just because they are famous' (Sheldon 2001:803).

The 1960s heralded the first empirical (or experimental) tests of the effectiveness of health and welfare programs. These were applied initially to the assessment of generic early intervention programs, such as the Perry Pre-School and Head Start programs in the United States, which were designed to eliminate social and economic class differences by improving the cognitive and social competence of disadvantaged young children (Zigler & Styfco 1996; Ochiltree 1999; Tomison & Wise 1999).

With the dawn of the 'program evaluation' era, came the expectation that public sector programs should be able to objectively and scientifically demonstrate program success and client satisfaction (Rist 1997). Subsequent research has indicated that various forms of home visiting services; maternal and child support programs; parenting skills training; family relationship education; family counselling; and increasing community awareness about the availability of local services and resources; may all be effective approaches to supporting families.

Australia

In general, significant trends in Australian family support provision have been informed by overseas research. Relatively few 'quality' Australian studies have been completed.

In an assessment of 1800 programs collected as part of a National Audit of Child Abuse Prevention Programs, Tomison and Poole (2000) identified a general trend of service providers becoming increasingly aware of the importance of evaluations. This was evident in the growing number of agencies attempting to evaluate their work and the increasing recognition by service providers of the importance of 'adopting a degree of rigour in program evaluation research' (Tomison & Poole 2000:101).

Unfortunately, the majority of programs were still being evaluated using simple, non-experimental client attendance and satisfaction measures. Most agencies had stopped short of conducting more rigorous forms of evaluation where control over internal and external variables was exercised, a control or comparison group was employed and follow up assessments were undertaken. On a positive note however, it was found that one quarter of all programs in the Audit had attempted to incorporate pre- and post- test comparisons of participants (a substantial increase of previous assessments).

The likelihood that a quality evaluation will be undertaken (in Australia and elsewhere) has been reduced by a number of factors, including:

- a lack of in-house agency experience in conducting program evaluations;
- the difficulties associated with investigating such complex, highly sensitive, real-world phenomena;
- researchers' failure to translate findings into a form that is useful for the family support sector and/or policymakers - leading to a culture where an investment in research, and in particular, 'homegrown' research, has not been valued by governments and the wider professional sector;
- the common tendency of funding demonstration or pilot projects of limited duration (Melton & Flood 1994; Tomison 2000), which directly works against the longer time frame required to undertake a thorough evaluation.

Finally, program implementation issues may also impact negatively on attempts to measure effectiveness. Australia has a long history of creating a variety of new initiatives and adaptations based on international (and sometimes local) programs. A negative consequence of this is that there is often a lack of uniformity within program types. For example, many agencies have adopted the Australian-designed Triple P parent education program (Matt Sanders, University of Queensland), given it is one of the few programs that can demonstrate its effectiveness. However, various agencies have adapted the program for a variety of audiences, and objectives, tailoring the program to suit their specific needs (e.g. Tomison & Poole 2000). These variations, and others such as changes to the program's components, duration and intensity of treatment and length of follow-up, will impact on program effectiveness. In general, such adaptation has confounded efforts to identify promising interventions.

'Program development and service innovation have exceeded the capacity of the service system to conduct meaningful evaluation and research studies on existing programs, interventions, and strategies to integrate such research into service delivery efforts' (Chalk & King 1998:91).

Further, the variations cannot be assumed to be effective, given that they are often quite different to the original program, and may be used in ways not originally intended, and for different target audiences.

MEETING THE CHANGING NEEDS OF FAMILIES

Across the prevention of a number of social ills, such as crime, drug abuse, domestic violence and child maltreatment, there have been a number of significant, interrelated trends currently shaping efforts to support Australian families: the renewed popularity of prevention and early intervention approaches, particularly those targeting the first three years of life (Tomison & Wise 1999); the concomitant development of 'health promotion' or initiatives designed to enhance child and family health and wellbeing (Tomison 1997; Tomison & Wise 1999); the development of holistic approaches to family support; cross-sectoral collaboration and a focus on community participation and ownership.

Early intervention - prevention is better than cure

As noted above, early intervention strategies, often closely linked with universal services, are one of the most effective ways to prevent the occurrence of social ills or problems (Tomison & Wise 1999). It has been argued that early intervention approaches should incorporate both the promotion of health and wellbeing and the prevention of social ills.

Early intervention programs first run in the 1960s in the United States, programs like the Perry Preschool program (Zigler & Styfco 1996), Head Start (Zigler & Styfco 1996), and later, the Elmira Prenatal/Early Infancy home visiting program (Olds et al. 1997) have demonstrated some improvement in disadvantaged children's lives. These programs were effectively secondary prevention programs, given that they targeted specific 'at risk' populations for service provision; more accurately however, their focus was one of health promotion and the development of resiliency.

Although early intervention to prevent child maltreatment or other social ills (such as crime; National Crime Prevention 1999) may be beneficial across the lifespan from birth to adulthood, the prenatal/perinatal period, in particular, has become a predominant focus for intervention. Infancy is a period of developmental transition that has been identified as providing an ideal opportunity to enhance parental competencies and to reduce risks that may have implications for the lifelong developmental processes of both children and parents (Holden, Willis & Corcoran 1992). In Australia, the National Investment For The Early Years (NIFTeY) group (Vimpani 2000) has been developed by a body of researchers and practitioners dedicated to promoting the benefits of early intervention in infancy.

Equally, if not more important, was the development of evidence that early intervention programs are *cost-effective*. For example, in an often-quoted Perry Preschool study, Barnett (1993) calculated that by the age of 27 years, for every dollar taxpayers spent on the preschool children enrolled in the Perry Preschool early intervention program (developed in the 1960s), there had been a subsequent saving of over seven dollars in health, welfare, criminal justice and social security expenditure. Such cost-benefit analyses have resulted in a revitalised attitude towards the effectiveness of such early intervention programs, given that not only were they able to assist the nation to attain educational targets, but they were 'lucrative social investments' (Zigler & Styfco 1996:144).

These programs provide best practice examples of the sort of evidence that is required to accurately demonstrate effectiveness. Unfortunately, it is commonly difficult to achieve.

Early intervention services

Family support services carrying out an 'early detection' role, especially home visiting services, have been particularly noted for their success in identifying families at risk of maltreatment prior to the concerns reaching a level that would require statutory protective intervention. Whether they be similar to the Home Visitor service operating in the United Kingdom child protection system, the universal maternal and child health nurses operating in Scandinavian countries, or the infant welfare nurses operating across Australia, such services are well placed to monitor the family over time. Where resources allow, they are able to support and educate parents, and are much more likely to detect problematic changes in family functioning (Drotar 1992). These services are also able to divert/refer families to the most appropriate support and can often alleviate the family situation without the necessity of child protection services involvement.

However, the value of the preventative role played by the non-government sector, including early detection services, in preventing child abuse and neglect was relatively unacknowledged and undervalued, particularly by governments intent on cost-cutting during the recession of the late 1980s and early 1990s. The subsequent widespread service reduction caused by the significant decrease in available funding, combined with a substantial increase in requests for assistance, resulted in the cessation of much of the preventative family support work being done with 'at risk' families by child welfare and family support services. With very few exceptions, the non-government sector focused predominantly on providing assistance to the families in greatest need, typically those referred by child protection services as substantiated child maltreatment families. Thus, those 'at risk' families who sought assistance were left to resolve their problems without professional assistance, and not surprisingly, a number subsequently failed to cope and eventually became abusive or neglectful.

It was not until the shift to a family support model of child protection practice in the mid to late 1990s, and a greater recognition of the benefits of home visiting and other early intervention programs, that governments began re-investing in the family support system and the non-government child welfare and family support system began to reclaim some of its prevention role with 'at risk' families. One of the differences was that governments now explicitly funded the provision of treatment and support for families identified as maltreating, but explicitly set about developing and funding a number of services specifically designed to work with 'at risk' families.

Strengthening families and communities - creating resiliency

Researchers investigating the 'risk factors' that may heighten children's vulnerability to various social ills, such as child abuse and neglect, have consistently identified some children who are able to achieve positive outcomes in the face of adversity – children who are 'resilient' despite facing stressful, high risk situations (Kirby & Fraser 1997). Resilience appears to be determined by the presence of risk factors in combination or interaction with the positive forces (protective factors; e.g. supportive family environment; a sense of optimism; the availability of positive external supports) that contribute to adaptive outcomes (Garmezy 1993).

The enhancement of protective factors or 'strengths' has become a key facet of strategies to prevent a variety of social ills, including violence. Governments are now using it as the basis for Australian community-level interventions, and as a valued part of a policy of promoting family and community health and wellbeing.

Thus, a second big shift towards 'preventative family support' has been the emphasis on working with the community as a whole to improve the health and wellbeing of children, families and communities so that when faced with adversity or stress, they are better equipped to cope and respond in a non-destructive way, reducing the incidence of child maltreatment, domestic violence, substance abuse, youth suicide and a host of other ills. This approach goes beyond direct prevention of social ills, it is better described as a 'wellness' or health promotion approach (Tomison & Poole 2000).

However, in order to prevent social ills more effectively, strategies are required that focus on both *reducing risk factors* and *strengthening the protective factors* that foster resiliency (LeGreca & Varni 1993; Tremblay and Craig 1995; Cox 1997). For example, Tremblay and Craig (1995:156-157) describe 'developmental prevention', a key component of crime prevention strategies, as 'interventions aiming to reduce risk factors and increase protective factors that are hypothesised to have a significant effect on an individual's adjustment at later points of . . . development.'

Health promotion

A developmental prevention approach has implications for not only the creation of future prevention strategies but, more specifically, the terminology employed. Prevention initiatives have historically taken a problem-focused approach, where the objective is the prevention of a social ill and a reduction in risk rather than the promotion of positive, life-enhancing strategies (protective factors), such as good interpersonal relationships, appropriate parenting and pro-child policies (Tomison 1997). Thus, any models framed around *prevention* without *promotion* may be considered to offer a somewhat restrictive means to address social ills (NSW Child Protection Council 1995; Albee 1996; Zubrick, Silburn, Burton & Blair 2000).

Recently however, a 'revolution' has begun among professionals working in the child protection and child welfare arenas, such that there has been considerable focus on the development of broad-based, 'health promotion' or 'wellness'-type programs (Prilleltensky & Peirson 1999b), where the objective is the promotion of positive, life-enhancing strategies, such as good interpersonal relationships, appropriate parenting and pro-child policies, rather than the prevention of social ills per se. Taking an example from an allied health field, the prevention of mental disorder in the community is generally described as mental health promotion (encouraging the development of positive mental health) rather than mental illness prevention (the prevention of a social ill). Competence building and mental health promotion efforts are perceived as being among the most promising strategies for preventing mental illness (Reppucci, Woolard & Fried 1999).

Overall, it appears that associated health fields and elements of the family support system have moved to adopt a philosophy (and associated terminology) that promote universal health, wellbeing and the enhancement of individuals', families' or communities' ability to cope effectively with life's challenges and crises, rather than those which merely signify the minimisation of social ills (World Health Organisation 1986; Australian Health Ministers Conference 1995; NSW Child

Protection Council 1997; National Crime Prevention 1999). As Reppucci et al. (1999: 401) note: 'In the 1990s principles of community mobilisation and development have increasingly been used in health and wellness promotion efforts . . . concentration of effort on at-risk populations has been de-emphasised, in favor of promoting healthy behaviors in all people within a community.'

Thus, the promotion of general health and wellbeing, or 'wellness' (Prilleltensky & Peirson 1999b) is best perceived as a broad, field of action focused on the development of child, family and community resiliency via the enhancement of a number of protective factors. Therefore, the range of prevention initiatives (public health model) developed to address specifically the variety of social ills, may best be thought of as nested within an overarching framework of health promotion activity.

'Whole of community' approaches - the impact of local community

The larger socio-economic system in which child and family are embedded can influence family functioning, child development and the availability of helping resources, such as universal child and health services, within communities and neighbourhoods, (Martin 1976; Garbarino 1977; Garbarino & Sherman 1980; Schorr 1988; US Advisory Board on Child Abuse and Neglect 1993; Hashima & Amato 1994).

The importance of community is currently undergoing a resurgence of interest (Korbin & Coulton 1996), with governments and the child welfare and family support sectors redesigning services to become more community-centred, and forging alliances with local communities to help improve their physical and social environments (Cohen, Ooms & Hutchins 1995; Argyle & Brown 1998) and to develop 'social capital' (Coleman 1988; Fegan & Bowes 1999).

Until recently, despite the development of ecological theories (e.g. Bronfenbrenner), researchers, policy makers and practitioners working to prevent social ills like child maltreatment, often perceived such structural forces as being beyond the scope of prevention. The tendency has been to tailor prevention activities to run within environmental or structural constraints (Parton 1991; Garbarino 1995). However, there has been growing recognition that truly to prevent social ills requires the development of the means to address the societal factors underpinning behaviour (Altepeter & Walker 1992; Tomison 1997).

This in turn, has led to the adoption of holistic prevention strategies with a focus on 'whole of community' approaches and early intervention strategies designed to influence a broad network of relationships and processes within the family and across the wider community (Wachtel 1994; Hay & Jones 1994; US Advisory Board on Child Abuse and Neglect 1993; Tomison 1997; NSW Child Protection Council 1997; National Crime Prevention 1999).

Community participation

The crux of a 'whole of community' approach is the development of an effective partnership between professionals and the local community, such that participants are more likely to have some control of decision making and a sense of mutuality and common purpose (Smith & Herbert 1997). Participation leads to a greater sense of empowerment when addressing a problem, with participants having a greater sense of ownership of the plans and activities that result from such a process (Kaufman & Poulin 1994; Smith & Herbert 1997).

An underlying aim of the approach may be the development of a level of self-sufficiency and independent action such that the local community eventually take a greater role in the development of activities and ventures aimed at improving the health and wellbeing of community members, with less involvement by the government or the professional sector.

The 'promotion of voluntary involvement in community-based initiatives can be an effective additional means of helping people on low incomes to find new ways of improving their personal and family living standards ... [Community-based initiatives] offer more opportunities and greater choices, which in turn can enhance the capacity of all citizens, particularly those on low incomes, to participate constructively in . . . society' (Smith & Herbert 1997:65).

Stronger Families and Communities Strategy

The Commonwealth Government's Stronger Families and Communities Strategy exemplifies the 'whole of community' approach. It is based on the following tenets:

- families have strengths that can be built on;
- families require advice and support, particularly in times of transition;
- strong communities are characterised by networks that create opportunities for their members and protect vulnerable people;
- strong communities support families, and vice versa; and
- a focus on early intervention and prevention is more effective in the long-term than responding to crises.

The Stronger Families and Communities Strategy works at both the family and community level through a set of early intervention and prevention projects and initiatives to build resilience so that families can break the cycle and deal with issues before they turn into problems. These activities are based on strength-based approaches that enhance and build on strengths rather than focusing on deficits (Stern 2002). One of the innovative aspects of the Strategy which will contribute to knowledge about what works and doesn't work in family support and community development projects, is the development of a Stronger Families Learning Exchange.

Stronger Families Learning Exchange

As part of the Strategy, the Australian Institute of Family Studies was contracted by the Commonwealth Department of Family and Community Services to develop and operate the Stronger Families Learning Exchange. A major component of the Learning Exchange is the provision of action research evaluation support to 60-70 government-funded community development projects. These have been designed to strengthen coordination and integration of local services and to help communities to find new ways to strengthen family functioning, with a focus on early childhood development and effective parenting.

In order to provide research support to the projects, the Institute has developed a Training and Support Team of researchers who will each support a number of the funded projects over the next three years. The Team will assist projects to design and carry out an evaluation of their project using an action research approach, providing advice and support on issues such as: action research processes; research design and methods; the analysis and interpretation of data; and the production of project reports.

In the longer term, the project will generate national data (via the Institute) on effective practice and early intervention strategies. The results will inform Government policy, community development and service delivery, and research practices.

Solution focused work

A similar 'strengths' approach is also evident at the micro-level. Many family support agencies have now re-focused their work with families to empower clients, focusing on a family's potential for change rather than on their problems, and attempting to engage family members in a truly cooperative venture to find solutions to their issues. A 'strengths-based' or 'solution-focused' approach to practice is based on the development of an effective collaborative relationship with children and their families (De Jong & Miller 1995).

The underlying tenet of this perspective is that all families have strengths and capabilities. If practitioners take the time to identify these qualities and build on them, and attempt to develop a true collaborative partnership between family members and themselves rather than focusing on the correction of skills deficits or weaknesses, families are more likely to respond favourably to interventions: thus the likelihood of making a positive impact on the family unit is considerably enhanced (Dunst, Trivette & Deal 1988). As Durrant notes, a 'focus on strengths does not deny shortcomings – it suggests that focusing on the shortcomings is often not a helpful way in which to address them' (Scott & O'Neill 1996:xiii).

THE PROCESS OF FAMILY SUPPORT

Adopting an holistic approach

In order to address the needs of what are often multiproblem, disadvantaged, dysfunctional families, effective family support requires the adoption of an holistic approach to assessment and service provision. It has been demonstrated that attempts focusing primarily on remedying a single family problem are often not as effective as approaches that utilise a multivariate, holistic approach. Such programs target the influence of constellations of family factors and/or problems, often working in collaboration with other services (Tomison 1996b; Durlak 1998). Examples of the adoption of holistic approaches are provided by using data collected for the National Audit of Child Abuse Prevention Programs (Tomison & Poole 2000).

A clear example in the Audit of an holistic approach, was the finding that the majority of all programs included in the Audit attempted to address domestic violence, in combination with the various forms of child maltreatment. That is, many programs were involved in holistic, *violence prevention*, rather than focusing only on either the prevention of child abuse and neglect, or the prevention of domestic violence. The magnitude of the violence prevention programs provided evidence of cross-sectoral acknowledgment of the need to prevent violence holistically. Many of the agencies involved in violence prevention were adult-focused services (such as women's refuges or domestic violence centres), agencies traditionally not occupying a central child abuse prevention role. Yet these services had perceived a need to take an holistic approach to the prevention of family violence and to address the needs of children by incorporating some form of child abuse prevention in their service provision.

Child and Family Centres

The adoption of an holistic, multidisciplinary approach was also exemplified by the continued development and refinement of Child and Family Centres. Child and Family Centres, frequently referred to as 'one-stop shops', are multiservice community centres that adopt a holistic approach to preventing child maltreatment and promoting healthy communities, providing support to families on a number of dimensions (Tomison & Wise 1999).

Similar programs, known as Family Resource Centers in the United States or 'multi-component community-based programs' in Canada (Prilleltensky & Peirson 1999a), have been operating for some time (Tomison & Wise 1999). Designed to be non-stigmatising and easily accessible, the Centres offer highly integrated services that promote child and family wellbeing rather than allowing family problems to develop to the extent that secondary or tertiary prevention becomes the focus of centre activity.

The intention is to engage children and families in the local community, to promote health and wellbeing, and to encourage families proactively to seek assistance in order to ameliorate a variety of family problems prior to the development of a crisis. While retaining the flexibility to cater for more traditional preventative strategies, the centres are ideally placed to take early intervention and health promotion approaches, underpinned by their holistic service philosophy. The Centres are also well-placed to facilitate a sense of community and the development of social support networks within neighbourhoods.

Involving the wider professional community – cross-sectoral partnerships

As noted above, a *developmental prevention* approach (the enhancement of protective factors in combination with a reduction in risks) (Tremblay & Craig 1995) has been adopted in order to prevent a variety of social ills. As part of a developmental preventative strategy, most sectors have adopted universal, early intervention and health promotion approaches to prevent social ills; and many of these interventions and initiatives share the same underlying philosophy and constructs. It is becoming common for complex health and social issues to be managed by a number of professionals (Jones, Pickett, Oates & Barbor, 1987). Within the Australian child welfare and family support systems, a variety of government and non-government agencies and professions are involved with different aspects of support and treatment.

Overall, taking into account the need to consider and address a variety of sector-specific issues, what is apparent is the current, high degree of congruence between the prevention of the various forms of violence and/or social ills, in terms of the priorities and strategies for action that have been proposed and undertaken. Thus, the prevention of a range of social ills, and the promotion of health and wellbeing would appear to be facilitated by greater cross-sectoral collaboration and coordination from government, researchers and non-government agencies from policy-level linkages down to the enhancement of relationships between sectors and agencies at the service provision level.

As Durlak notes:

'those working with prevention in different fields must realize that the convergence of their approaches in targeting common risk and protective factors means that the results of their programs are likely to overlap. . . We are just beginning to learn how this occurs. Categorical approaches to prevention that focus on single domains of functioning should be expanded to more comprehensive programs with multiple goals. Future prevention programs, therefore, will need to be more multidisciplinary and collaborative. Also needed are comprehensive process and outcome assessments of how risk and protective factors influence outcomes in multiple domains' (Durlak 1998:518).

Interagency and interprofessional partnerships

Clearly, effective communication and collaboration between agencies, and interagency or interprofessional partnerships, can produce a range of benefits for service providers, and including the creation of opportunities for professional development and the strengthening and expanding of professional networks.

Interagency (and interprofessional) coordination and communication have been well-documented as having the potential to enhance or undermine family support work. Ensuring effective interagency (or interprofessional) cooperation and coordination has been a common theme and an ongoing, significant issue for the provision of child protection and family support services for many years (e.g. Hallett & Birchall 1992).

A coordinated response to the problem of child abuse and neglect can produce more effective interventions, greater efficiency in the use of resources; improved service delivery by the avoidance of duplication and overlap between existing services; the minimisation of gaps or discontinuity of services; clarification of agency or professional roles and responsibilities in 'frontier problems' and demarcation disputes; and the delivery of comprehensive services (Hallett & Birchall 1992; Morrison 1998). Overall, the generally accepted objectives of a coordinated child protection response are: to achieve a comprehensive perspective in case assessment; comprehensive caseplans or interventions; support and consultation for the workers involved in child protection; and the avoidance of duplication or gaps in service delivery (Hallett & Birchall 1992).

Interagency coordination however, is not a natural state of affairs and it does not result merely from good intentions (Reid 1969). Among the various agencies involved in family support work there are variations in philosophy of service, work protocols, and the issues that they are able to address. Thus, while there would appear to be overall agreement that coordination is a necessary and valuable practice, it has been commonly reported as being difficult to achieve (for example, Dale et al. 1986; Jones et al. 1987; Morrison 1998).

Problems of service coordination, especially where many services are involved, have often been cited in the literature as leading to less than optimal case management (Jones et al. 1987; Hallett & Birchall 1992; Morrison 1998; Tomison 1999). There is the potential for children and families to miss out on services, or to become victims of duplicated services, or incompatible treatments, potentially causing the child and family more distress (Hallett & Birchall, 1992).

For these reasons many social scientists have argued for a clearly structured 'teamwork' approach to 'working together' (eg. Jones et al. 1987; Tomison 1999), and stressed the importance of the participating services being coordinated by a designated key worker and/or agency.

In situations where the development of multidisciplinary teams is not a possibility, it is important that professionals have access to training in cross-sectoral issues, the opportunity to interact and develop working relationships with other professionals, and if possible, regular access to specialist expertise. For example, relationship counsellors confronted by couples where domestic violence is present (or the potential for violence has been identified), is likely to require assistance to deal effectively with the family's concerns.

One other coordination model that has gained some support in recent years is an extension of the key worker concept, such that one service acts as a service broker and/or case coordinator, purchasing and/or supervising a multiservice caseplan. For example, Victoria operates a statewide *Strengthening Families* program, where 'at risk' families are referred to a key agency in each region who have been funded to engage with the family, develop a caseplan (based on a solution focused approach) and then to coordinate the service response, brokering or purchasing both the therapeutic work and practical items to meet the family's need.

National Audit - coordination and collaboration

In the National Audit (Tomison & Poole 2000), the service providers involved in approximately one-quarter of all 1800 programs could be said to be working collaboratively or in partnership with another agency.

These partnerships generally involved a family support agency working with another, more specialist agency (for example, drug rehabilitation service). Most of the partnerships identified in the Audit however, were not cross-sectoral in nature, but merely involved different agencies with a shared understanding or focus on the development of particular *child abuse prevention* initiatives. This was not entirely surprising, given that most prevention work has traditionally been done in isolation, focused primarily on addressing one form of violence or social ill in particular. For example, in an earlier assessment of the Commonwealth's role in the prevention of child abuse and neglect, Rayner (1994) found that prevention was a very fragmented exercise, with many institutional structures not geared towards perceiving or identifying aspects of their work that had a preventative role.

A number of programs demonstrated acknowledgment of cross-sectoral issues, although most of these were not usually conducted in partnership with other agencies. Health education and a variety of universal, community development programs both recognised and attempted to address a number of social ills and/or to promote general health and wellbeing. In general, these programs were not truly 'cross-sectoral' in that they did not involve the pooling of shared resources or the collaborative development of programs by services from a variety of sectors, where the prevention of child maltreatment was merely one facet of a program addressing a variety of social ills.

A failure to recognise the potential for cross-sectoral impact

In order to facilitate the development of cross-sectoral work, a first step would appear to be ensuring that service providers recognise the role (or potential role) they may play in preventing various social ills, and that they are aware of the potential for various sectors to collaborate under a broad developmental prevention approach. In the National Audit attempts were made to access those agencies or community groups not traditionally considered to be part of the child abuse prevention network, but who might be involved in child abuse prevention work. Such groups included: child care services; neighbourhood community centres; community nursing services; drug and alcohol services; disability services; and migrant resource centres.

A substantial number of these agencies were identified as operating programs that were clearly aimed at preventing child abuse and neglect (for example, they ran a parent education program), yet the agency staff did not view their work as child abuse prevention. This finding appeared mainly to be a reflection of services' differing priorities and/or the multiple aims and functions of many services. That is, child abuse prevention may have been an accidental or unforeseen benefit of a program with another focus, such as substance abuse prevention, with these unexpected child abuse prevention benefits going unrecognised.

The failure to articulate or acknowledge child abuse prevention as an aim within services, particularly in urban areas where service networks are more dissipated, is likely to impact on the extent to which services access interagency support, receive feedback on the value and relevance of their work and contribute to the development of the child abuse prevention field as a whole. The reduction of any sense of shared purpose between agencies in a local network will reduce opportunities to disseminate information both within and between agencies and the potential for collaborative and/or cross-sectoral work.

Thus, one option to facilitate the development of cross-sectoral work, would appear to be assessing the extent to which child abuse prevention is formally (and informally) acknowledged as an objective of various services across the health, welfare, education and criminal justice sectors, and then identifying mechanisms to ensure that the potential for child abuse prevention is acknowledged, and the opportunities for interagency networking, information sharing and cross-pollination are enhanced.

Overall, despite the greater recognition of cross-sectoral issues and the benefits of collaborative approaches, the potential benefits offered by involvement in interagency, and particularly cross-sectoral, collaborative partnerships remain relatively untapped.

Tailoring support to family needs

Any understanding of family support needs to be 'informed by an awareness of the diversity of family forms and recognition of the different responses of family members to challenges along their life course' (McGurk 1997:v).

It therefore follows that any family support system requires some flexibility to meet families needs (both therapeutic and physical), particularly if the collaborative, solution focused approach is to be effective. Further, the adoption of a systems approach to 'family issues' needs to be balanced against meeting the needs of individual families. Nowhere is this issue more clearer than when considering how best to meet children's needs. Can children's needs be met via the provision of generalised support to the family unit?

The traditional assumption made in western societies (and thus, in family policies) is that children's needs will be met as dependants within the family context with adults mediating their needs (Makrinoti 1994). While in general this may be the correct assumption, there will be times when the needs of the individual child will require a tailored response (e.g. child abuse trauma; bullying; residence and access issues).

Special populations

The issue of generic versus specialist programs is perhaps most evident when assessing the needs of particular Australian communities (see *Access to services* below). For example, the development of culturally-sensitive prevention programs specifically targeting Aboriginal and Torres Strait Islander or non-English speaking background (NESB) communities appears to be necessary to ensure family engagement and access to services.

In contrast, it appears that flexible, generalist prevention programs are able to cater for the needs of children and families where a disability or mental disorder is present (Tomison 1996a). The provision of adequate resources such that services are able to be provided for as long as families require them, rather than the development of specialist services to meet particular family needs, appears to be the crux of service provision to families where a member has a disability (or mental disorder). Unfortunately, existing family support services appear to be unable to provide the services required on an indefinite basis; rationing of services is a common result (Tomison 1997b; Scott 1998).

Access to services

One area becoming more and more the focus of discussion is clients' access to services. Why is it that those most in need of assistance or 'at risk' of harm often fail to gain access to services? What is known is that the demand for services by client families requiring postvention or crisis services has often swamped services operating with a prevention/early intervention focus. We also know that this situation can create more demand, not less, as families unable to gain assistance when problems first hit, may re-present with exacerbated problems or subsequently develop more serious problems (e.g. the child protection sector; Tomison 1996c).

There is growing recognition that to be truly effective, service sectors need to investigate this issue and develop methods of enhancing accessibility. As a result, governments are investing in capacity-building and prevention/early intervention. As investigations of accessibility issues are rare, the National Child Protection Clearinghouse is presently undertaking exploratory research to gain further understanding of the issues around how families, with a child at risk of being maltreated, access programs designed to prevent maltreatment.

Issues being considered include: how program design and implementation impact on accessibility for the service user, factors associated with the service users, such as knowledge of a program's existence and design, and how identified barriers to accessibility can be overcome.

Access - special populations

As noted above, the development of culturally-sensitive prevention programs specifically targeting Aboriginal and Torres Strait Islander or non-English speaking background (NESB) communities appears to be necessary to ensure access to services.

For example, Aboriginal and Torres Strait Islander peoples often prefer to attend services offering culturally relevant programs, staffed and managed by their own communities (Wilson 1995; Tomison 1996b). Indigenous families appear less likely to attend generalist services, preferring to work with services run by their own communities, or if there is inadequate access to Indigenous services, are more likely to fail to seek assistance. Unfortunately, the number of culturally appropriate services is relatively low. For example, in the National Audit (Tomison & Poole 2000), although 16 per cent of all 1814 programs reported targeting Aboriginal and Torres Strait Islander peoples, only one quarter of these programs (23 per cent – 68 of the 296) appeared to have been specifically developed or tailored for the Indigenous population.

The need to enhance Aboriginal and Torres Strait Islander access to culturally appropriate services has been widely recognised and a number of approaches have been put into place to address the issue (Tomison & Poole 2000). First, there has been much work done around the provision of cross-cultural awareness training (for example, Deemal-Hall & McDonald 1998; Firebrace 1998), to ensure that non-Indigenous workers are sensitive to the needs of their Indigenous clients.

Second, cultural issues and sensitivities (for Indigenous and non-English-speaking communities) have been incorporated into a variety of programs, such as the Barnardos Family Work program that operates in a number of centres across New South Wales. Aboriginal and Torres Strait Islander communities have also been given a voice in the development of culturally-appropriate materials via representation on decision-making bodies.

Finally, in an attempt to develop more Indigenous services, a number of government and non-government agencies have developed Aboriginal or Torres Strait Islander teams, or employed Indigenous workers to work with local communities. The Commonwealth, for example, as part of the National Rural Health Strategy (Department of Health and Aged Care 1996), has funded initiatives that support the funding and training of Aboriginal health education officers, and other means of increasing Aboriginal and Torres Strait Islander involvement in the delivery of culturally-appropriate services and in the management of health services. The Government has also undertaken to accelerate the development of education programs for Aboriginal health workers, and to pilot various service delivery models to encourage and support nurses and Aboriginal and Torres Strait Islander health workers operating in rural and remote areas that are under-supplied with medical services.

In summary, it is apparent that the need to enhance accessibility and cultural appropriateness for services aiming to work with Aboriginal and Torres Strait Islander communities has been recognised by the government and non-government sectors, with some attempts being made to remedy the situation. Clearly, the education and training of Aboriginal and Torres Strait Islander workers and the encouragement of Indigenous management of community-based support services should remain priorities, if the issue of accessibility is to be addressed effectively (Tomison & Poole 2000).

IN CONCLUSION

The past 50 years has seen significant changes to Australian families and communities, the identification of a variety of new social issues, and as a result, substantial expansion and changes to the family support system. At present, we can only roughly estimate the effectiveness with which we are meeting the needs of Australian families are being met.

The key issues driving the field at this point are first: the need to further develop an evidence-based approach in order to more accurately determine what sorts of interventions, models of service provision etc. will produce the greatest social benefits.

Second, there is a need to develop explicitly multi-faceted, comprehensive strategies to enhance the health and wellbeing of Australian families and communities. Early intervention approaches have demonstrated that they are a cost-effective means of supporting families and improving health and wellbeing. Such programs are an important part of any strategy, but they are not a panacea. No one initiative, in isolation, can be expected to support families adequately.

Third, it is important to ensure that a greater emphasis on health promotion and efforts to develop resiliency do not detrimentally affect prevention efforts. The most effective approach for the prevention of social ills would appear to be the adoption of a developmental prevention approach, where the aim is to reduce risk *and* to promote protective factors (Tremblay & Craig 1995). A focus on resiliency without a continued focus on reducing risk factors is, in effect, only a partial solution. Effective family support requires a truly holistic approach where risk and resiliency continue to be acknowledged as inter-related and solutions are developed to address the former and to promote the latter.

Fourth, there is a need to recognise the importance of working cross-sectorally and flexibly to meet the diverse needs of families. To continue to shift towards greater professional collaboration and to explore and develop new mechanisms to facilitate such contact.

Finally, there has been a strong move to embrace community participation and a focus on developing family and community resiliency. It is important that we not lose sight of the need to work to address the social forces/ills/issues (the 'risks') that impact on families. As further information becomes available as to the benefits (and limitations) of community participation, it will be important to maintain a balance between engagement and involvement on the one hand, with the need for the service sector to use their professional knowledge, training and experience to inform community initiatives and to undertake work with families who are require more than community-driven support.

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