families commission
kōmihana ā whānau

SAFETY OF SUBSEQUENT CHILDREN

International literature review

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COMPANION REPORT: REVIEW OF SELECTED LITERATURE

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EXECUTIVE SUMMARY

INTRODUCTION

This literature review was a response to the Minister for Social Development and Employment's request that the Families Commission undertake an "international literature review about parents who lose custody of children through a care and protection intervention who then have additional children who may be at risk … [with particular focus on] … what could be done with these families to prevent additional children coming into these families and being put at risk while the parents are still addressing their complex issues".

The review will consider:
what will assist families overcome their complex issues so that subsequent children are not at risk
what can be done to prevent subsequent children coming into families (while parents are still addressing their complex issues).

Throughout this review, we use the term 'subsequent children' to refer to children coming into families at some point after a sibling was removed. We argue that families who have subsequent children removed are a subset of 'complex families', who have multiple needs.

The literature review focuses on the identification of this group of families and children, assessment, support for parents to ensure their children's safety and relevant services, policies, practices and legislation. A separate review of selected literature on the needs of whānau Māori who have had previous children removed complements this report (Cram, 2011). Whānau Māori are overrepresented in the child welfare system, including child removal statistics. Cram explores how these whānau can be supported in their childrearing roles to develop safe environments for subsequent children, and examines the determinants of positive whānau outcomes.

BACKGROUND

Child, Youth and Family (CYF) is New Zealand's national statutory child protection agency; care and protection services are also delivered by non-statutory agencies. Anyone who is concerned about a child's welfare may make a referral to CYF: CYF is able to remove a child from their family at any stage during assessment if significant concerns are raised.

During the past two years in New Zealand there has been significant interest in investigating how to improve systems so that children born into families where abuse or neglect has occurred can be more readily identified and, therefore, protected:
The independent Experts' Forum on Child Abuse (2009) explored the concept of an 'always-open' file as a means for professionals to be alerted to potential risks for subsequent children. The Experts' Forum also recommended improvements to interagency information sharing.
In 2007, CYF introduced 'vulnerable infants practice triggers' to raise the profile of this group of children and to enhance CYF's assessment and response. The triggers are used to guide decision-making and to assist case planning. In 2009, CYF established a Vulnerable Infants team responsible for establishing a number of initiatives that focus on vulnerable infants. A number of the team's projects have now been completed.

In February 2010 CYF added a new requirement to their Engagement and Safety Policy: Safety Assessments must be conducted when CYF receives a report of concern for a child whose parents/caregivers have previously had a child removed from their care.
Alert processes are being developed within the national Medical Warning System so that health professionals can 'flag' children who have been treated for abuse, and pregnant women whose unborn children are considered at risk of harm. The Ministry of Social Development is also trialling alerts within its own information systems.
CYF and Work and Income are undertaking an information-sharing pilot that aims to identify new parenting arrangements involving adults whom CYF believes may pose a risk to children. The pilot aims to prevent child maltreatment.
In March 2011 the Law Commission released its ministerial briefing on information sharing.

DATA

Establishing exact figures on the number of families who have had a child removed and go on to have subsequent children is challenging, due to administrative issues.

Of the 4,238[1] children in out-of-home care[2] in 2010, 52 percent were of Māori ethnicity, 39 percent NZ European and 6 percent Pacific. Forty-five percent (n=1,895) also had siblings who had previously been removed from their parents/caregivers by CYF. The proportion was similar across ethnicities in 2010 (Pacific 48 percent, Māori 45 percent and NZ European 42 percent; noting Pacific children made up a very small proportion of the total children in out-of-home care[3]).

Notifications for unborn children form about 1 percent of all notifications in any year. In 2010, CYF received 1,274 notifications expressing concern about unborn children, resulting in 54 custody orders on unborn children. Of these, 39 had siblings previously placed in out-of-home care by CYF.

METHOD

Conclusive evidence on effective practice with families who have had previous children removed is scarce. The review identified only one study where the key variable was that a family had a subsequent child removed from their care. To extend the literature available for our review, we included studies of complex families,[4] studies of high-risk or vulnerable infants, recurrent child maltreatment research and reviews of child deaths and serious maltreatment incidents. Because we consider the prevention of harm to a

[1] This figure includes children who entered out-of-home care placements prior to 2010.
[2] Out-of-home placements include kin-care placements.
[3] These statistics are calculated using data on children with custody orders taken in 2010.
[4] Complex families may or may not have previously had children removed, but have multiple needs, including parents and young people who are "particularly difficult to engage or to help in a way that achieves necessary change" (Thoburn, 2009, p. 3). They may be highly mobile (Eddy, 2011), parental relationships may be transient and pathways may need to work across localities. Families who have subsequent children removed are likely to be a subset of complex families.

subsequent child (where a previous child has been removed from a family) to be a prevention of recurrence, we have focused on interventions or treatments that aim to prevent recurrence.

Using a combination of key terms, a systematic search of databases was undertaken by a librarian within the Ministry of Social Development's Knowledge Services Unit. This was complemented by searches by an information services advisor at Family Planning, internet searches by the authors of the review and information provided by personal contacts within other agencies.

CONCEPTUAL FRAMEWORK

The literature was analysed using a conceptual framework that:
is guided by Bronfenbrenner's (1979) ecological systems theory (children are nested within families, which are nested within communities, which are nested within society). All systems influence one another and play a role in responding to child maltreatment
is grounded in the legislation and conventions that govern the care and protection of New Zealand children
reflects the care and protection framework employed by CYF, which has three overlapping perspectives:[5] child-centred; family-led and culturally responsive; and strengths- and evidence-based.

EFFECTIVE IDENTIFICATION

The literature suggests a key issue for protecting children is the identification of those families within which maltreatment is likely to [re]occur (Thoburn, 2009).

Characteristics of families where subsequent children may be at risk

A broad range of child, parent and environmental factors and characteristics potentially pose a risk to children. The following characteristics were predominant within the literature with respect to families with care and protection issues: neglect; previous child removal; parental mental health; parental intellectual disability; substance abuse; family violence; and certain child characteristics (eg, prematurity).

We must consider the interrelationship between these factors and their cumulative effect on children. Of these factors, the single (small-scale) study focused on families who have previously had children removed found that neglect is a key characteristic (Department of Human Services, 2001). This could indicate that neglect is an area where assessment of, and intervention with, such families should be focused; however, further research is needed.

Referral pathways

Children entering families where previous children have been removed can be most easily identified when their family's case is still active with social services. If cases are closed, alternative referral pathways are needed. There is potential for improvements to referrals and, consequently, identification of subsequent children through public and professional education, alert systems, mandatory reporting, improved relationships

[5] http://www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/care-and-protection/perspectives/index.html

between health and social sector agencies and interagency information sharing. Some or all of these may be complementary components of a comprehensive approach to identifying child abuse. As we could not locate any evaluations of these pathways we are unable to state with any confidence how effective these approaches may be in identifying subsequent children.

Assessment

There are still many unknowns about how assessments should be conducted with families who have had previous children removed, what tools should be used and what practices should be followed.

The literature suggests effective assessments will:
be conducted by well-trained professional staff with good supervision
consider the cumulative and interactive effects of family risks and strengths
consider changes in family structure (particularly the introduction of new men into households)
be undertaken in families who are already known to child protection agencies as new information arises or circumstances change (re-assessment)
be informed by professional judgement and information from evidence-based assessment tools.

FAMILY-FOCUSED INTERVENTIONS

Responses to child maltreatment lie along a continuum ranging from primary prevention, early intervention and family support through to more investigative, legalistic responses focused on child protection. Interventions include discrete programmes, CYF casework approaches, policies and legislation, support from families and communities and changing attitudes toward child maltreatment and family violence. The review concentrates predominantly on specialist child protection interventions.

Principles of effective practice

Principles emerging from the literature regarding effective practice with complex families included:
successful engagement and empathy balanced with critical questioning
effective, comprehensive, multiagency assessment
continual efforts to sustain change
a range of intervention lengths and intensities (including intensive casework) tailored to the needs of individual families
complementary interventions, rather than single-focus programmes
inclusion of fathers/male partners in assessment and intervention
culturally responsive support, mindful of families' strengths and capabilities
effective targeting of programmes; when manualised,[6] programme integrity is required to ensure programmes are working as intended
referral for specialist treatment (eg, to mental health services), if indicated
good supervision of staff.

Effective interventions in families with a previous child removed

[6] A standardised set of practices is followed for each programme participant.

There is very little literature focusing specifically on families who have had previous children removed. Most studies focus on effective interventions with complex/vulnerable families, or effective interventions with a particular 'problem' (eg, substance abuse). Only one study considered interventions that specifically prevent maltreatment of subsequent children in families where previous children have been removed. It suggested that successful interventions are likely to be similar to those that are effective with other families who have been involved with social services (but may not have had multiple children removed). The study also suggested that this group requires more intensive risk assessment and long-term case management than other groups, and interventions that address chronic neglect. However, both this and other studies acknowledge that there is little evidence of what works to address neglect, and suggest further research is required.

Effective programmes for complex families

Because of the dearth of literature around interventions specifically tailored to families who have had children removed, we explored the effectiveness of a range of interventions for complex families, including: intensive family preservation services; multi-component programmes; home visitation services; parent education programmes; therapeutic programmes; strategies during pregnancy; interventions after a child has been removed (including family reunification programmes); and programmes targeting parents with particular characteristics (eg, intellectual disabilities, substance abuse issues).

The evidence regarding the effectiveness of these programmes is mixed. While several programmes are effective at reducing child abuse, enhancing parent education and improving parent–child relationships, they are less effective at addressing adults' needs or the family's broader social needs in the longer term. Chronic neglect is a significant issue for complex families, and we were unable to identify any programmes that prove they address neglect long term. Family reunification programmes do not appear effective with families where the child/ren are neglected.

These findings have a range of implications. Most importantly, while a programmatic approach may help address some parent–child relationships, to resolve a complex family's full range of needs, a more comprehensive approach—utilising a mix of intervention types, lengths and intensities—is required.

Considered from an ecological perspective, such approaches include addressing problems with parental functioning and remedying systemic issues (eg, poverty, housing, discrimination). Interventions need to be complementary; support to address the full range of issues should come not only from professionals but also from within the family themselves and communities with whom they interact. A team-around-the-family casework or multi-component approach, supported by effective universal policies (eg, prevention of family violence, reducing child poverty) may work at all of these levels.

A retrospective study of families who have had subsequent children removed, or who have retained subsequent children, could provide insight into these families' characteristics and the effectiveness of the interventions they experienced.

PREVENTING ADDITIONAL CHILDREN COMING INTO FAMILIES

The review explores family planning as a pathway to prevention. As we did not locate any research literature specifically focusing on family planning approaches for families where previous children have been removed, the review focuses instead on family planning for complex families who demonstrate some of the characteristics of families

who have had children removed. Two key areas are explored: family planning education and coerced contraception and sterilisation.

Family planning education

Family planning education and practices can help prevent unintended pregnancies, as well as offering control over the spacing and number of children. The literature confirms that unplanned pregnancy is linked to child maltreatment; some vulnerable women (including those in our target group) are likely to have had unplanned pregnancies. There are also links between maltreatment and large families, and those with children close in age—some of our target group may also fit this description.

Families who have had previous children removed are likely to suffer intense feelings of loss and may go on to have a 'replacement child' who may also be at risk (Baum & Burns, 2007; Jordan & Sketchley, 2009; Turner, 2006). Suggestions for approaching this include support to address parental grief, and sensitive discussions around long-acting birth control. Little is known about the effectiveness of such approaches. Access to contraception may delay the conception of subsequent children and allow parents more time to address their complex issues. In particular, wider availability and uptake of long-acting reversible contraceptives (LARC) could help to reduce the number of unintended pregnancies.

Men and women have the right to: access healthcare services (including those related to family planning); make free and responsible decisions about the number and spacing of their children; and access the information, education and means to enable them to exercise these rights. In New Zealand, Lead Maternity Carers must provide information about contraception following childbirth, although not all women who have had children removed will have recently had a baby.

Because there are barriers to some women accessing family planning and contraceptive services, we must consider how access can be improved, how services should be delivered, what they should look like, who should deliver them and what underlying policies and protocols may be needed (particularly to ensure appropriate referrals within or across agencies). There may be scope for targeting family planning education to parents who have had previous children removed, as part of the package of child maltreatment interventions delivered to families.

Coerced contraception and sterilisation

The research literature uses the term 'coerced' to refer to legislative proposals that mandate or provide incentives for women to undergo sterilisation or use long-acting birth control methods. Coerced contraception and sterilisation raise human rights, legal and ethical issues and are unlikely to be viable options.

DISCUSSION

The literature review identifies several key themes:

Pathways: Becoming aware of subsequent children entering families where children have previously been removed is challenging. Keeping files open and monitoring families raises resourcing issues and privacy issues, and may be disempowering for families. For improving referral pathways, the roles of alert systems, mandatory reporting, improved interagency relationships and information sharing, and public and professional education were considered, but there is no evidence of their effectiveness in preventing harm to subsequent children or in preventing subsequent children from

entering families. Other options for consideration include longer-term monitoring and support for families who have had a child removed, including by community agencies, and enhanced education about child maltreatment for families and communities, who may be aware before professionals that a child is entering a family where a previous child has been removed.

Neglect: While not conclusive, there is some evidence neglect is a characteristic of families who have had previous children removed. The literature tells us sustained neglect can result in serious long-term negative outcomes for children, particularly when it occurs early in life. If neglect is a key feature in families who have had previous children removed, there are implications for the seriousness and urgency with which agencies respond to referrals about subsequent children. A review of the tools and training currently used to inform professional judgement around the assessment of neglect could be considered, as well as a review of how neglect is defined across different agencies. Effective interventions for neglect are also required.

Effective interventions and adult issues: While some programmes were effective in reducing child abuse and/or improving parent–child relationships, there was little evidence of their effectiveness in addressing adult needs or the family's broader social needs for the long term. Interventions that address the full range of a family's needs are required to address the heart of the issues that led to the first child's removal and to prevent risk to a subsequent child. There is scope for adult-focused services (eg, mental health and drug and alcohol services) to become more child-sensitive, and for child-focused services to be more responsive to parents and their parenting needs; this applies even after a child has been removed. There may be opportunities to engage more fully with extended family and communities to support at-risk families, including during the prenatal period.

Family planning: There are links between unplanned pregnancy and child maltreatment. Some unintended pregnancies can be prevented by greater awareness of, and access to, contraception. As part of the package of child maltreatment interventions, there may be scope for targeting family planning education to families who have had children removed, with potential implications for CYF, Family Planning, midwives and general health services.

A systems perspective: Applying an ecological approach to the research questions, we conclude that responsibilities for 'keeping an eye on' vulnerable children range across systems; government policies and approaches should encourage and support this. Assessment should consider not only individual child/adult/family characteristics, but also systemic factors, such as the availability of support within the community and from government. Interventions and support can be provided from within all levels of ecological systems, by immediate and extended families, agencies, communities and government. Raising awareness about signs that a child may be at risk, as well as educating people about who to contact with concerns, and how, may help to engender a culture of collective responsibility.

CONCLUSIONS

There are significant gaps in the literature specifically addressing what works with families where previous children have been removed and how to protect subsequent children. Related literature suggests a range of principles for working with such families; addressing the family's full range of issues (including parental issues) before subsequent children enter the family may be 'key'.

More information about the reasons why initial and subsequent children have been removed would be useful to help develop and target assistance for these families. Further research on effective interventions with this specific group is needed. A retrospective study of families who have had subsequent children removed, and those who have had subsequent children remain in their care, may be worth considering.

PART ONE: INTRODUCTION

In March 2010 the Minister for Social Development and Employment, Paula Bennett, requested the Families Commission undertake an "international literature review about parents who lose custody of children through a care and protection intervention who then have additional children who may be at risk … [with particular focus on] … what could be done with these families to prevent additional children coming into these families and being put at risk while the parents are still addressing their complex issues".

In response, this literature review's objectives are:
to consider what can be done to assist families to overcome their complex issues so subsequent children are not at risk
to consider what can be done to prevent subsequent children coming into families (while parents are still addressing their complex issues).

The literature review focuses on several key areas, including the identification of this group of families and the new children entering into them, assessment, support for parents to ensure their children's safety and relevant services, policies, practices and legislation.

Throughout this review, we use the term 'subsequent children' to refer to children coming into families at some point after a sibling was removed. Outcomes following child removal vary: some may return home to their parent/s, others may be permanently placed. Subsequent children primarily enter families through birth; however, children may come into families in other ways, such as the formation of blended families, adoption, short- or long-term non-kinship or kinship care (including the customary Māori whāngai[7] practice of kin raising children).

The Families Commission contracted a complementary literature review exploring the needs of whānau Māori, with a focus on how whānau who have had a child removed can be supported in their childrearing roles and responsibilities to develop safe environments for further children who may come into their care. Whānau Māori are overrepresented in the child welfare system, including in child removal statistics. In the complementary review, findings drawn from international literature (particularly indigenous literature) are considered from a Māori perspective (Cram, 2011).

Background

Incidents of child abuse, or deaths as a result of child abuse, are commonly reported by the media; in some of those instances the children have previously been known to Child, Youth and Family (CYF). Some have been abused before or have siblings (or other family members) who have been abused or removed. Enhancing the ability to identify families where children are likely to be at risk, particularly those families where children have already been removed, is the key issue behind this review.

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[7] See McRae and Nikora (2006).

Care and protection services in New Zealand are delivered both by statutory and non-statutory agencies. CYF is New Zealand's national statutory child protection agency. Anyone who has a welfare concern about a child may make a referral[8] to CYF (a 'notification'), which can result in CYF conducting a Safety Assessment and a full assessment or investigation.[9] CYF investigations and assessments incorporate use of a range of practice tools and processes[10] and result in a decision about whether allegations are substantiated. At any stage during assessment, if concerns are significant, CYF is able to place children away from their families. Children may be formally removed from their family's care through court proceedings. In some cases, usually where a child has been in out-of-home or kin care for an extended period,[11] the new caregivers may become legal guardians and CYF may close the child's file. In such cases, CYF would not necessarily know of any new children being born into the original family.

In September 2009, a 22-month-old child died of a non-accidental injury. CYF had no prior knowledge of this child; however, they had previously removed two of her older siblings from their parents' care. These siblings went to live with family members.

In response to concerns raised about this case, a new requirement was added to CYF's Engagement and Safety Policy (Care and Protection). Safety Assessments are now required "in situations where a report of concern has been received for a child whose parents/caregivers have previously had a child removed from their care due to safety concerns".[12] However, in cases where CYF does not have ongoing contact with a family who has had previous children removed, they are reliant on third parties to notify them of a new child's existence before they can make a Safety Assessment.

In November 2009, an Independent Experts' Forum on Child Abuse[13] was convened. This forum reported concerns about the vulnerability of children "…who come to official notice, but whose management or monitoring [subsequently] ceases". The forum explored the concept of an 'always-open' file, as a means to alert health and other professionals to potential risks for subsequent children. The forum recommended improvements to interagency information sharing, noting that although the families of child victims of abuse and neglect are often known to multiple government agencies and non-government organisations (NGOs), information sharing across agencies is limited. It recommended that a culture of shared responsibility should be engendered along with

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8 New Zealand does not have mandatory reporting of child abuse/neglect; however, there are protocols in place between CYF and most community providers to guide providers to make referrals where they have concerns regarding a child or young person.
9 An investigation differs from an assessment in that it is a response to a serious child abuse notification and is completed in consultation with Police. An assessment is less intrusive and less forensically focused than an investigation.
10 Further detail on CYF processes and practice tools is available at http://www.practicecentre.cyf.govt.nz/index.html
11 The length of time prior to new caregivers seeking guardianship differs from case to case and is at the discretion of those caregivers.
12 http://practicecentre.cyf.govt.nz/policy/engagement-and-safety/key-information/am-i-safe-now.html
13 http://www.beehive.govt.nz/sites/all/files/ExpertsForumChildAbuse.pdf

an "integrated, graduated and increasingly multidisciplinary approach to the prevention and treatment of child abuse and neglect" (Experts' Forum on Child Abuse, 2009, p. 5).

Subsequent to the Experts' Forum report, Minister Bennett called for "system changes that would raise alerts for officials when mothers of abused children had more children" (Brennan, 2010).

A Child Protection Alert System within health has been trialled in Hawke's Bay since 2003[14] (Kelly, Ritchie, Wills, & McLaren, 2010b). The system enables health professionals to place flags on the national Medical Warning System[15] for children and pregnant women who meet particular criteria.[16] The system may potentially alert health staff if a previous child removal has been flagged on a parent's file; however, this information would still need to be communicated to CYF to trigger its response. Concerns have been raised around issues of privacy, confidentiality and human rights. In Hawke's Bay, rigorous criteria for placing flags, multidisciplinary decision-making and training for health workers have been developed to counter some of these concerns, and similar systems and resources are being developed for the National Child Protection Alert System. The interface between primary and tertiary healthcare (general practitioners and hospitals) remains an issue as they do not share information systems.

A Privacy Impact Assessment report has been completed to support the development of the National Child Protection Alert System (Kelly, Ritchie, & Belt, 2010a).

Flagging cases of concern is also being considered by Work and Income, and CYF's Business Plan 2010–2011[17] notes that CYF will:

Improve information sharing with Health and Work and Income, introducing red flags on their systems when we have serious concerns about children and families. (Section 1, Keeping Kids Safe)

The issue of mandatory reporting[18] of child maltreatment has been recently raised by the Minister for Social Development and Employment (Bennett, 2011). While mandatory reporting has been imposed in some countries (eg, Australia) as a solution to overcoming a reluctance to make referrals, New Zealand currently has a voluntary reporting system. The debate about whether or not to legislate for mandatory reporting has been active since the 1950s in New Zealand (Brown, 2000); ongoing questions about the effectiveness and efficacy of this system are explored in more detail in this report.

14 Child protection alert systems have also existed within several other district health boards (DHBs) for 10 years. Hawke's Bay DHB was the first to place alerts on the Medical Warning System.
15 An alert service linked to National Health Index numbers.
16 These criteria include children who have been treated for abuse and pregnant women whose unborn children are considered at risk of harm.
17 http://www.cyf.govt.nz/documents/about-us/publications/reports/26706-bbf-brochure-final.pdf
18 The legal requirement of specified groups to report actual and suspected cases of child abuse and neglect to the statutory child protection agency and/or to the Police (Hill, 2010).

Another area of developing interest, both nationally and internationally, is in vulnerable infants. A growing body of research describes the detrimental and long-lasting effects of child abuse and neglect on infants, given the rapid brain development that takes place during infancy and infants' significant vulnerabilities.[19] Reviews of the research note that cumulative and sustained stress, trauma or neglect can seriously impair children's growth, with stress hormones potentially harming both neurological and cognitive development (Jordan & Sketchley, 2009; Waldegrave & Waldegrave, 2009). In response to this developing knowledge, in 2007 CYF introduced 'vulnerable infants practice triggers' to raise the profile of this group of children and to enhance CYF's assessment and response. The triggers are used to guide decision-making and to assist case planning. In 2009, CYF established a Vulnerable Infants team tasked with establishing a number of initiatives with a focus on vulnerable infants. This team worked on a range of projects including multiagency safety plans (for children in hospital as the result of abuse), interagency information sharing and the introduction of CYF social workers in the hospitals. A number of the projects worked on by the Vulnerable Infants team have now been completed.

In summary, during the past two years in New Zealand there has been significant interest in investigating how to improve systems so that children born into families where abuse or neglect has already occurred can be more readily identified and, therefore, protected. This is the key issue behind this literature review.

Data

There are challenges in establishing the proportion of children who fit into the category explored by this literature review. Ideally we would have data on the number of children who have been in medium- to long-term out-of-home care[20] and whose parents go on to have another child, and the proportion of these 'new' children who also end up in medium- to long-term out-of-home care. However, establishing exact figures on the number of families who have had one child removed and go on to have subsequent children is challenging due to administrative issues (siblings having different parents, different names being used, formal versus informal custody arrangements, having a sufficiently long data series,[21] problems with data entry, etc). In addition, unless the family comes to notice again there is no reason for CYF to be aware of the entry of a 'new' child into the family. These difficulties have resulted in us using CYF data to

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[19] These vulnerabilities include dependence on others, physical immaturity, undeveloped verbal communication skills and 'social invisibility' (Connolly, Wells, & Field, 2007; Jordan & Sketchley, 2009; Waldegrave & Waldegrave, 2009).

[20] Out-of-home care in this context is defined as a placement away from the originating caregivers, which is facilitated by CYF and involves use of a custody order. Out-of-home care can include kin-care arrangements where CYF has been involved and custody orders have been issued. While informal out-of-home care arrangements are possible, these are outside of the parameters defined by Minister Bennett's request. For the purposes of this report we requested data from CYF on longer-term custody orders, specifically sections 78, 101, 102, 110(2)(a), 238(1)(d), 345, 311 orders. Appendix 1 provides further details on the orders included and excluded from this data request.

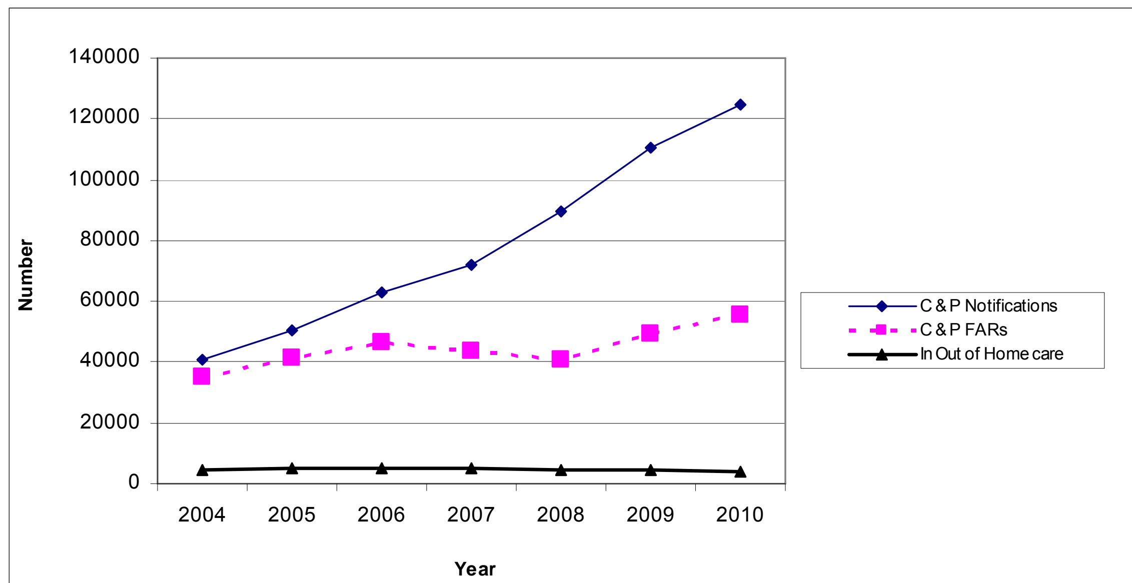
[21] Children can be born into a family many years after an initial child was taken into care. This necessitates having data available for a lengthy follow-up period if the incidence of subsequent removal is to be established.

establish a related, but different, statistic—the proportion of children who are taken into out-of-home-care, who have had a sibling previously placed in out-of-home care. The following information has been supplied to the Families Commission by CYF.

Care and protection context

Figure 1 shows the number of notifications received each year by CYF for the years 2004–10. The figure also shows the number of these notifications that are assessed as requiring further action and the number of children in out-of-home care at 30 June of that year. There has been a large increase in the number of notifications during this period, with a lesser increase in those requiring further action. CYF explains this increase as a result of the introduction of a new policy in 2006 requiring Police to notify CYF when they attend a family violence callout and children are present in the home (CYF and Ministry of Social Development, 2008).

Figure 1 CYF care and protection notifications, further action required (FAR) cases and out-of-home care placements (as at 30 June), by year

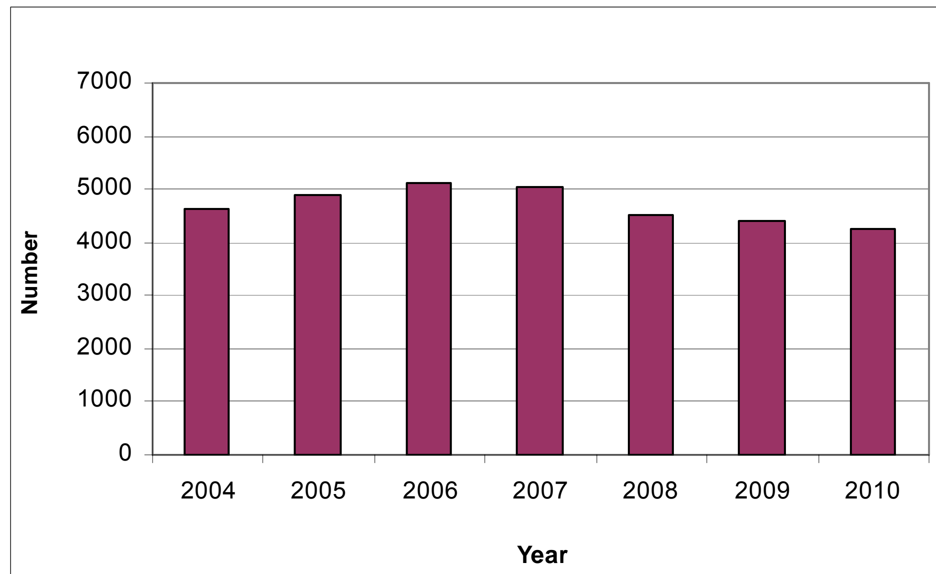


Source: CYF CEI data

Out-of-home placements

Figure 2 shows the actual numbers of children in out-of-home placements (including both kin and non-kin placements) as at 30 June, for the years 2004–10. Note that some children may have been in care during the year, but have left out-of-home care by 30 June, and are therefore not included in the 30 June figure. On 30 June 2010 there were 4,238 children in out-of-home placements.

Figure 2 Number of children in out-of-home care (as at 30 June each year)



Source: CYF CEI data

Of those in out-of-home care on 30 June 2010, almost three-quarters (72 percent) had been in care for over a year, with 14 percent in care for up to six months and another 14 percent for between six months and a year. Of those in care, around a half (49 percent) were aged 10 to 17 years, 27 percent were aged five to nine years and around 24 percent were aged under five years.[22] A half of those in out-of-home care were of Māori ethnicity (52 percent), 39 percent NZ European and 6 percent Pacific.

Out-of-home placement with sibling in care

Data were provided by CYF on children in care (those with a current open legal status and/or an open placement record as at 30 June 2010) who had a first out-of-home placement sometime in the period 2004–10 (n=4,180).[23] Data were provided on whether or not these children had a sibling who had previously been in out-of-home care when they first came into care.

Of these children who had been in, or were currently in, an out-of-home placement, 1,895 (45 percent) also had siblings who had previously been removed from their parents/caregivers by CYF.[24] Figure 3 shows the percentage with a sibling who had previously been removed, by the year in which the child was first placed in out-of-home care. The figure indicates that the proportion with a sibling previously taken into care did not vary greatly by the year the child first came into care.

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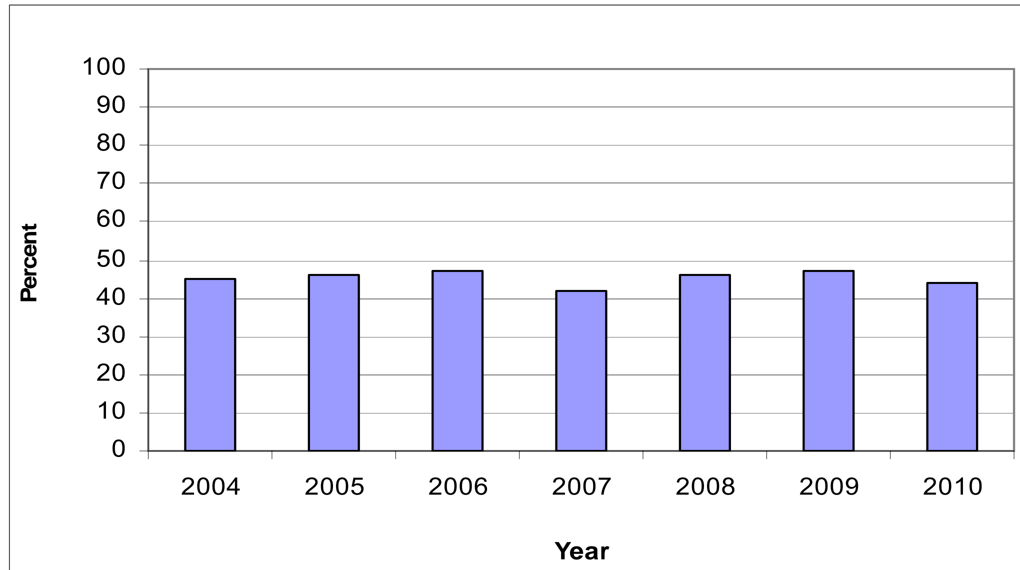
[22] *The Statistical Report 2009*, Ministry of Social Development. http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/statistical-report/statistical-report-2009.html

[23] This sample will have considerable overlap with the previous sample of all those in out-of-home care, 30 June 2010.

[24] Noting the parents from whom the previous child had been removed may differ from those from whom the subsequent child was removed, in the case of blended families.

Figure 3 Children in out-of-home placement at 30 June 2010 with a sibling previously in care (by year child first came into care)



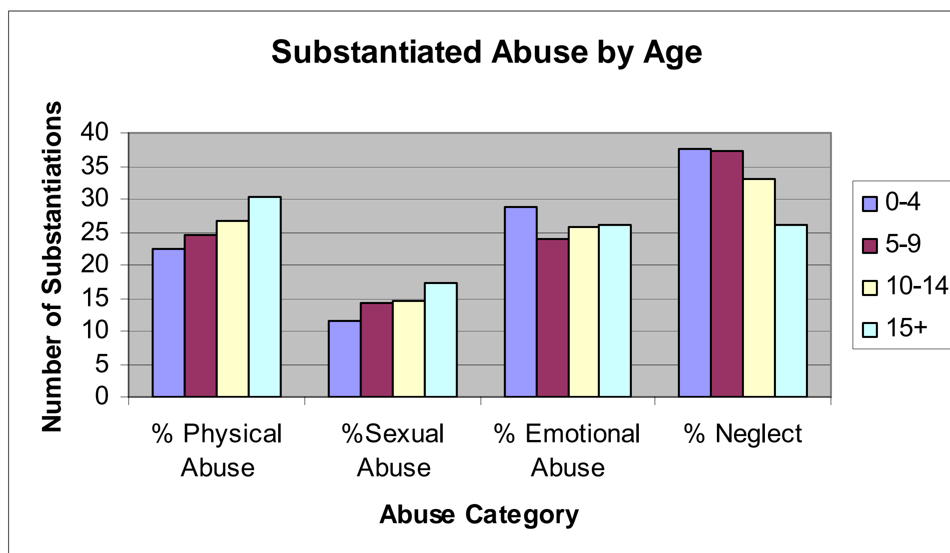
Source: CYF operational data. Numbers per year: 2004: 252; 2005: 299; 2006: 446; 2007: 504; 2008: 573; 2009: 921; 2010: 1,185.

Of those children with open files[25] and who had been subject to custody orders in 2010, the proportion who had a sibling previously removed was similar across ethnicities: 48 percent of Pacific children; 45 percent of Māori children; and 42 percent of NZ European children (noting Pacific children made up a very small proportion of those in out-of-home care).

Figure 4 shows the substantiated abuse types for children with an open placement record at 30 June 2010 and who had a sibling who had previously been in out-of-home care. While the figure indicates that neglect features more commonly than other abuse types for all but the oldest age group, it must be noted that multiple abuse types can be substantiated for each notification (eg, emotional abuse is commonly substantiated alongside physical or sexual abuse).

Figure 4 Substantiated abuse types by age—for subsequent children in care 2004–10

[25] As at 30 June 2010.



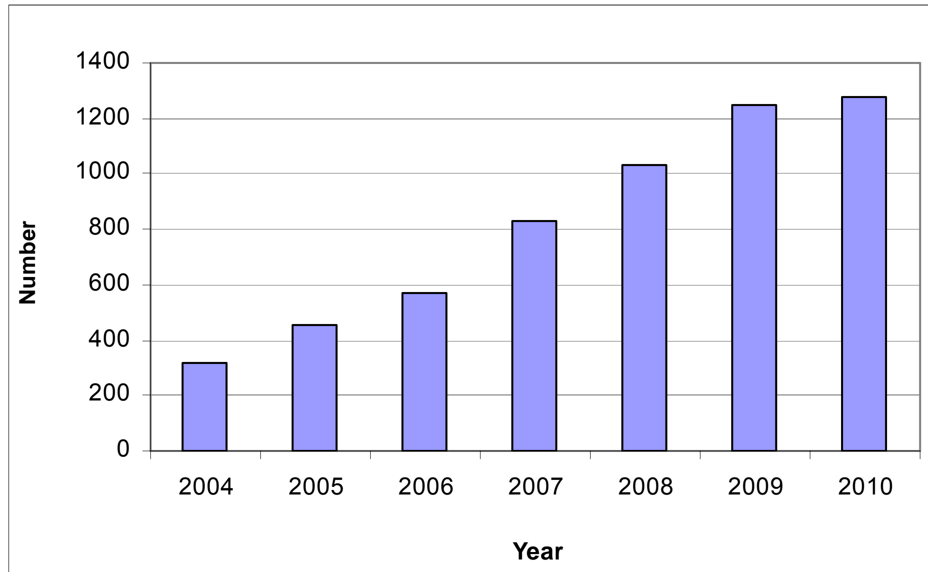
Source: CYF CYRAS data

In order to determine whether there is a particular trend in abuse types for children whose siblings have previously been removed, it would be necessary to compare these results to general CYF trends in abuse substantiation during the same period. It may be more insightful to understand what events or family characteristics triggered the maltreatment and substantiations; such information could inform future prevention and intervention work with these families. CYF data do not easily lend themself to such analysis and detailed case reviews would be required.

Unborn children

We know that previous statutory removal of a child can be an indicator of risk for subsequent children, and this information may contribute to CYF decision-making around taking custody (removal) orders on unborn children. Figure 5 shows the number of notifications for unborn children per year during 2004–10. As with all care and protection notifications (Figure 1) there has been a large increase in these notifications during this period.

Figure 5 Number of care and protection notifications for unborn children by year



Source: CYF operational data

However, as seen by the data in Table 1 (below), notifications for unborn children are about 1 percent of all notifications in any year. This has been fairly consistent during the past seven years.

Table 1 Notifications for unborn children as percentage of all notifications (2004–10)

	2004	2005	2006	2007	2008	2009	2010
Notifications for unborn children	315	457	567	829	1,032	1,246	1,274
Care and protection notifications	40,939	50,488	62,739	71,927	89,461	110,797	124,921
Unborn notifications as % all notifications	0.8	0.9	0.9	1.2	1.2	1.1	1.0

Source: CYF operational data

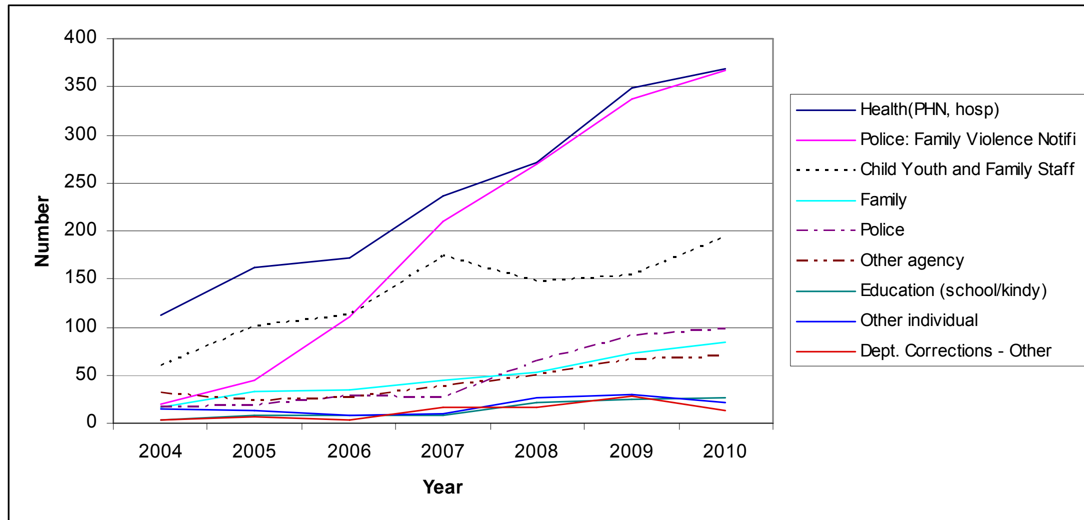
CYF becomes aware of many of these impending births because of local relationships between health professionals, Police, social workers and community workers. If information sharing does not take place, CYF may not be aware of an impending birth, and cannot take steps to support the child. Figure 6 shows the main notifiers for concerns regarding unborn children during 2004–10. In 2010, CYF received 1,274[26] notifications expressing concern about unborn children. The majority of these notifications came from Police family violence notifications[27] (29 percent), health (public health nurses or hospitals) (29 percent) and CYF workers (15 percent). It is worth noting

[26] Notifications received between one and 270 days before birth were captured. There may be some errors due to wrong/missing dates of birth entries on CYRAS (CYF's case management system).

[27] Noting the introduction of Police POL400 notifications from 2004.

that GPs made very few referrals regarding unborn children,[28] and data on referrals by midwives were unavailable.

Figure 6 Who notified care and protection concerns for unborn children, by year notified



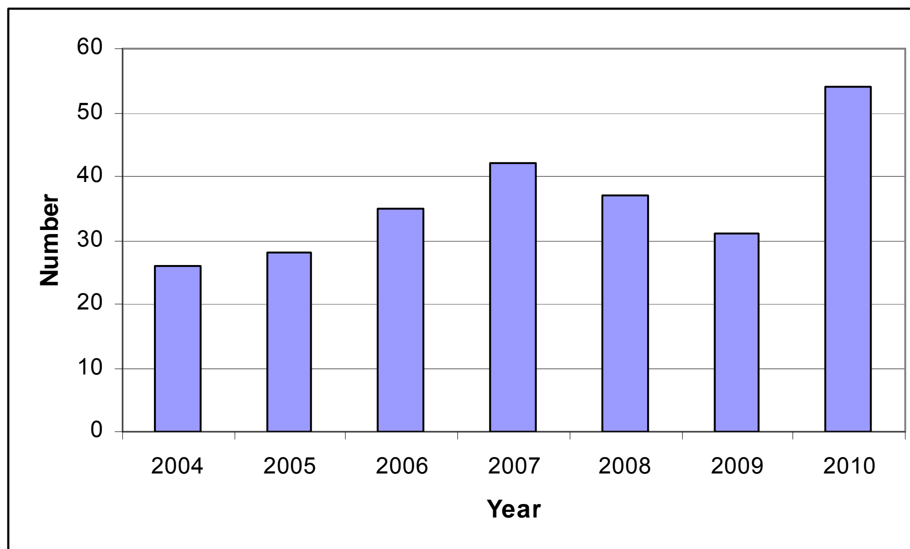
Source: CYF operational data

In response to these notifications, 54 custody orders (s78, s101[29]) were taken on unborn children in 2010. Figure 7 shows the number of s78 and s101 custody orders issued for unborn children from 2004–10.

Figure 7 Number of s78 and s101 orders issued to unborn children, by year

[28] Possibly because very few GPs are Lead Maternity Carers.

[29] s78 is an interim custody order in favour of the chief executive, while a s101 order is a final custody order.



Source: CYF operational data

Of the 54 unborn children subject to s78 and s101 custody orders in 2010, 39 (72 percent) had siblings previously placed in out-of-home care by CYF. Similar proportions of children in the years 2004–9 had previously had a sibling removed.

Key points from CYF data are:
While there has been a large increase in the number of notifications from 2004 (40,939) to 2010 (124,921), the number of children in care has stayed relatively constant.
On 30 June 2010 there were 4,238 children in out-of-home placements:
72 percent had been in care for over a year, 14 percent for up to six months and 14 percent for between six months and a year
52 percent were of Māori ethnicity, 39 percent NZ European and 6 percent Pacific
48–50 percent were aged 10–17 years, 27 percent were aged 5–9 years and around 24 percent were aged under five years.
Of the children who had been in, or were currently in, an out-of-home placement, 1,895 (45 percent) also had siblings who had previously been removed from their parents/caregivers by CYF.
Similar percentages of Pacific (48 percent), Māori (45 percent) and NZ European children (42 percent) had had a sibling previously removed (although Pacific children made up a very small proportion of the 4,238 children in out-of-home care).
Notifications for unborn children are about 1 percent of all notifications in any year.
In 2010, CYF received 1,274 notifications expressing concern about unborn children. The majority of these notifications came from Police family violence notifications (29 percent), health (29 percent) and CYF (15 percent).
In 2010, 54 custody orders were taken on unborn children. Of these, 39 had siblings previously placed in out-of-home care by CYF.

Method

Scope of review

Although many publications address child protection issues, the initial literature search—in response to the Minister's request—focused on families in which previous children have been removed. The research team developed a set of inclusion and exclusion criteria that restricted the review to literature of direct relevance to the project.

Despite widespread recognition of the importance of ensuring the safety of subsequent children, we were able to identify only one study where the key variable was that a family had a subsequent child removed from their care. Other studies noted instances where parents had multiple children removed; however, this was not a key factor in the analysis of those studies.

To extend the literature available for our review, we included broader studies on complex families, studies of high-risk or vulnerable infants, recurrent child maltreatment research and reviews of child deaths and serious maltreatment incidents. We consider the prevention of harm to a subsequent child (where a previous child has been removed from a family) to be a prevention of recurrence. As such we have limited our consideration of interventions, or treatments, to those that aim to prevent recurrence.

In reviewing the research literature, we contend that:
families who have children removed from their care have some or all of the following characteristics: complexity; vulnerability; recurrent abuse notifications; experiences of non-accidental child death or serious maltreatment incidents
the support that families require to prevent subsequent children being removed is similar to the support complex families require (regardless of child removal status)
families need additional support when they have had a child removed because of:
the configuration of issues that has led to that removal
the grief that a family experiences following a removal.

We use the term ‘complex families’ to refer to families with multiple and complex needs; other terms used in the literature include ‘vulnerable families’ and ‘families with complex needs’.

Search strategy

The Ministry of Social Development Knowledge Services Enterprise Content Unit and Family Planning undertook systematic searches of multiple databases. The databases and other sources searched were: National Bibliographical Database; Index New Zealand; ChildData; Social Care; InfoTrac; Master FILE Premier; E-Journals; The Australia/NZ Reference Centre; SocINDEX; Australia/New Zealand Reference Centre; EJS E-Journals; SocINDEX; Social Services Abstracts; Sociological Abstracts; ERIC; ProQuest Psychology Journals; ProQuest Social Science Journals; Knowledge Services Database (MSD); Cochrane Library; Medscape; Opposing Viewpoints Resource Centre; Pubmed; Proquest; IDS Bulletin; Perspectives in Reproductive Health; Google Scholar.

Variations of the following search strings and terms were used (see Appendix 2 for details):
preventing and/or protecting additional/subsequent children coming into families that have had children removed:
child removal; loss of child; loss of custody
older child/sibling; previous; subsequent child
unborn/infant/child/baby; pregnancy/pre-natal referral/notifications
referral pathway
vulnerable infants
recurrent removal
contraception
services/programmes/effective
supporting parents with complex issues:
family preservation services/programmes/initiatives
reunification; family reunification services
complex families
parental intellectual disability and subsequent child removal/protection:
mental health.

Literature and other relevant material were acquired through downloads, library interloan or direct access. Members of the research team scanned abstracts and full documents to determine relevance to the project brief. Additional material was sourced through internet searches made by the research team, and through personal contacts within other agencies.

Quality of the research

While a broad range of research has been considered, we have prioritised good-quality literature syntheses over single studies, with systematic reviews taking precedence. We drew on reviews of evidence, literature and meta-analyses, where these were available, taking into account methodological limitations (eg, sample size, nature of the sample, measures used, study design). We have also drawn on literature reviews by experts in the field of child welfare/protection; where little evidence exists, we have drawn on expert consensus (eg, findings from experts’ panels or forums). We recognise that not all literature describing experiences and practices in overseas countries is of direct relevance to New Zealand and differences in legislation, policies, practices and socio-cultural contexts must be considered.

In outlining the hierarchy above, we acknowledge the need for research methods to fit the research question and that, while experimental approaches (in particular, randomised control trials) may be considered the research 'gold standard' for evaluating interventions, other methods may be more appropriate and produce valid results. Contextual factors are important to consider; for example, the applicability of the evidence across cultures, the target population and the general feasibility of an intervention (Jackson, Fazal, & Giesbrecht, circa 2009).

Structure of this review

Following this introduction, the review has five parts:
Part Two sets out the conceptual framework underpinning the literature review.
Part Three considers the effective identification of families where subsequent children might be at risk.
Part Four summarises family-focused interventions.
Part Five discusses ways to prevent subsequent children coming into families.
Part Six provides a discussion and conclusions.

PART TWO: CONCEPTUAL FRAMEWORK

The conceptual framework underpinning this project:
is guided by Bronfenbrenner's (1979) ecological systems theory
is grounded in the legislation and conventions that govern the care and protection of New Zealand children
reflects the care and protection framework employed by CYF, which has three overlapping perspectives:[30] child-centred; family-led and culturally responsive; strengths- and evidence-based.

In the complementary literature review focusing on whānau Māori (Cram, 2011), the determinants of positive whānau outcomes are examined through ecological models that consider what Māori view as the factors that determine health and wellness.

Ecological systems theory

This review has been guided by Bronfenbrenner's (1979) ecological framework, which considers the child and their family to be part of a broader set of systems that interact with, impact upon and are impacted upon by children and their families. Important elements that must be considered within this ecological framework are New Zealand's care and protection legislation, and the relevant international conventions, outlined below.

Bronfenbrenner's ecological systems theory identifies five environmental systems that shape child development. Locating children with care and protection needs and their families within this system highlights where pressures and supports might be present. These are described in the following table.

TABLE 2

System	Description	Examples relevant to this literature review
Microsystem	Where the child lives: their family, friends, school, neighbourhood, community, plus their own biological makeup (eg, physical, intellectual ability)	Safety of home, people living in child's home Quality of parent's relationship Support of grandparents, aunts etc Strength of relationship with hapū/iwi
Mesosystem	Connections or interactions between microsystem settings	Connections with social, health support services Family's relationship with CYF Quality of relationships between professionals working with family
Exosystem	Links between the child and a social setting in	Drug and alcohol use by family members Parental intellectual disability

[30] http://www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/care-and-protection/perspectives/index.html

	which they are not actively or personally involved	Parental mental health History of family involvement with CYF including current placement of older sibling(s)
Macrosystem	Culture in which the child lives, including ethnicity and socio-economic factors	Impact of poverty, unemployment Care and protection policy and law Access to health services
Chronosystem	Events and transitions over time	Parents separating Parents re-partnering Moving house Child maturing and achieving developmental milestones

Legislation and international conventions

Legislation and international conventions variously applicable to children, adults, parents, families and the state set parameters around rights, responsibilities and the safety and wellbeing of children in New Zealand; in particular, the New Zealand Bill of Rights Act 1990, United Nations Convention on the Rights of the Child 1989, Convention on the Elimination of all forms of Discrimination Against Women, Contraception, Sterilisation and Abortion Act 1977, Care of Children Act 2004, and Children, Young Persons and Their Families (CYPF) Act 1989 (see Appendix 3). The 'paramountcy principle' is key: the welfare and interests of the child shall be the first and paramount consideration (Section 6, Children, Young Persons and Their Families Act 1989).

The overarching principles in Sections 5 and 6, and the care and protection provisions in Part 2 of the CYPF Act 1989 are relevant to this project. The principles in Section 13 of the Act state that the primary role in caring for and protecting children lies with the child's family, whānau, hapū, iwi and family group and, accordingly, they should be supported, assisted and protected as much as possible. Interventions into family life should be the minimum necessary to ensure the child's safety. Where a child or young person is considered to need care or protection, wherever practicable they should be cared for by their family, or in a family-like setting in the same geographical area where they can maintain contact with their family, maintain their personal and cultural identity and develop an attachment with their caregiver.

Care and protection services in New Zealand

Care and protection services in New Zealand are delivered both by statutory and non-statutory agencies and responses to children and families vary depending on their level of need. CYF is New Zealand's national statutory child protection agency. NGOs and iwi agencies also provide services to children, young people and their families who have never been in contact with CYF, although they are obliged to make referrals to CYF should the child or young person need care and protection.

CYF's care and protection framework has three interlinking parts.[31] It is:
child-centred: focusing on the child's needs and best interests, their safety, care support, wellbeing and rights
family-led and culturally responsive: working with families, empowering and supporting them in their primary role of carers and protectors of their children, using processes to involve the broader family in decision-making for their children, supporting the cultural context of the family
strengths- and evidence-based: practice needs to have a strong knowledge base and be informed by evidence; emphasises the importance of using a strengths-based approach.

Anyone may make a referral (a 'notification') to CYF if they are concerned about the abuse, neglect, self-harm or behaviour of a child. NGOs are also able to make a direct referral (s19 referral) to CYF for a family group conference. Families or professionals can make a referral directly to an NGO/iwi social service/support agency to provide support to a family if there are less-immediate child protection concerns.

The flowchart below outlines CYF's differential response approach.[32]

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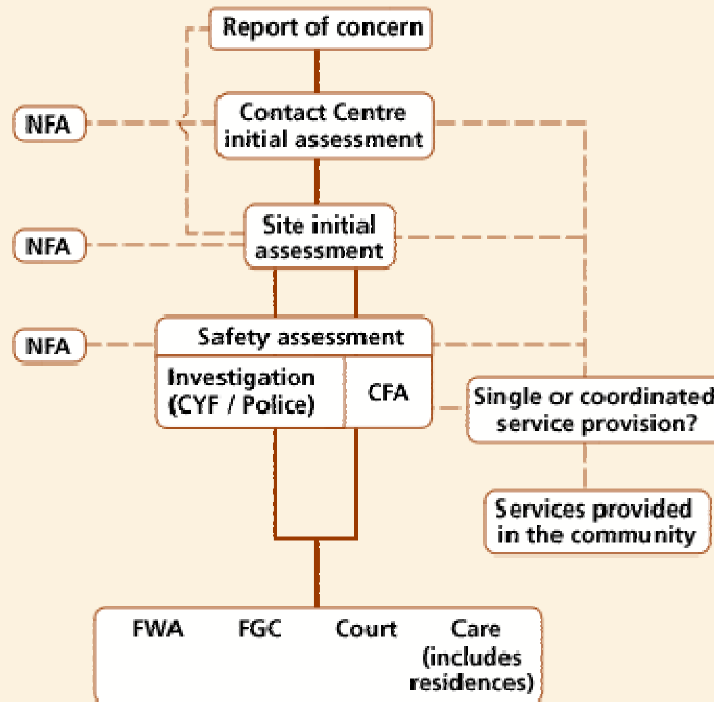
[31] www.practicecentre.cyf.govt.nz/knolwedge-base-practice-frameworks/care-and-protection
[32] CYF's Differential Response approach is a model for deciding on responses to notifications (Child, Youth and Family and Ministry of Social Development, 2008). It enables non-government agencies to become involved in initial responses to notifications through service provision particularly at an early intervention stage. Assessment and investigations of serious abuse or violence cases continue to be completed by CYF.



Key: NFA = no further action; CFA = Child and Family Assessment; FWA = Family/Whānau Agreement; FGC = Family Group Conference

CYF's service pathway begins with an initial Safety Assessment, which determines the child's immediate safety and whether further statutory assessment is required. A specific CYF assessment framework is used and a range of practice tools are also available to use at certain points within the assessment (eg, the Safety Assessment Tool, Child and Family Group Supervision Tool, the Three Houses). Both on- and off-site training are provided, as is regular supervision.

Summary

The conceptual framework underpinning this review is guided by ecological systems theory, legislation and conventions and CYF's care and protection framework. Within the New Zealand context, the following principles are predominant:

The welfare and interests of the child shall be the first and paramount consideration.

Children's rights should be respected, and children should be at the centre of care and protection considerations.

All levels of the system surrounding children and their parents need to be considered and strengthened to ensure a full and sustainable response is made to care and protection issues.

Parents, families and the state have responsibilities and rights that need to be fulfilled to ensure the care and protection of children.

Families should be empowered to be fully involved in responses to care and protection issues.

PART THREE: EFFECTIVE IDENTIFICATION

A key challenge in the child protection sector is the identification of families where maltreatment is likely to [re]occur (Thoburn, 2009). A number of death reviews suggest child protection and social services are likely to have had contact with only a proportion of children at risk of serious incident or death before the incident took place. Internationally, this proportion is estimated to be between 25 percent and 80 percent (Brandon, 2008, in Thoburn, 2009; Connolly & Doolan, 2007).[33] Connolly and Doolan (2007) found that only 19 percent of child homicide cases in New Zealand from 1996–2000 involved children previously known to CYF.

Identifying families at risk of having a subsequent child removed is a complex task, requiring effective communication between people who know the family, knowledge of what these families 'look like', understanding of the factors that pose a risk to children within such families and effective assessment of the family's strengths and risks in order to inform decision-making about the child's safety.

This section describes the characteristics of families in which subsequent children may be at risk, as well as what is known about the characteristics of families who have previously had children removed. We explore how agencies (and 'agents') may become aware of new children entering families where a previous child has been removed, including consideration of referral pathways, mandatory reporting, collaborative approaches (information sharing) and how pathways and approaches might be improved. Finally, we explore child and family assessment practices and how these contribute to effective identification of subsequent children who may be at risk.

Characteristics of families where subsequent children may be at risk

Identifying the characteristics of families where subsequent children may be at risk may help potential referrers recognise these families early. Analysis of these characteristics can inform assessment, either prior to or following notification to social services.

Key risk factors for child abuse identified in the research (Bromfield, Lamont, Parker, & Horsfall, 2010; Ellaway et al, 2004; Moore, Hawke, & Dungey, 1999; Thoburn, 2009) include parental mental illness, substance abuse, parental intellectual disability, child disability, teenage motherhood, pre-term birth, parental childhood experiences (eg, abuse and neglect, state care), family violence, a criminal record, lack of parenting knowledge and skills, economic disadvantage, social isolation, insecure or disturbed attachment behaviours or distorted mother–infant interactions, and previous history of perpetration of child abuse (which may have resulted in children being removed from their family).

[33] Noting the timeframes within which 'contact' is measured may vary and these studies may or may not consider previous contact that care and protection services have had with the child's siblings.

Not all families exhibiting such characteristics will necessarily be more predisposed towards violence or neglect; rather, it is the interaction of these factors.

In a New Zealand study of the family characteristics of 6,699 children aged under two years notified to CYF in 2006, CYF (2010) found families often had CYF involvement regarding other children. Their analyses suggest there are two key groups for which early notifications of vulnerable infants occur: parents with an intellectual disability; and a separate group who exhibit antisocial behaviour, transience and long child welfare histories (including in their own childhoods).

Throughout this review we draw on a 2001 report by the Department of Human Services, Victoria (Australia), the only literature located that specifically focuses on the needs of newborn siblings born into families where previous children have been removed. The report, supplemented by a literature search, is based on a retrospective study of 14 cases in which young children had died; all had an older sibling who had previously been placed in the care of child protection services.

The report singled out neglect as a key characteristic among many of the 14 cases reviewed:

It became apparent to the panel that a significant number of characteristics of the presenting cases demonstrated aspects of neglect. There was also evidence to suggest that this was intergenerational in some cases. In examining the cause of death and the reasons that older siblings had been removed in each case, the panel determined that symptoms of neglect existed in a large proportion of the cases. (Department of Human Services, Victoria, 2001, p. 8)

Neglect is explored in further detail in this section, as well as the following characteristics of complex families: previous child abuse/removal; parental mental illness; parental intellectual disability; substance abuse; family violence; and child characteristics. The interrelationships between risk factors and cumulative effects are also considered.

Neglect

Neglect can be a challenge to identify and respond to. Mardani (2010) defines child neglect as:

…a failure to provide for a child's basic needs or to protect a child from harm or potential harm … a form of child maltreatment and family violence, which is categorised by four core components:

the child's unmet needs
the responsible parties' capability and culpability
the harm or risk of harm to the child [and]
established standards of care.

Neglect may be physical, emotional, medical, educational or supervisory … the harm neglect causes depends on the child's age (neglect in the early years is more detrimental), the length of time their needs were unmet and whether action to prevent long-term impairment was undertaken. (Davies, Rowe & Hassall, 2009, in Mardani, 2010, p. ix)

Literature identified by Lamont and Bromfield (2009) highlights neglect as a passive rather than an active form of abuse and typically chronic in nature (although it can be a one-off incident), with neglectful families often experiencing multiple problems. A

parent's ability to care for their child may by hindered either temporarily or permanently by their physical and/or mental health.[34]

Table 3 outlines the factors that increase vulnerability to child neglect, using an ecological approach.

Table 3 Factors that increase vulnerability to child neglect

Ecological level	Factors
Child	High needs (eg, born prematurely, one child from a multiple birth, has a disability or chronic illness) Personality or temperament traits that are perceived by the parent as problematic
Parent/caregiver	Difficulty bonding and less empathy with the child Maltreatment as a child Lack of understanding of child development Poor parenting skills (can be a result of young age or lack of education) Parental psychopathology or cognitive impairment Parental stress and social isolation, low self-esteem and lesser problem-solving skills Substance abuse (estimated to be a factor in 80 percent of child maltreatment in US)
Family life	Other siblings who are demanding of parental attention, family size A family member with physical, mental or developmental health problems Financial difficulties, chronic poverty Family breakup Family violence Frequent changes in household members Homelessness Involvement with criminal activity
Community factors	Isolated in the community, lack of a support network Poor pre-natal and post-natal care Discrimination against the family because of ethnicity, religion, sexual orientation, lifestyle etc Lack of or inadequate housing Transient neighbourhoods The easy availability of alcohol A local drug trade Inadequate policies and programmes within institutions

[34] http://practicecentre.cyf.govt.nz/policy/engagement-and-safety/key-information/what-did-we-find-recording-findings-from-investigations-and-child-and-family-assessments.html

Societal factors	Socio-economic inequalities Poor living standards, poverty Gender and social inequality Lack of services and institutions to support families High levels of unemployment Poor social, economic, health and education policies Social and cultural norms that diminish the status of the child or demand rigid gender roles

Sources: Daniel et al, 2010; Donohue, 2004; Heller, Larrieu, D'Imperio, & Boris, 1999; Hildyard & Wolfe, 2002; Krug et al, 2002; Reading et al, 2009; WHO & ISPCAN, 2006, in Mardani (2010,
p. 11)

Mardani emphasises that early exposure to neglect can have a "cascade of negative impacts", with adverse outcomes identified in the areas of intellectual development, and mental, physical and social health. Amongst the professionals Mardani interviewed,[35] neglect was perceived to be harder to define and harder to prove than physical abuse. Her study identified a lack of shared understanding of what constitutes neglect; operational definitions differ between professions, communities and cultural groups (citing McSherry, 2007). Professionals commonly talked about the challenges of supporting parents who did not understand the concept of neglect:

Without this understanding, professionals found it difficult to help parents develop insight or obtain buy-in to interventions. (Mardani, 2010, p. 58)

Mardani (2010) reports that there is no mechanism for regularly measuring the prevalence of child neglect in New Zealand; CYF data provide an indication of epidemiology (albeit with 'significant limitations') with additional sources of data being hospitals and Police. Drawing on 2009 CYF data, Mardani shows that neglect is more commonly identified in pre-school children, with 43.7 percent of children with identified neglect in 2009 aged between 0–4 years. Across all age groups, Māori children had the highest rate of identified neglect.

She suggests that a shared understanding of child neglect and an intervention pathway is central to collaborative efforts to prevent the occurrence and recurrence of neglect.

Previous child removal

Brayden et al (1993) and Ellaway et al (2004) found that having a previous child removed from parental care is likely to indicate risk to subsequent children (as are previous notifications; see Tilbury, 2003). There is also some suggestion that previous child removals may be an indicator of future neglect.

In their large-scale study, English, Marshall, Brummel, & Orme (1999) found that prior involvement with child protective services "greatly increases the likelihood of referral, and that the rate of referral increases with the number of prior referrals" (p. 302). In particular, they note that children placed in foster care and then reunited—or siblings in

[35] A total of 47 interviews were conducted with 121 professionals from health, education, Police and CYF.

the same family as a foster-care placement—were more likely to experience recurrences of abuse and neglect.

Damashek and Bonner (2010) examined social-ecological factors related to the likelihood that siblings would be removed from their homes after a child maltreatment fatality. After analysing available data for 250 families (which was limited regarding parental characteristics), three factors were found to be significant predictors of sibling removal after a child maltreatment fatality: sibling age (younger siblings were more likely to be removed); previous number of family child protection service reports; and maltreatment type (ie, abuse rather than neglect).

Although much of the research literature has emerged from the US, several New Zealand studies have also looked at parental characteristics. Connolly et al (2007) studied the case files of 171 infants who were notified to CYF during a one-year period and found evidence of high levels of CYF involvement with the families of these infants. Infants were often being cared for by parents who had substantive involvement with CYF with other children; in many cases, parents had CYF involvement during their own childhood too (echoing findings from researchers such as Moore et al, 1999). The CYF (2010) study found a significant group of children aged under two years who were notified to CYF were born to older[36] parents with a number of children, and that families often had CYF involvement with other children. Seven percent of this group of under-twos were placed in CYF care at some point in 2006.

Doolan (2005) reported on the findings of a study of the case reviews of nine children who died "as the result of aggressive actions"; all were known to CYF prior to their deaths. Amongst the numerous factors warranting child protection intervention across these cases was an agency history of involvement with the family network in cases of neglect and/or abuse (although the extent and nature of this involvement are not specified).

Parental mental health

Mental illness is recognised as a risk factor for child abuse and neglect, although many parents with mental illness cope well and are not involved with the child protection sector. Mercovich (2008) notes that with appropriate treatment and care, mental health issues can be well managed and parents can care for their children adequately. However, she cautions that there can be tensions between services providing support for the parent and those focusing on child outcomes, and these may surface when a subsequent child is born:

While child protection services may have a long history of involvement with a family and consider a range of risk factors to predict future harm, an adult-focused service may view the recent and current presentation of their client as being a fresh start. A new birth can be a catalyst for change in a parent and a great motivator to consistently seek help and support. At what point should the practitioner consider there to be no further capacity for change and how much does the past inform the future? (p. 75)

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[36] More infants notified to CYF were born to older parents than to teen parents (maternal age: 17 percent over 35 years and 14 percent under 20 years; paternal age: 25 percent over 35 years and 7 percent under 20 years).

Hollingsworth (2004) analysed data from a longitudinal study of women with persistent, severe mental illness, supplemented by additional qualitative data. She notes that certain diagnoses may be characterised by lack of warmth, chaotic behaviour, apathy, impulsiveness and reduced tolerance to stress, irritability and depressive delusions—which may lead to abuse or neglect of children. Social and environmental influences (eg, family violence, poverty) can exacerbate problems, heightening the risk to children.

Hollingsworth found that the likelihood of child custody loss was increased when a woman with a history of persistent severe mental illness was unmarried, had a household income at or below the poverty line, a larger number of children, less social support with childcare and lacked adequate parenting knowledge and values. Compared with women who had never lost custody of their children, women who had lost custody had longer periods of mental illness and more psychiatric hospitalisations over their lifetime, although their diagnoses did not differ.

Parental intellectual disability

McConnell and Llewellyn (2002) observe that becoming a parent is now a more realistic aspiration for young adults with intellectual disability,[37] compared with previous generations. However, they suggest that children may be unnecessarily removed; not necessarily to protect the child, but based on misguided or prejudicial beliefs about parenting skills. Research indicates that parents with intellectual disabilities are overrepresented in child protection and legal proceedings in a number of countries (Lamont & Bromfield, 2009). In Connolly et al's New Zealand study (2007), amongst the families of babies notified before they were born, 28 percent of mothers were described as having an intellectual disability:

A high proportion of families with a parent with an intellectual disability will come to the attention of child protection and support agencies due to allegations that a child has been or is at risk of abuse or neglect. (James, 2004, in Lamont & Bromfield, 2009 p. 1)

An examination of care and protection court files in New South Wales (Australia) found a disproportionate number of children of parents with intellectual disability were made state wards. Llewellyn, McConnell and Ferronato (2003) suggest that this could be due to court pessimism and stereotypical beliefs about the parents, and a real or perceived lack of available or appropriate support services for parents.

Evidence suggests that allegations of child abuse by parents with intellectual disability are quite rare, with concerns about neglect being the most common, although often non-specific (McConnell & Llewellyn, 2002). Lamont and Bromfield (2009, citing James, 2004) note that, amongst these parents, neglect can be associated with a lack of support services and/or knowledge regarding healthcare and child safety.

Although mothers with learning disabilities are rarely abusive, their children may be vulnerable due to the behaviour of mothers' partners or relatives, particularly if mothers are unable to address protection issues (James, 2004).

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[37] Inconsistent terminology is used to describe intellectual disability (with variations including 'learning disability' and 'developmental disability'); there is no generally accepted definition.

Substance abuse

There are links between substance abuse (eg, of drugs or alcohol) and child maltreatment. For example, Murphy et al (1991) report that parents with documented substance abuse were significantly more likely than non-substance-abusing parents to have been referred previously to child protective agencies, to be rated by court investigators as presenting high risk to their children and to have their children permanently removed. Amongst the case files they studied, Connolly et al (2007) found higher levels of mental health and/or substance abuse problems amongst mothers whose babies were placed in care than for other groups. They note that these factors (and other parental issues, such as being in a violent relationship) are known to significantly affect the successful care, nurture and development of infants.

Schilling, Mares and El-Bassel (2004) state that children exposed to some drugs in utero (eg, opiates) are at heightened risk for developing conduct problems; researchers have difficulty disentangling the effects of the multiple prenatal, neonatal and later influences on child development. In their study of 256 women involved in detoxification programmes, they found that women who did not live in their own home, had less education and used multiple drugs were more likely to have lost guardianship of one or more children. Of the 613 children born to the mothers participating in the study, one-third were in the care of their mothers. Less than a quarter of the women in the study were the guardians of all their minor children. Eighty-six percent of the women indicated that drug abuse had harmed their ability to be good parents.

Family violence

Bromfield et al (2010, citing TAFT, 2002) emphasise the importance of considering violence between intimate partners in the context of parenting, as research has confirmed that violence between partners is more likely to occur between couples with children, often beginning during pregnancy.

Family violence is commonly associated with child protection involvement and is one of the key risk factors for child abuse and neglect (Bromfield et al, 2010). A Ministry of Social Development report (2008) refers to a number of studies presenting substantial evidence for the co-occurrence of adult partner violence and child maltreatment, and for the damage to children of living in families where adult-to-adult violence occurs.

Child characteristics

The characteristics of children and young people should also be taken into account, particularly those that may lead to them being hard to engage, help or change (and therefore vulnerable) especially when combined with parental risk factors (Thoburn, 2009). Thoburn identifies this group of children and young people as having one or more of the following characteristics:[38]
born prematurely and/or affected by intrauterine drug and/or alcohol abuse (which can affect temperament, responsiveness and feeding patterns)

[38] Not all of these characteristics will be observable in, or applicable to, unborn or newborn children.

disabled, or with other characteristics that make parenting a challenge/unrewarding for parents lacking self-esteem and confidence[39]
individual members of sibling groups being singled out for rejection and/or targeted for abuse
children returning home from care, especially if suffering the loss of an attachment figure (typically a foster carer)
teenagers who engage in risk-taking or anti-social behaviour.

Connolly and Doolan (2007) refer to the need for robust assessments of parenting ability and capacity in the face of 'extreme child behavioural issues'.

Considering children's characteristics, a subsequent child with different characteristics from a sibling who has been removed may be 'easier' to parent and, consequently, be at less risk of harm.

Interrelationship between risk factors and cumulative effects

In discussing assessment of risk to infants, Moore et al (1999) point to the effects of an interrelationship of risk factors, rather than the existence of a single factor or pattern of factors. Similarly, a CYF and Ministry of Social Development report (2006) identifying factors associated with an increased risk of fatal child maltreatment stresses the cumulative and interactive effects of risk and protective factors. In essence, this view argues that:
risk factors can accumulate from childhood to adulthood
risk factors can interact or 'mutually reinforce' one another (eg, mental health issues, substance abuse and family violence are often interacting risk factors)
these cumulative and interactive effects can trigger an episode(s) of maltreatment—with the caveat that "many people with one or more risk factors will never harm children and adversity in childhood does not necessarily transfer into adulthood" (CYF and Ministry of Social Development, 2006, p. 21).

Family resilience factors (eg, parental education, higher income, healthy parental relationships, stable employment) can mediate or reduce these effects.

Referral pathways

To identify and work with complex child protection cases, clear and effective referral and support pathways are required (Thoburn, 2009). These enable professionals and others to be aware of—and offer support and intervention to—vulnerable children and families. Thoburn suggests pathways need to be non-stigmatising and empowering so that families engage with services.

The Department of Human Services, Victoria report (2001) notes that when social services are still actively involved with children in a family in which previous children have been removed, there is more likelihood that services will become aware of new

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[39] Bromfield and Holzer (2008) note that families in which there is a parent or child with a disability are particularly vulnerable, especially if the individual's care needs exceed the family's ability to provide them.

children entering the family, creating opportunities for intervening and providing support early. This implies that there are potential benefits from keeping cases open longer.

Families who have had previous children removed do not necessarily have ongoing involvement with social (or other) services after the removal. Some of these families may deliberately "disengage with the sector [and] 'fall through the gaps'" (Department of Human Services, Victoria, 2001, p. 7) out of fear that contact with services will lead to subsequent children being removed. Consequently, child protection services do not necessarily know when a subsequent child enters a family unless they are notified about that child. Effective pathways to supporting the family and making CYF aware of a new child's existence are essential. These pathways may involve both formal (eg, agency) and informal (eg, friends and whānau) networks.

The British Government's *Framework for the Assessment of Children in Need and Their Families* (Department of Health, Department for Education and Employment, Home Office, 2000) provides guidance for health, education and social services professionals regarding when and how families should be referred to child protection services. However, parents and professionals have mixed perceptions of the framework as a route to services (Thoburn, 2009). Some hospital and healthcare professionals do not make referrals, as they are not confident that the referral will result in a service, or are concerned that response to a referral may result in the family withdrawing from primary care services. This suggests that one of the key barriers to child protection agencies finding out about children who are potentially vulnerable (including subsequent children) is a reluctance to make referrals to relevant agencies.

Mandatory reporting

Mandatory reporting refers to the legal requirement of specified groups to report actual and suspected cases of child abuse and neglect to the statutory child protection agency and/or to the Police (Hill, 2010).[40] Although sharing many common features, there are significant differences in reporting laws within and between nations (such as the US and Australia) that broaden or narrow the scope of cases required to be reported and by whom (Mathews & Kenny, 2010). New Zealand has no mandatory reporting laws. There are ongoing debates worldwide about the effectiveness and efficacy of mandatory reporting.

Tomison (2002) discusses the underlying theory of mandatory reporting and suggests that mandatory reporting sends a clear message that the state does not condone child abuse and/or neglect, and affirms children's rights to be protected through legislation.

Mandatory reporting has been imposed in some jurisdictions as a solution to overcoming a reluctance to make referrals. In New Zealand, the debate about whether or not to legislate for mandatory reporting has been active since the 1950s (Brown, 2000). During the development of the CYPF Act, there was considerable discussion about whether mandatory reporting should be introduced. Amendments to the CYPF Act in 1995 gave the Director General of Social Welfare new duties to raise public awareness and to develop protocols for reporting abuse (Dyhrberg, 2002; see Appendix 4[41]).

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[40] http://www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=OFb3kiC_2xs%3D&tabid=161&mid=560

[41] s7(2)(ba)(ii)(i) of the CYPF Act 1989.

Interagency protocols encourage agencies to work together to identify abuse and refer families, but they do not penalise inaction. For example, the protocol between CYF and Police sets out how these organisations will work alongside each other in situations of serious child abuse. The protocol clarifies the roles and responsibilities of each organisation, and the process to be followed for working collaboratively at the local level, to ensure a prompt and effective response to cases of serious child abuse. It is a formally agreed, national-level document.

Brown (2000) cautioned that if voluntary reporting could not be adequately delivered, mandatory reporting would become a necessity. He encouraged renewed effort and expenditure on the development and use of voluntary reporting protocols and interagency collaboration to protect children.

With reference to the mandatory reporting Acts and Regulations in Australia, Higgins, Bromfield, Richardson, Holzer and Berlyn (2010) identify the differing groups of people mandated to notify their concerns, suspicions or beliefs to the appropriate statutory child protection authority. In some states, particular occupations (eg, doctors) are mandated to report; in other areas, there are generic descriptions (eg, 'professionals working with children'). There are also differences in the abuse types that must be reported.

Mandatory reporting laws specify those conditions under which an individual is *legally required* to report. However, Higgins et al (2010) note that this does not preclude an individual from making a report to the statutory child protection service if they have concerns for a child's safety and wellbeing that do not fall within mandatory reporting requirements.

Drawing on national and international research literature, Hill (2010) outlines the benefits and disadvantages of mandatory reporting, cautioning that there is a lack of empirical data on the effectiveness of mandatory reporting systems.

Benefits include:
enforcing a legal responsibility for professionals to report, which reduces the number of cases professionals choose not to report
raising public awareness of child abuse and educating professionals and the wider community about appropriate reporting processes
encouraging early identification and reporting, which leads to effective intervention and reduced risk of further harm for the child.

Disadvantages include:
substantial increases in reports of child abuse may pose significant problems if there are inadequate resources to respond effectively
professional and public trust in the system may diminish if cases are not responded to effectively once they are reported; this can increase the risk of future cases not being reported
resources become dominated by the need to investigate with less attention to ongoing help that is needed.

Although anecdotal reports suggest that parents and caregivers may avoid seeking medical or other care for their children if they fear being reported, Kelly (2000) reports that there is no hard evidence that abused children are less likely to be taken to the doctor.

Hill summarises the key issues below:

Some claim that without a system of mandated reporting many cases of abuse and neglect do not come to the attention of authorities and helping agencies. Consequently, these societies are far less able to protect children and assist families. Others argue that mandated reporting produces a large number of reports (both unsubstantiated and substantiated) and overloads child protection systems. The most significant problem with a mandatory system is the lack of resource to respond effectively, rather than in the reporting itself .There is little evidence worldwide that mandatory reporting has effective outcomes for children; however, alternative systems are not necessarily effective either. (Hill, 2010, Executive summary)

Higgins et al (2010) warn that the threshold or level of seriousness of reports that require investigation may change to cope with a substantial increase in the number of reports (if there are insufficient resources to respond to the demand). They cite New South Wales as an example, where in 2010 the threshold for child maltreatment changed from 'risk of harm' to 'risk of significant harm'.

Whether a mandatory reporting system is required relates to the broader question of whether and how to bring cases of abuse and neglect to light (Mathews & Bross, 2008):

Even with a good system of mandated reporting, many children's experience[s] will go undetected. Without it, and without a proven alternative, many … more children will be left to suffer, incurring even more health and economic costs. (Mathews & Bross, 2008, p. 515)

If New Zealand is to reconsider mandatory reporting, as well as asking how the resulting increased number of notifications will be resourced, the issues of 'Who must report?' and 'What should be reported?' need to be addressed (Brown, 2000). Being pregnant and/or having children previously removed by the state may not be sufficient grounds for reporting under a mandatory system, which requires reporting of actual or suspected cases of child abuse or neglect:

Are reports required only of past or present abuse, or are reports also required of suspected risk of future abuse (and, if so, under what circumstances)? (Mathews & Kenny, 2010, p. 62)

Even under a mandatory reporting system, the issues of identifying pregnant women and babies who may be at risk are likely to remain.

Experts argue that mandatory reporting, public and professional education and support from whānau are complementary components of a comprehensive approach to addressing child abuse (Kelly, 2000). Educating potential referrers about when and what to report to CYF (under s7(2)(ba)(ii)(i) of the CYPF Act 1989) is part of this approach.

Education and support for referrers

Whether or not mandatory reporting is legislated, referrers must understand child risks and family protective factors so that they can identify when a child or family is vulnerable and when a referral to child protection services is necessary.

Thoburn (2009) emphasises the need for all frontline workers (health, social services and education) to be adequately trained in child protection matters, including their ability to identify and address neglect. They should be aware of the importance of engaging directly with children, rather than speaking to the parent/s only.

Focused questions could help to alert agencies to previous children having been removed by a formal care and protection intervention, which may not be otherwise known. For example, Moore et al (1999) suggest that questions to women regarding previous pregnancies and births could include:

Are these children living with you?
If not, where are they?
Although professionals play a key role in identifying and protecting vulnerable children and families, anyone who comes into contact with a child or family could potentially protect and support children in at-risk situations. Through an ecological lens, this includes family and whānau networks, the community and all agencies in contact with the family.
The literature suggests that protective outcomes for children are improved where professionals (and 'agents', more broadly) across a child's ecological spectrum are well educated about the characteristics of vulnerable children, and thus readily able to identify and respond to safety concerns for the child (Fauth, Jelicic, Hart, Burton, & Shemmings, 2010; Thoburn, 2009). CYF encourages consideration of the 'Five Eyes on Under Fives' concept.[42] This involves five sets of 'eyes' which look out for the safety and wellbeing of children under the age of five:
a household family member
a member of the extended family/whānau
a health professional (eg, GP or Well Child provider)
an educator (eg, at an early childhood service)

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[42] http://www.practicecentre.cyf.govt.nz/policy/engagement-and-safety/key-information/strengthening-practice-with-vulnerable-infants.html

a community member (eg, a family support agency).

Improved social sector–health alliance

Strengthening the alliance between social services and public health agencies may improve referral pathways. There is potential for maternity and child health services, given their access and proximity to families, to "integrate screening of high-risk families of infants with their health role" (Jackson, Johnson, Millar, & Cameron, 1999, p. 15). GPs and primary health settings also provide an ideal opportunity for early detection and intervention for problems within the infant–parent relationship (Angus, 2010; Jordan & Sketchley, 2009).

Health services (particularly hospitals) have the ability to adopt both identifying and monitoring roles with high-risk families, who have substantially more use of hospitals than non-risk families (Leventhal et al, in Jackson et al, 1999). Jackson et al (1999, p. 15) cite research (Stoleru & Morales-Huet, 1988) suggesting that co-work between health and social services can enhance the family's willingness to sustain contact with helping services, particularly when mothers have a history of mental illness. They describe a successful social service–public health alliance partnership underpinned by mutual respect for the skill and knowledge base of workers' professions, a shared approach and understanding of intervention and support from agencies' administration.

Unborn child reports and alert systems

Some jurisdictions have formal mechanisms that notify social service agencies about potential risk to an unborn child. Unborn child reports rely on others knowing that a child will be born into a family where a child has been removed, or there are other concerns.

In Victoria, Australia, the Children, Youth and Families Act 2005 (CYFA) provides two pathways for the report or referral of an unborn child where people have "a significant concern for the wellbeing of the child after his or her birth": confidential reports to Child Protection and referrals to Child FIRST (Family Information, Referral and Support Team):[43]

The intent of the legislation is to prevent future harm and reduce the likelihood of Child Protection intervention after the child's birth by working earlier and in partnership with the mother and appropriate support services to address the need or risk factors. The guiding practice principle is one of supportive intervention, rather than interference with the rights of the pregnant woman.[44]

In Queensland, the Unborn Child High Risk Alert system addresses child safety issues where a mother has had a previous child removed or there are other concerns. Legislative changes in 2004 enabled Queensland's Department of Child Safety to investigate the circumstances of an unborn child and offer support to the pregnant

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[43] Approximately 570 unborn child reports are received each year in Victoria, many progressing to an investigation (*Supporting Parents, Supporting Children* report, Children, Youth and Families Division, Victorian Government Department of Human Services, Melbourne, 2010).

[44] http://www.dhs.vic.gov.au/office-for-children/cpmanual/Output%20files/Practice%20research/Output%20files/Execute/unborn-child-reports-guidance.pdf

woman and her partner, or the father of the unborn child, to increase their capacity to protect the child following birth. If families do not consent to an assessment, an unborn child alert is recorded on the Child Protection Information System, with information sent to local hospitals and to the woman's general practitioner (if known). Midwives are required to search the alert database every time a pregnant woman is admitted to deliver a child, and the 'nominated position' (within health) must notify the Department of Child Safety immediately when a pregnant woman presents for delivery.

As neither of these two Australian referral pathways for unborn children has been evaluated, we are unable to make any conclusions about their effectiveness in reducing risks to subsequent children.

As outlined earlier, a Child Protection Alert System within health is currently being developed and trialled in New Zealand. While such systems may enhance agency awareness of children at risk, as noted by Ritchie and Wills (2006), alert systems have potential legal, ethical, clinical and information technology complications:

When implemented poorly they risk falsely labelling and stigmatising parents of children with accidental injuries. Clinicians may be falsely reassured when children who lack an alert present with non-accidental injuries. The decision whether or not to inform parents that an alert has been placed on their child is a complex balance of ethical and legal issues.

One concern is the length of time that flags may remain on a child's file; flags may stigmatise a family whose circumstances and ability to manage challenges improve significantly over time. Concerns have also been raised that as the alert system will be based in DHB IT systems, primary care-based health providers and systems will be excluded (Eddy, 2011).

Information sharing

Barriers to information sharing between agencies can hinder referrals to—and communication with—social services. Lips, O'Neill and Eppel (2009) empirically examined information-sharing practices between agencies in New Zealand (ie, where social policy agencies are dealing with complex, multiple problems of an individual or family) to look at how cross-government information sharing could be improved, taking into account individuals' fundamental rights to privacy and confidentiality. They note that countries with similar jurisdictions to New Zealand (eg, Australia and the UK) are developing strategies to "overcome [the] tensions between goals of service transformation and the privacy protection of individuals, with a current focus on allowing specific information sharing arrangements for targeted user groups, such as children … and developing cross-government identity management (IDM) solutions" (Lips et al, 2009, p. 3).

Their project involved qualitative research, a study of existing strategies and arrangements for cross-government information sharing in the UK, Canada and Australia, and focus groups. They note that the efforts of government agencies to work together can be viewed on a continuum: ranging from informal, ad-hoc arrangements and information exchanges, to formalised, shared working initiatives on integrated service delivery:

The style and specifics of interagency working are highly contingent on the specific context, issues to be solved, and the people involved … complex problems do not lend themselves to simple solutions. (Lips et al, 2009, p. 9).

Lips et al found that officials are conscious about the need to protect the personal information of their clients; privacy values shape operational information-sharing practices, guided by privacy legislation. Professionals can be uncertain about whether—and what—information can be shared, leading to a decision not to share critical information:

This default position of not sharing information leads to situations in which the complex needs of the client are not being met … [and] also stands in the way of sharing information with public service providers in the health domain and/or with health practitioners, which is often required to do a professional job towards individuals or families at risk. (p. 79)

Lips et al conclude that there is a clear need for legal support of information sharing in the provision of social services, similar to the working of Principle 11[45] under the Privacy Act 1993. They propose 14 solutions and associated recommendations. These include: development of a Code of Practice for Welfare (under the current privacy legislation); using information-sharing protocols to commit to shared outcomes and build trust and relationships across agencies; regular evaluations of protocols; inclusion of NGOs in protocols; and providing training and education on the 'do's and don'ts' of information sharing under privacy legislation, across the public sector and NGOs.

Experts in New Zealand have called for improved information sharing and interagency functioning in the interests of protecting children (Experts' Forum on Child Abuse report, 2009). Forum members noted that, as there is no formal mechanism for data sharing, "this impedes the ability of professionals to make informed decisions about a child's future safety" (p. 3).

A lack of information sharing between agencies can result in CYF not being aware of the birth of—or risks to—a subsequent child. Inconsistencies in the quality and extent of information available to be shared across agencies may present obstacles. A CYF and Ministry of Social Development report (2006) focusing on children at increased risk of death from maltreatment and strategies for prevention notes that different agencies collect different data about children (and their families), using different definitions and coding protocols and levels of scrutiny. Connell, Bergeron, Katz, Saunders and Kraemer Tebes (2007), in their study of the influence of child, family and case characteristics on risk status and re-referral to child protective services, outline some of the limitations of administrative data (and urge caution about relying on research for which such data are used). Data may capture limited information, or rely on caseworker knowledge and time pressures—which may result in missing data, or data entry errors. Tilbury (2003) acknowledges criticisms levelled at administrative data, yet concludes that, provided child protection data sets are carefully interpreted, the data can inform policy and improve practice.

Assessment

When families are referred to child protection agencies, the child's safety within that family, and the family's needs, are assessed, considering a range of factors and

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[45] Principle 11: Limits on disclosure of personal information. http://privacy.org.nz/information-privacy-principles

characteristics. Research provides guidance on how to effectively assess families, including what to consider and how assessments should be conducted.

Although the research literature identifies a range of risk factors, on their own they cannot determine how safe a child will be. The interrelationship of factors may be as important as individual risk and protective factors, and assessments need to consider interrelationships. Assessment is likely to be an ongoing process, requiring skills, knowledge and adequate supervision to be carried out effectively.

The Department of Human Services, Victoria study (2001) states that there was general agreement that a higher likelihood for harm existed for a new baby born into a family where older children had previously been removed and that these cases required a further level of investigation, given the family history. It identified the pre-birth period as a critical time to assess a parent's capacity to care, and recommended specific tools be developed to assess parenting prior to a subsequent child's birth. The study recommends:
the development of tools to assist in assessing parenting capacity (including the positive changes that have taken place following a previous child's removal and the capacity for changes to be sustained)
that these tools should be used across the health and community sector
that workers read case files in their entirety and be well supervised in undertaking thorough risk assessments
that the role and capacity of (adult) males within the family should be assessed.

General assessments commonly consider parenting quality. Assessing minimal parental competence is a 'significant issue' due to a lack of agreed definitions about adequate parenting and inconsistent standards (Lamont & Bromfield, 2009). Taylor, Lauder, Moy and Corlett (2009) suggest that most professionals can describe the characteristics of a 'good' or 'poor' parent, yet it can be a challenge to determine when parenting is 'good enough'.[46]

The recently released "Munro Report"[47] (Munro, 2011) warns against depending on the use of prescriptive and compliance-based tools and processes (including during assessment) and calls for a move toward a learning culture where workers are given more scope to use professional judgement. Munro notes that this approach will need to be 'robustly' managed, and workers will need support to develop their expertise and confidence.

Thoburn (2009) emphasises that front-line staff should be trained in assessment and aware of the importance of asking focused questions "on more than one occasion", with respectful and non-judgemental attitudes:

Multi-disciplinary assessment of the overall profile of the family's past and present functioning as well as the type of maltreatment is essential to the achievement of sound

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[46] The concept of 'good enough' parenting was introduced by Winnicott, a British paediatrician. Taylor et al (2009) note agreement that this would include boundary setting, consistency and putting the child's needs first.
[47] The Munro Review of Child Protection: Final Report.

and cost-effective decisions about duration and intensity of the service needed to prevent re-abuse. (p. 3)

Wills, Ritchie and Wilson (2008) conducted research on detection and assessment of child abuse by health sector workers, describing how an eclectic, formal organisational change approach was used to change clinical practice within a mid-sized regional health service in New Zealand. The approach included partnerships with community organisations. Staff were trained in the dual assessment of child and partner abuse. Improved rates of identification and quality of assessment were achieved and sustained; clinicians were also more confident about referring cases of abuse.[48] Ongoing training and support was required, with recommendations that training and practice change strategies be tailored to each service and profession.

Wills et al (2008) note that training in child and partner abuse, which is mandatory in services primarily serving women and children, occurs only after other systems (eg, policy, documentation and supervision) are in place. Monitoring and evaluation of the programme is ongoing. At the time the article was written, child protection notifications from the DHB to CYF had increased from 10 per quarter to 70 per quarter, with CYF reporting that notifications were appropriate and informative, and that interagency relationships were strengthening.

Thoburn (2009) identifies three overlapping groups requiring different approaches to identification, assessment, support, protection and therapy. These families:
have circumstances that are particularly complex
are hard to identify or engage
may be well known to services, but are hard to change.

Families who have had previous children removed may fit into some or all of these categories.

Connolly and Doolan (2007) observe that families may be uncooperative and evasive in their responses. They emphasise that social workers should understand the nature, quality and strength of adult–child relationships and attachment bonds, which should be factored into an assessment of risk. Workers need to be able to confidently assess parenting skills and knowledge so that they can provide appropriate support. Where parents have particular characteristics, such as intellectual disability or mental health issues, workers require specialist skills and knowledge.

Likelihood of sustained parental change

Researchers such as Thoburn (2009), English et al (1999) and the authors of the Department of Human Services, Victoria study (2001) suggest that regularly reviewed comprehensive assessments must be based not only on ‘here and now’ observations, but also a psycho-social or ecological history of all family members and their relationships—taking into account the overall pattern of family functioning, as well as earlier responses to services. We must understand the reasons why previous children were removed, and consider whether risk factors existing at that time are still present, to

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[48] The article provides no description of the cases referred (eg, family structure or complexity; whether or not the cases referred were subsequent children).

determine whether positive changes have occurred, which make subsequent children less vulnerable.

Campbell, Jackson, Cameron, Smith and Goodman (2000) evaluated the three main strategies of the Australian High Risk Infants Quality Improvement Initiatives Project.[49] They note that if a parent has already had children, there is a greater tendency to treat assessment of high risk as a retrospective exercise; for example, drawing on evidence of past parenting behaviour, and considering continuities of personality, knowledge and environmental variables since that experience.

Campbell et al emphasise the importance of the analysis of parental change; in particular, whether there has been sufficient change to be confident that a subsequent child will be safer than a previous child (in the same family). They believe that parents should be provided with an opportunity to successfully demonstrate that their care of this child was (or will be) better than in the past. Follow-up support and monitoring are essential.

When considering the presence or absence of change (particularly within the court system), Campbell et al suggest that it may be helpful to use chronologies of, and testimony about, past events, although gathering such information is time-consuming for the child protection worker. As change is not uniform, the court may want to hear about both positive developments and significant deterioration. Assessments may involve psychologists who can help to explore the capacity and motivation of parents to change.

Campbell et al identify criteria that tend to be used for determining whether parents who already have children are unlikely to protect new children:
previous child was harmed while in parental care
demonstrated failure of parent to protect previous child from harm
previous children removed and placed (especially in permanent alternate care)
continued presence of same risk factors in parent/s and environment
lack of new compensating protective factors in parent/s and environment.

However, Campbell et al caution that such criteria are based on assumptions that past parenting behaviour is indicative of parenting capacity. These criteria can be problematic for these reasons:
poor practices or mistaken judgements in earlier interventions
improvements or deterioration in the parent's condition, beliefs or knowledge
changed family and social circumstances (among which re-partnering is common)
differences in the characteristics or meaning of the new child compared with previous children.

Campbell et al conclude that there is scope for more detailed exploration of theories of change, as well as training for specialist infant protective workers "focusing on how to operationalise change concepts in the assessment and planning with repeat presentation parents" (2000, p. 137).

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[49] The Specialist Infant Protective Worker; Parenting Assessment and Skill Development Services; the use of a Flexible Budget concept.

The influence of workers' attitudes

Workers' attitudes to families must be considered. Several commentators have warned that workers often do not make full assessments when families have a long history of involvement with child protection services, or when cases are 'active'.

The British Government's Framework for the Assessment of Children in Need and *Their Families*[50] (Department of Health, Department for Education and Employment, Home Office, 2000) notes that some children may become 'lost' to statutory agencies; their wellbeing or need for immediate services may be overlooked and subsequent planning and intervention for them may be less than satisfactory. Families, including siblings (which could include siblings who have been removed), may have a long history of contact with social services and other child welfare agencies:

Their circumstances may be chaotic; files numerous; many staff may have been involved; they may not currently have an allocated worker. Any of these circumstances may result in the need for assessment or reassessment at this point in time not being recognised. (p. 47)

Fauth et al (2010) cite research highlighting the 'unjustified optimism' that practitioners may develop when they work with families who have had a long-term involvement with child protection services and have made small steps in the 'right' (agency-compliant) direction. This has been referred to as 'start again syndrome'; in families where children have already been removed because of neglect, the parents' history is not fully analysed to consider their current capacity to care for a new child. Instead, agencies support the family to 'start again',[51] putting aside what they know about families' past behaviours to focus on the present (Brandon et al, 2008b, in Fauth et al, 2010). This links to concepts of professional dangerousness and collusion (Furlong, 2001 and Morrison, 1995), whereby workers may minimise or deny concerns, disengage from a family or empathise with and accept a family's explanation without critical questioning or confrontation. These situations can result in workers failing to adequately protect children. Fauth et al (2010) caution that, while a strengths-based focus and breaking down parenting practice into achievable segments may be good practice with families with lower levels of need, this approach is often ineffective with families with multiple, entrenched problems:

In these most difficult cases, where the best choice may be to remove the child from the home, progress needed to be balanced with maintaining an overview of families' full histories and actual progress to date (Brandon et al 2008b), and practitioners should not be overly reliant on what parents say is occurring relative to what practitioners are observing… It is of critical importance that practitioners remain focused on outcomes for children. (p. 32)

Assessing neglect

The Department of Human Services, Victoria report (2001) noted that symptoms of neglect existed in a significant proportion of the 14 cases they investigated, and emphasised the importance of professionals being able to recognise and address neglect, which may be aggravated by co-existing factors:

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[50] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014430.pdf

[51] http://www.nottinghamcity.gov.uk/CHttpHandler.ashx?id=3221&p=0

Given the very young age group of the identified cases … the risk of harm due to neglect is significantly higher than the norm. It follows that issues relating to the parental capacity to care for and protect the child become paramount in any risk assessment. The risk to the child is further exacerbated where other factors impacting on that level of care such as substance use, psychiatric illness and domestic violence are present. (p. 9)

The report acknowledges that identifying cases of neglect, and its impact on children, is "a difficult and often daunting challenge for protective workers" (Department of Human Services 2001, p. 8); it is an act of omission rather than commission. As noted earlier, the report recommends that further research be conducted to develop tools to assess parental capacity for change (particularly in light of neglect), to be used prior to a child's birth.

Lamont and Bromfield (2009, citing Sullivan, 2000) say that neglectful parents are characterised by having poor problem-solving skills, a lack of understanding of human relationships, particularly parent–child relationships, a lack of knowledge of child development and an inability to engage positively with their children. Mardani (2010) cautions that full assessments of neglect are complex and time-consuming, and that relying on risk assessment tools to identify children at high risk of neglect is "fraught with difficulty", as screening tools can have poor specificity and lack predictive strength. Tools may, however, complement other forms of professional assessment. Referencing McSherry (2007), Mardani says that establishing neglect often requires the systematic collection of information for a period of time. The Department of Human Services, Victoria report (2001) recommends that the responsibility for assessing the risk of long-term neglect should be shared by community, government and agencies.

CYF acknowledges that workers must be able to assess when neglect affects a child's safe care and development.[52] The findings from Mardani's (2010) small-scale study suggest that further research is required, to determine what extra training workers need to identify and assess neglect.

The consequences of not recognising, assessing and addressing neglect can be serious. Entrenched neglect will begin to impair all aspects of a child's growth and development, as well as their desire or ability to relate; it will also negatively affect the attachment between a parent and their child (Miller, 2007):

It is critical that neglect is not considered a lesser problem than other forms of maltreatment given the evidence that its consequences can be damaging. It is also important that the presence of chronic neglect does not obscure other forms of maltreatment. (Frederico, Jackson, & Jones, 2006, p. 18, in Miller, 2007)

Assessing parents with intellectual disabilities

Lamont and Bromfield (2009) caution that the literature around parents with intellectual disabilities is based on limited research and small sample sizes, and more research is needed to build an evidence base. The available literature suggests that effective assessment of parents with

[52] http://www.practicecentre.cyf.govt.nz/policy/engagement-and-safety/key-information/what-did-we-find-recording-findings-from-investigations-and-child-and-family-assessments.html

intellectual disabilities should consider socio-economic factors (eg, poverty, unemployment), social isolation, stressors, relationship difficulties health, age and characteristics of their child/ren, protective factors and neglect, and should be non-discriminatory. Access to support networks must also be considered, given the need for additional support (eg, from extended family) that parents with intellectual disabilities may require.

Lamont and Bromfield (2009) note that the competency of parents will vary and assessments must be made on a case-by-case basis. Although intellectual disability is likely to adversely affect parenting to varying degrees, it is not clear whether children of parents with intellectual disability are at greater risk than other children. As noted earlier, neglect issues within this population may be associated with a lack of support services and/or a lack of knowledge about healthcare and child safety.

Thomson, Chapman and Carter (2010) refer to a growing number of New Zealand practitioners (social workers and differential response coordinators) "who have the skills, knowledge and lack of prejudice to achieve success for families where parents have an intellectual disability" (p. 26). They present a case study outlining how a range of support and resources have been provided to two parents with an intellectual disability, by way of the Strengthening Families model. The parents are reported as feeling stronger and more secure in their parenting role and have been discharged from CYF.

Assessing parents with mental illness

Tensions between the need for parental mental health services to be adult-focused rather than child-focused need to be considered when assessments of the family are undertaken.

Drawing on data from the state of Victoria, which reflects a growing number of parents with mental illness coming into contact with the child protection system, Mercovich (2008) describes children and families coming into the system as having increasingly complex needs and characteristics. Because of the range of concerns within these families, she suggests that child protection practitioners may need to provide a differential risk assessment and service response. To ensure an infant's safety, where there are concerns about the mother's mental health, support networks within the immediate and extended family and community should be explored, including discussions with her partner (if she is in a relationship) to gauge their level of awareness and ability to provide support.

Assessing parents who are substance abusers

Earlier we noted links between substance abuse and child maltreatment. Drug-dependent mothers often do not welcome the birth of a child (Schilling et al, 2004) and "attachment potentials are strained when maternal ambivalence interacts with the infant's challenging temperament" (p. 464). Their parenting skills can also be compromised by their own childhood history of neglect and inadequate parenting, lack of education, poor problem-solving and interpersonal skills and inadequate resources (eg, lack of financial and social support).

Drug- and alcohol-related physical and mental illnesses can make parenting very difficult. Assessments of parents who are substance abusers should consider both adult and child characteristics, and the interaction of the two, as well as environmental influences. They must consider factors such as parental history, comorbidity (substance abuse and mental illnesses often co-exist), socio-economic variables, parental illness and wellbeing, parent–child attachment and the child's health (eg, some infants will undergo withdrawal at birth).

Assessment regarding changes in family structure and risk to children

Much of the focus of this review is on children born into families in which previous children have been removed; however, as acknowledged earlier, there are other ways that children enter families. Changes in family structure may expose a new set of children to abuse and neglect. For example, a parent may enter a relationship with a new partner; children coming into these relationships (whether through birth or through the formation of a blended family) may be at risk if either partner is abusive. The literature also identifies being step-parented as a risk factor (Connolly & Doolan, 2007).

Jonson-Reid, Drake, Chung and Way (2003) analysed data on child abuse reporting at the child and perpetrator levels to look at the degree that children and perpetrators were involved in multiple types of maltreatment over time. They suggest that understanding maltreatment typologies may require different assessment strategies, depending on whether the focus is on patterns for a child, or for a parent. Because perpetrators of sexual abuse may move from one victim to another within or across families, the reduction of risk of a re-report for a particular child may not signal a reduction of risk that the perpetrator will re-offend. Thus, for subsequent children coming into families in which a previous child is removed, workers must be aware of the reasons why that child was removed. Where this was due to the behaviours of an adult within the family, child protection workers must know whether or not that adult is still within the home.

Taking account of men in the household

The role of any adult male in the family must be considered when assessments are undertaken, rather than focusing solely on the mother (Connolly et al, 2007; Department of Human Services, Victoria, 2001). He may, for example, be the child's biological father, or a mother's new partner (who may or may not assume the role of a stepparent).

Brandon et al's (2009) serious case review analysis found that services often failed to know about or consider men in the household. Assessments and support plans tended to focus on the mother's parenting skills without considering men and the potential risks they posed, given their previous history, including their convictions or allegations against them:

There appeared to be a minimalist 'need to know' attitude to sharing information about the appearance of new men in a household, so that unless specific questions were pursued (for example in relation to domestic violence) the presence of an unknown male would not be passed on and these men became invisible to practitioners working with the family or child. (p. 52)

However, there was evidence that some of the new men were positive figures in children's lives, including new men unrelated to the child.

The Department of Human Services, Victoria report (2001) notes that the dynamics of the family may have changed since an older sibling was removed from the home. While acknowledging that some men not only support the mother, but are also more effective in protecting the child, the report raises concerns about new male partners:
They may be with the family for only a short while.
They often don't see themselves as having a role with children who are not their own.
They may be unwilling to get involved with Child Protection.
They may not be at home when Child Protection workers visit.

A Ministry of Social Development report (2008) refers to evidence of differences in the types and severity of child abuse depending on the gender of the perpetrator, and describes the characteristics of males who may pose a risk to children:

Children are more likely to experience the more severe forms of abuse and to suffer injuries (including fatal injuries) if the perpetrator is male (father, stepfather or mother's young boyfriend) (Cavanagh et al, 2007; Guterman & Lee, 2005). Studies suggest that mothers' young boyfriends, stepfathers and 'substitute parents', with similar risk factors to abusive fathers, ie, with criminal histories, poor impulse control, a pattern of violence to their partners and with inappropriate expectations of children's behaviour, pose a particular risk to children and at a much higher level than stepmothers and fathers' partners. Some evidence suggests that where children of young mothers are abused and the mother is also victimised, the abuse is more likely to be inflicted by the mother's boyfriends or other males present in the house, than by the mothers themselves (Cassidy, 2003; Fergusson et al, 1972; McCormack et al, 2006). (Ministry of Social Development, 2008, p. 14)

Some mothers will have a history of multiple partners and transient relationships;[53] some will not show signs of change and will continue to partner with violent males. Fauth et al (2010) cite UK research reporting that men were largely invisible in case records of vulnerable families in two studies. They caution that risk assessments should consider family members separately: one partner may pose a direct risk to the child, while the other may be unable to protect the child from harm.

Summary

A broad range of child, parent and environmental factors and characteristics have been identified as potentially posing a risk to children. The following characteristics dominated the literature on families with care and protection issues: neglect; previous child removal; parental mental health issues; parental intellectual disability; substance abuse; family violence; and certain child characteristics.

The interrelationship between these factors and their cumulative effect on children must be considered. Of these factors, neglect seems to be a key factor, judging by the single study focused on families who had children removed. However, this study was based on a small sample size. While it could indicate that neglect is an area where assessment of families, and intervention, should be focused, there needs to be more research into neglect as a characteristic of families where subsequent children are removed. There may be scope to build on CYF's (2010) study, exploring the characteristics of those within their sample who had multiple children removed, and following up on how many have had more children, whether those children have remained in the home or been removed, what interventions the families have received and from whom.

[53] See the Fragile Families and Child Wellbeing Study summary of data regarding the longevity and stability of parental partnerships in a study involving approximately 5,000 children born in large US cities.
http://www.fragilefamilies.princeton.edu/documents/FragileFamiliesandChildWellbeingStudyFactSheet.pdf

Children entering families in which previous children have been removed can be most easily identified when cases are still active with social services. When this is not the case or cases are closed, effective referral pathways are needed. There is potential for improved identification of subsequent children through public and professional education, alert systems, mandatory reporting, improved relationships between health and social sector agencies and interagency information sharing. Some or all of these may be complementary components of a comprehensive approach to identifying child abuse. Evaluations of such pathways are needed to determine the effectiveness of these approaches in identifying subsequent children.

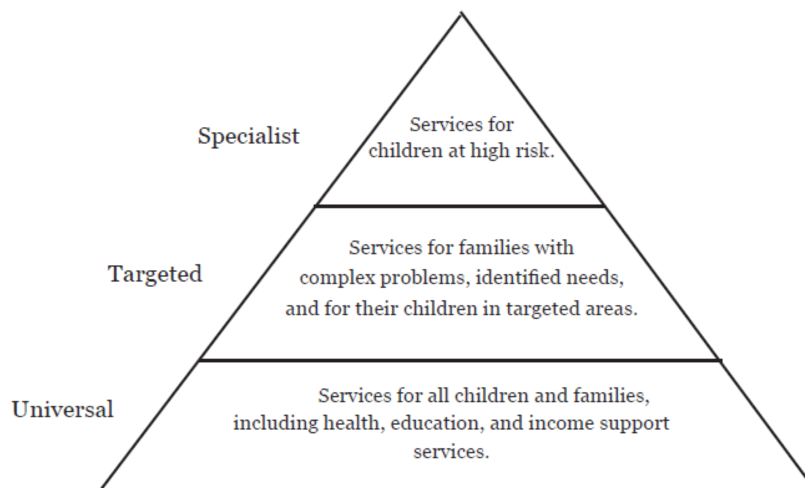
Once families have been referred to agencies, an assessment of the child's safety and the family's needs helps to identify families who require support. The literature suggests effective assessments will:
rely not only on the results of assessment tools, but consider also a worker's professional judgement
be conducted by well-trained, professional staff with good supervision, and avoid issues of 'start again syndrome', collusion and professional dangerousness
consider the cumulative and interactive effects of family risks and strengths, taking into account past histories and parental ability to sustain change
consider changes in family structure (particularly the introduction of new men into households)
be undertaken in families who are already known to child protection agencies as new information arises or circumstances change (reassessment).

Although this literature provides some guidance, there are still many unknowns about how assessments should be conducted with families who have had previous children removed, what tools should be used and what practices should be followed. Research into effective assessments with such families is needed; in particular, assessment of (chronic) neglect may be an area for further study.

PART FOUR: FAMILY-FOCUSED INTERVENTIONS

Responses to child maltreatment lie along a continuum, ranging from primary prevention, early intervention and family support through to more investigative, legalistic responses focused on child protection, depending on the nature of the concern for the child. Within this context and using an ecological lens, interventions include discrete programmes, casework approaches such as those delivered by CYF, policies and legislation that support those interventions, support from families and communities and global attitudes toward child maltreatment and family violence.

A number of experts (Connolly & Doolan, 2007; Gray, 2009) argue the range of services available to address child maltreatment should follow a public health model that encompasses both prevention and 'treatment' of child abuse. This model of welfare (depicted below) provides universal, targeted and specialist services for families across a continuum of services.

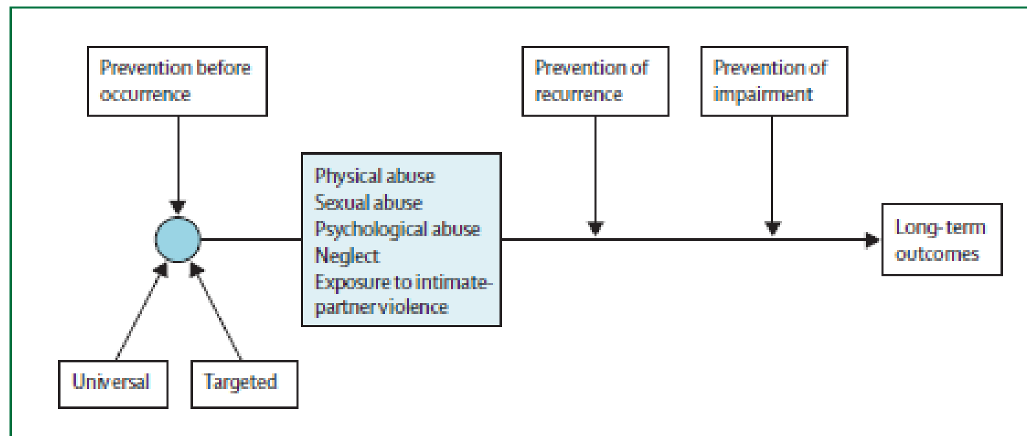


Source: Connolly and Doolan (2006), from CYF and Ministry of Social Development (2006, p. 27)

This review focuses on a narrowly defined group of high-needs children and families, those receiving 'specialist' services at the child protection end of the services continuum. However, we acknowledge the need for more prevention-focused, universal interventions to prevent other families from moving into the high-needs category.

MacMillan et al (2009) provide a useful framework for considering the range of interventions available to address child abuse, and when these may occur.

Framework for prevention of child maltreatment and associated impairment



Source: MacMillan et al (2009, p. 251)

This model is particularly useful in the context of this report, in that it distinguishes between interventions that occur before a maltreatment event, and interventions that may prevent a recurrence of maltreatment. It notes the prevention of a maltreatment recurrence is sometimes referred to as treatment.

For this review, we consider the prevention of harm to a subsequent child (where a previous child has been removed from a family) to be a prevention of recurrence. As such, we are only considering interventions (or treatments) that aim to prevent recurrence, and will explore their effectiveness.

While the subject of this review is families who have had previous children removed, a dearth of literature specifically focusing on this group has led us to also draw on the literature regarding complex families, of whom families with previous children removed can be considered a subset. We have noted these distinctions where they occur.

We start by examining principles of effective practice for working with complex families; these provide guidance about the components of effective programmes and interventions. We then explore the literature on effective programmes for families who have had previous children removed, followed by a review of programmes for complex families. Conclusions about effective programmes for families who have had previous children removed are drawn out in the summary.

Principles of effective practice

In this section we explore principles emerging from the literature regarding effective practice with complex families, based on our assumption that families who have had previous children removed are a subset of complex families.

Balancing engagement and critical questioning

One of the key issues raised in the literature is that families who have had previous experiences with child protection agencies may resist further contact (Fauth et al, 2010). If a previous child has been removed, they may be reluctant to seek or receive support for parenting subsequent children. To facilitate change, effective engagement is required, and a lack of engagement was an area of concern identified by one study:

Engagement with families and individuals where a previous involvement with Child Protection has occurred was identified by all groups as the main area of concern… Non-government agencies identified successful engagement with families as vital in ensuring the best long-term outcome for their involvement. (Department of Human Services, Victoria, 2001, pp. 13-14)

Fauth et al (2010) and Thoburn (2009) note relationships with practitioners need to be dependable and respectful, that workers should convey empathy and acceptance. Continuity of support is also important and may be possible within a community-based setting, where there is one key worker identified:

Continuity of social support is essential for complex families with whom change is hard to achieve or maintain. (Thoburn, 2009, p. 10)

However, Fauth et al (2010) and Thoburn (2009) suggest empathy and effective relationships are insufficient on their own. They must be balanced with a worker's "eyes-wide-open, boundaried, authoritative approach aimed at containing anxiety and ensuring the child's needs stay in sharp focus" (Fauth et al, 2010, p. 2), particularly with complex and resistant families. Critical questions about the family's actions and behaviours must be asked, and real evidence of change must be sought (Department of Human Services, Victoria, 2001). Thoburn (2009) suggests critical questions must be asked repeatedly so the real issues are not overlooked.

Similarly, Fauth et al (2010) suggest that when families make progress, workers must not lose sight of the family's history, or become overly optimistic. CYF (2010) also notes the importance of collecting a family's full history, including information from other agencies who have previously supported the family. Such approaches prevent professional issues such as 'start again syndrome', collusion and professional dangerousness (as discussed in the Assessment section).

Finally, Thoburn (2009) notes there can be a tension between a 'partnership' relationship between worker and family, and the potential need for the worker to use compulsion (eg, to remove the child legally if the child is at imminent risk of harm). Fauth et al (2010) found that when a worker's power was used positively ('with' families) it empowered them, but when power was used 'over' families they would "take the path of least resistance" which may result in 'false compliance' (ie, where families suggest that they are making changes but may not actually be doing so). This work also suggested the power dynamic should be acknowledged when workers first meet families.

Intensive casework approach

Several pieces of literature suggest that complex families require an intensive casework approach (Department of Human Services, Victoria, 2001; Fauth et al, 2010; Forrester, Copello, Waissbeing, & Pokhrel, 2008; Thoburn, 2009; Tully, 2008). Thoburn (2009) identifies three key forms of intensive casework: a team around the family (which often requires a different professional working with each family member to achieve successful outcomes); a single case worker with a small caseload and access to 24-hour supervision; or a co-working situation. She explains the significance of both the intensive casework and supervision enabled by the approaches described above as they apply to hard-to-reach families:

With some of the most emotionally scarred or mentally ill parents and their children it will not be possible to achieve a trusting professional relationship, and it is in these cases that family members may withhold facts or deliberately tell untruths. It is only when skilled and committed workers have time to spend with and empathise with these

parents that it becomes possible to understand when important information or serious problems are being concealed and more intrusive measures to protect the child are needed. In these cases, to ensure that the child's welfare remains the paramount consideration, the role of an equally skilled and knowledgeable casework supervisor becomes even more vital. (Woodhouse and Pengelly 1991; Brandon et al 2008, 2009; Burton 2009). (Thoburn, 2009, p. 8)

Thoburn (2009) suggests that any additional community supports should supplement rather than replace a casework approach. She also acknowledges that an intensive approach may be enhanced where it is preceded or followed by "targeted lower intensity or episodic services, or if the same service has 'permeable boundaries'…" (Thoburn, 2009, p. 11).

A multiagency, multidisciplinary, coordinated approach

A number of studies emphasise the need for multiagency/multidisciplinary services to be well coordinated when working with complex families, in order to enhance responsiveness (Connolly et al, 2007). For example, Hollingsworth (2004) encourages mental health services providers supporting mothers with persistent serious mental illness to be mindful of their parenting status and the wellbeing of their children, and mothers who are planning their own treatment must also be involved in an ongoing basis in considering the wellbeing and safety of their children. She recommends that beyond meeting the needs directly related to their mental illness (eg, for medication reviews), women may benefit from additional services, including those that will help their parenting, such as parenting advice and education, respite care and childcare.

Mercovich (2008), when reflecting on the dangers of 'case drift' within families with a parent with mental illness, emphasises the importance of child protection practitioners clearly identifying the tasks and progress that a parent needs to achieve to ensure their child's safety. She stresses the importance, from birth, of bonding and attachment, noting that the infant cannot 'wait' until the parent is ready.

Fauth et al (2010) suggest that effective practice with complex families requires working beyond child welfare boundaries and interacting with parents (even if their child is not in their care) to ensure they are making changes.

Good supervision

As mentioned in relation to intensive caseworking, effective supervision is fundamental to working with complex families (Department of Human Services, Victoria, 2001; Fauth et al, 2010; Love, Suarez, & Love, 2008; Thoburn, 2009). Love et al (2008) argue that staff turnover and a lack of training in specific protocols are a common reality in mental health, and the "key to delivering a protocol with integrity is the supervisor" (Love et al, 2008, p. 1445).

Other practices

Fauth et al (2010) also suggest that, in intervening with highly resistant families, workers should observe parent–child interactions first hand, should listen to the child directly (dependent on their communication skills) and should not allow a parent's needs to eclipse the child's needs.

Making an assessment of progress is also important and Fauth et al (2010) say that linking the client to services is not always sufficient—the service must be effective and the social worker must perceive positive change in the parent.

CYF (2010) suggests other effective practices include monitoring and supervision of vulnerable families (eg, keeping ‘five eyes on the under fives’) where monitoring may come from the community and the family themselves. It also suggests that workers should take the time to make pregnancy prevention a focus of planning with young women prior to transition from foster care, given what is known about the number of parents of vulnerable infants who have had previous involvement with child protection services. However, the effectiveness of these two practices in the longer term has not been evaluated.

Ongoing support for adults after initial removal

The psychological impact of child removal should be taken into account. Bromfield and Osborn (2007, citing Fernandez, 1996 and O’Neill, 2005) say parents who have their children removed experience a sense of powerlessness, alienation, sadness, loss and despair. Similarly, custody loss has been described as “a unique type of reproductive loss that can result in intense grief, depression, and trauma” (Haight et al, 2002, in Lewis, 2006).

Jordan and Sketchley (2009) encourage child protection services to support parents to deal with their emotional reaction to having their child placed in out-of-home care because they are unable to cope; this may also require helping parents to deal with intergenerational issues that have negatively affected their parenting. If these issues are not addressed, Jordan and Sketchley caution that if a ‘replacement child’ is born, this may lead to the cycle of abuse or neglect, and subsequent removal, being repeated. Baum and Burns’ (2007) report on a study conducted with eight women with learning disabilities whose children had been removed by statutory services investigated the impact of custody loss. Women described intense feelings of loss when the children were taken away, and subsequently. Three women reported that they had “filled the gap” by having another child, which had also been taken away. Similar findings were reported by Turner (2006) with regard to a study of ‘ultra-high-risk’ families.

Lewis (2006) suggests that social workers should be aware that removal of a child may have an impact on the maternal–foetal bond during subsequent pregnancies. Maternal–foetal bonding has been described as the emotional investment a woman has for her foetus (Lewis, 2006), providing the foundation for nurturance and protection. Some pregnant women are reluctant to attach to the foetus until they know they will retain custody (Raskin, 1992, in Lewis, 2006).

Lewis studied the effects of prior custody loss on the maternal–foetal bond during subsequent pregnancies in a sample of nine women in the New York City region. The women had lost custody of from one to six children. In this small study, the findings indicated that the women with a history of custody loss may have been more bonded to their current foetus than women who had not experienced a loss. However, they continued to be at risk of losing custody of future children as they were more likely to have used illicit drugs during their pregnancies. Lewis recommends that “focused discussions on long-acting birth control” may be a realistic approach when working with pregnant women who continue to use drugs. (Part Five of our review discusses family planning approaches with complex families.)

Effective programmes for complex families[54]

The programmes reviewed here are largely those provided to families by government and voluntary bodies, but we recognise that there may be other sources of support—from within the family or community—that may be built on, to improve outcomes for children.

In a national audit of Australian child abuse prevention programmes, Tomison and Poole (2000) suggested the prevention of child maltreatment needs to take a holistic approach to address what are often “multi-problem, disadvantaged, dysfunctional families”.

Focusing more specifically on interventions with complex families, Fauth et al (2010) suggest with highly resistant families (a subset of complex families) Intensive Family Preservation Services (IFPS; described later in this section) can have some effect (particularly when supported by other interventions before and after the IFPS), as well as multi-component programmes, social support and mutual aid programmes and parent training programmes.

A rigorous review of systematic reviews of child abuse ‘treatment’ services by MacMillan et al (2009) found that parent–child interaction therapy can prevent recurrent child physical abuse, and that no interventions have been shown to be effective in preventing recurrent neglect. It also concluded that, for maltreated children, foster care placement, particularly ‘enhanced foster care’, may compare more favourably in terms of benefits to children than the child remaining at home or being reunified with parents/caregivers.

We will now explore specific interventions and their effectiveness in preventing child abuse, particularly subsequent and recurrent maltreatment. We acknowledge that both effective programmes and more generic supports need to be employed to enable positive outcomes for children and their families.

Strategies during pregnancy

Our review of the literature suggests that antenatal care can educate parents, screen for health and socio-economic conditions that may lead to adverse outcomes (eg, for high blood pressure, overcrowded housing), enhance the health and wellbeing of mother and child, strengthen parent–child attachment and relationships and provide opportunities to intervene[55] or provide support when necessary (eg, treating diabetes, counselling about the potential effects of alcohol on foetal health) (Banta, 2003).

Studies by Hatters Friedman, Heneghan and Rosenthal (2009) and Brandon et al (2009) found an association between a lack of ante-natal care and children being removed from their parents. In a study of children born to 2,011 Ohio mothers who had not received pre-natal care, Hatters Friedman et al (2009) found those who had lost custody of

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[54] As noted earlier, this term refers to families who may or may not have previously had children removed but are described by the literature as experiencing multiple needs, including parents and young people who are “particularly difficult to engage or to help in a way that achieves necessary change” (Thoburn, 2009, p. 3). Families who have subsequent children removed are likely to be a subset of complex families.

[55] Banta notes that many ante-natal interventions still have not been evaluated.

previous children, or had substance abuse problems, were at highest risk of having their infants removed. Brandon et al (2009) reported that in a number of families in which children were killed or died, there had been limited ante-natal care and limited contact after discharge, including missed routine checks, missed immunisations and failure to keep appointments. While these studies suggest a lack of ante-natal care may point to indicators of risk to the child, they are unable to conclude that ante-natal care prevents initial or recurrent child maltreatment.

Access to ante-natal care has been found to be an issue for some families; in particular, single women, women having subsequent births, men, Māori and Pacific peoples have lower access rates to ante-natal care than other groups (Dwyer, 2009; Luketina, Davidson, & Palmer, 2009). There is some suggestion that improved tailoring of ante-natal services may result in better access rates.

In the UK, an evidence-based[56] set of draft clinical guidelines has recently been developed to improve ante-natal services to pregnant women with complex social needs[57] (National Collaborating Centre for Women's and Children's Health, 2010), including access to and continuity of services. The approaches endorsed by the guidelines include:
health practitioners to facilitate first contact with ante-natal or sexual health services
multiagency needs assessment (including child safety assessment)
integrating care plans and approaches across agencies
information to women with substance abuse issues about child welfare services (in an effort to allay fears or inform women about child removal)
information in a range of formats, languages and settings
specialised ante-natal services for teenagers and partnerships between primary health trusts, education and voluntary sectors
improved responses to women experiencing domestic violence.

The effectiveness of these approaches has not yet been evaluated.

Our review did not find any specific research on effective ante-natal services for families where children had previously been removed.

Intensive family preservation services

Intensive family preservation services (IFPS) are short-term (often four to six weeks' long), intensive services designed to intervene during a period of crisis. The main goal of these programmes is to prevent children moving into out-of-home care by addressing parenting problems and improving the way a family functions. IFPS are usually characterised by small worker caseloads and 24-hour availability of staff, and services are provided in the family's home. Services are tailored to families' needs and can include counselling, life skills education, parenting education, anger management, communication and assertiveness skills as well as practical assistance (food, clothing, housing, transportation, budgeting) and advocacy with social or other services.

[56] The development of these guidelines was informed by a systematic review of evidence and consultation with key stakeholders.
[57] The groups targeted include women who misuse substances, young mothers (under 20 years), women experiencing domestic violence and recent migrants and refugees.

These programmes have existed since the 1970s, and one of the more well-known versions is the Homebuilders (America) programme. Homebuilders was underpinned by crisis intervention theory, and was originally intended for difficult adolescents but has been more widely adapted. By and large, IFPS are designed to deal with crisis situations, rather than to manage long-term and chronic problems. IFPS have been subject to multiple international studies over the years; however, the quality and findings of these studies vary significantly (Tully, 2008).

In summary, the evidence about whether IFPS can prevent child removal or repeated maltreatment is mixed and inconclusive. While some studies report that IFPS have no effect (Littell & Schuerman, 1995; Westat, Chapin Hall Centre for Children, & James Bell Associates, 2002), others suggest under the right circumstances[58] and in the short term IFPS (particularly Homebuilders) may have some effect (Tully, 2008).

The research suggests IFPS are less successful in sustaining improved family functioning (including child abuse) and out-of-home care, particularly in complex families (Forrester et al, 2008; Littell & Schuerman, 1995). Researchers (Lindsey, Martin, & Doh, 2002; Littell & Schuerman, 1995) have questioned the extent to which time-limited interventions can address long-standing issues, and Littell and Schuerman (1995) emphasise the need for an effective mix of services, ranging in duration and intensity, tailored to the specific needs of chronic families:

The extent to which the intensive, short-term, crisis approach fits the needs of child welfare clients should be re-examined. The lives of these families are often full of difficulties—externally imposed and internally generated—such that their problems are better characterised as chronic, rather than crisis… The central point here is that we need a range of service lengths and service intensities to meet the needs of child welfare clients. (Westat, 2002, p. 24)

Littell and Schuerman (1995) also warn that many IFPS approaches have focused on the parent or the family but have ignored external environmental conditions that may be contributing to issues that families are facing.

Tully (2008) concludes:

While there may be value in providing these to families, Family Preservation Services alone are unlikely to be sufficient. (p. 16)

In our review of the research, none of the studies explored the extent to which ‘previous child removal’ was associated with the success or failure of IFPS and further research is necessary to determine with any certainty the appropriateness of these programmes for such families.

Home visitation programmes

Home visitation programmes vary in the nature of their design, but generally offer support to families by way of home visitation by a family and/or whānau worker who may

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[58] These circumstances include when the programme delivery is loyal to programme design: where there is an imminent crisis, a risk of child removal and where interventions are intense and time limited (Tully, 2008; Westat et al, 2002).

or may not be professionally qualified. Many aim to act as intensive early intervention services and are delivered to families with young children.

There is debate as to the effectiveness of home visitation services; in many cases, evaluations of these services are inconclusive or suffer from methodological limitations. In a review of interventions to prevent child maltreatment, MacMillan et al (2009, p. 250) state that "home-visiting services are not uniformly effective in reducing child physical abuse, neglect and outcomes such as injuries" and cite two programmes (Nurse–Family Partnership and Early Start) as showing positive effects.

We reviewed four programmes: three based in New Zealand (Early Start, Family Start and Family Help Trust) and Healthy Families Alaska.[59]

While Early Start and Family Start are designed to act prior to the first incident rather than as 'treatment' for families where children have already experienced harm (as is the case when previous children have been removed), it is possible these specific families may be involved with Family Start or Early Start and so they were included in our review.

A 2005 outcomes evaluation of Early Start (Fergusson, Horwood, Ridder, & Grant, 2005) utilising a randomised control trial methodology found the programme contributed to improved parenting practices and improved child outcomes. The evaluation reported that, 36 months on, 11.7 percent of the control group had experienced severe physical child assault, compared to 4.4 percent of the Early Start group.

The Family Start evaluation (Ministry of Social Development, 2005) and Family Help Trust evaluation (Turner, 2009) also reported improved outcomes for children (and improved parenting behaviours in the case of Family Help Trust); however, they were hampered by methodological problems and in neither case can the outcomes be exclusively attributed to the programmes.

The Healthy Families Alaska evaluation (Gessner, 2008), while methodologically sound, was unable to find any real programme effect on child maltreatment outcomes over time. Children on the programme were moderately less likely than other high-risk groups to have a substantiated neglect outcome.

None of the programmes had a significant effect on 'problematic' aspects of parental functioning (such as drug and alcohol abuse, mental health problems and domestic violence) or on family economic and material wellbeing (Fergusson et al, 2005; Gessner, 2008; Ministry of Social Development, 2005; Turner, 2009). Gessner (2008) suggests a revised programme that implements cognitive approaches, such as having home visitors address or make referrals for parental mental health concerns, substance use and domestic violence, might have more success.

Therapeutic programmes

Therapeutic programmes with high-risk families have been developed and trialled, with mixed results. While two such programmes reported improvements to parent–child relationships (Green, 2002) and attachment (Steele, Murphy, & Steele, 2010), there were limitations to study design. It is worth highlighting these therapeutic programmes

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[59] Appendix 5 presents a detailed summary of these and other intervention studies.

only addressed parent–child relationships and did not encompass other problems faced by the family (eg, family poverty, homelessness, parental mental health or alcohol and drug abuse). Complex families are likely to need more comprehensive interventions.

Multi-component programmes

The term ‘multi-component programmes’ is used here to describe interventions with families that involve multiple methods of delivery (eg, individual or group settings, home visits, office visits) with multiple foci (eg, health interventions and housing interventions, interventions focused on parents and those focused on the family group). Many studies already cited have advocated the use of a holistic, multidisciplinary approach to dealing with complex families (Fauth et al, 2010; Tomison & Poole, 2000); these are such approaches. We focus on the effectiveness of two approaches which target very high-needs families.

In Australia, the High Risk Infants Service Quality Initiatives: Parenting Assessment and Skill Development Programme (Campbell, Jackson, Smith, & Cameron, 2001) was developed to address the parenting needs of families with an infant considered to be ‘high risk’. While the programme was not limited to parents where previous children have been removed, eight out of 46 cases involved in the evaluation had experienced a previous child removal or death.

The programme was delivered to families at multiple sites (residential, day-stay, in-home) and involved integrated health (maternal and child) and welfare (family- and child-focused) practice approaches.

While the 2001 evaluation did not report on outcomes for children, it did suggest that better integration between the programme and specialist services was required (particularly with intellectual disability, drug and alcohol, mental health and domestic violence agencies) and, to support this, integration staff needed more resources.

The Westminster Family Recovery Programme (City of Westminster, 2010) is another multi-component intervention, employing a ‘team around the family’ approach. It follows a cost-recovery model, and is targeted at the top 3 percent of families at risk of losing their home, their liberty or their children. It arose from concerns about a cluster of families with complex needs, many of whom are receiving support from multiple agencies (including welfare, healthcare, criminal justice and educational sectors).

Each family’s professional ‘team’ differs but can include services for adult mental health, anti-social behaviour, benefits, domestic violence, education, health visiting, housing, police, children’s social work, substance misuse and access to training and employment (City of Westminster, 2010, p. 3). A single care plan that addresses the needs of all family members (not only the child) is developed, and there are two lead workers for each family. The teams work intensively with families for six to 12 months and a ‘contract of consequences’ (City of Westminster, 2010, p. 4) is developed with families, who must sign these before the programme begins. The service uses an ‘information desk’ to

gather 'intelligence' about all family members and their circumstances/agency involvement.[60]

While monitoring and evaluation are in their early stages,[61] the programme shows promise in working with high-needs families, in that it encompasses many of the good practice principles outlined in the first part of this section. For example, it offers a well-coordinated, multiagency approach including intensive casework, addresses needs across the family (including adults needs), takes a 'no wrong door'[62] approach, is empathetic and supportive yet makes the consequences for not meeting expectations clear, and is able to address practical matters such as housing.

However, in summary, while experts suggest that working with complex families requires a holistic/multidisciplinary approach, the literature does not provide enough information on the effectiveness of programmes that work in this manner: further evidence is required.

Supporting parents with intellectual disability

Studies from a range of countries indicate that there is a strong likelihood of permanent out-of-home care for children whose parents have learning difficulties (Booth, Booth, & McConnell, 2005).

The literature addressing intellectual disability and parenting does not specifically address the needs of subsequent children in families where previous children have been removed. However, literature outlining support gaps and challenges for parents with intellectual disabilities does provide some useful advice, particularly in terms of the support that these parents need to ensure their children's safety, and the challenges they face in accessing appropriate support. The needs of the parents, and their children, must be balanced.

Writing from an Australian perspective, Lamont and Bromfield (2009) refer to research indicating that there are significant gaps in effective services for parents with intellectual disability; parental strengths and competencies are not always acknowledged by child protection workers and support workers have reported feeling ill-equipped to meet

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[60] This information includes real-time data from local police, social care histories, existing assessments and details of previous interventions by all agencies, as well as a family network chart.

[61] Some preliminary analysis has been conducted. Of 10 families who had been through the programme, with child protection as their primary reason for referral, one case showed no progress, in six cases adults had achieved 'marked improvements' and the prospects for the other children were 'greatly improved' (Local Government Leadership and Westminster City Council, 2010).

[62] In a 'no wrong door' model, an individual could walk into any one of many doors in the community, have more or less the same intake experience and have access to the same information, resources and assistance. The term 'no wrong door' is used in a variety of contexts and may refer to a philosophy rather than a model. http://www.oregon.gov/DHS/spwpd/sua/docs/one-stop.pdf?ga=t

parental demands. A British literature review[63] found that parents may be reluctant to approach statutory services for support because they are afraid that their parenting skills will be judged negatively. McConnell, Llewellyn and Ferronato (2002) suggest that professionals often seek out-of-home placement over the more resource-intensive task of supporting families; additionally, support services that do exist are "widely spread and poorly coordinated".

Many authors suggest enhancing the range of support resources for parents with an intellectual disability (eg, support from extended family may compensate for limited parenting skills), and educating workers and the community about the options available, may result in more children being kept safe at home (Kovacs, 2002; McConnell & Llewellyn, 1998). Kovacs (2002) notes there will always be some families who will need external support with parenting, and others where removing children will be necessary to ensure their safety. However, if data regarding parental disability have not been consistently captured within child protection databases, it is difficult to accurately identify the number of disabled parents within the system and to ensure that there are adequate and appropriate resources available to support them.

Mildon, Matthews and Gavidia-Payne (no date) draw on other research to conclude that successful outcomes for parents with intellectual disabilities have been achieved by using effective teaching strategies (such as modelling), which have led to improvements in parents' skills, including developing parental decision-making strategies. If teaching methods are matched to parents' learning needs, they can learn, retain and generalise parenting skills. McConnell and Llewellyn (2000) emphasise the diversity of people with intellectual disabilities, who do not share "a common aetiology, personalities, behaviours, social situations or life experiences" (p. 890). Each parent's needs, strengths and circumstances will differ, and being classified as intellectually disabled should not automatically predict incompetent parenting, particularly when adequate supports are in place. McConnell and Llewellyn (2002) say that there is broad agreement about the key elements needed in parenting programmes for these parents: they need to be tailored to their individual learning needs; topics must be of interest to the parent; concrete skills must be taught in the environment in which they are to be applied; modelling and opportunities for practice must be accompanied by feedback; and periodic maintenance sessions may be required.

Substance abuse programmes

In the US, Tyler, Howard, Espinosa and Simpson Doakes (1997) describe marked growth in the number of children in court-mandated out-of-home placement, largely due to the 'substance abuse epidemic': in most urban areas, the majority of infants living in foster care have parents who are involved with drugs.

In a review of programmes for drug-using parents, Schilling et al (2004) cite some evidence that women may respond well to programmes that include parenting classes (as well as other components). However, they note that, more broadly, there is a shortage of research findings that point to effective and replicable prevention or intervention strategies to reduce out-of-home care for their children.

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[63] NHS Evidence—Learning Disabilities
http://www.library.nhs.uk/learningdisabilities/ViewResource.aspx?resID=259949&tabID=289

Strategies to address neglect

As discussed earlier, chronic neglect may be a characteristic of families who have had a child previously removed and are at risk of losing a subsequent child. The Victoria study of newborn siblings of children previously taken into care reported neglect interventions with the families in the study were considered "too short, too fragmented and under resourced" (Department of Human Services, Victoria, 2001; p. 19).

Reviews of the research have found insufficient evidence of the effectiveness of programmes to address either neglect or recurrent neglect (MacMillan et al, 2009; Mikton & Butchart, 2009, in Mardani, 2010).

Drawing on best practice guidelines and strategies, Mardani (2010) recommends that strategies for the prevention of neglect (primary rather than recurrent) should address the underlying causes and risk factors at the individual, family, community and societal levels.

Mardani identifies three key intervention points: prior to the first incident of neglect (primary prevention); after the incident of neglect (secondary prevention); and preventing long-term impairment as a consequence of neglect.

Family reunification programmes

Family reunification programmes[64] typically involve a planned process and a range of services and supports to reconnect children in out-of-home care with their families.

By exploring the reunification literature, we hoped to garner information about the types of interventions that may assist families to create conditions whereby a previously removed child can return to the family's care or a new child can remain in the family's care. We acknowledge that differences between the removed child and the new child may mean different conditions are required; however, we are more interested in the processes by which improved conditions are achieved.

Evidence on the longer-term effectiveness of family reunification programmes is thin. Reunification rates are low (Marsh, Ryan, Choi, & Testa, 2006; Ryan, Choi, Hong, Hernandez, & Larrison, 2008) and, while some programmes result in an initial return home, Wulczyn (2004) reported that 28 percent of children (from 12 American states[65]) who were reunified with parents in 1990 re-entered foster care within 10 years.

In Australia, Bromfield and Osborn (2007) drew on data from a longitudinal study, where findings indicated that ethnicity (Aboriginal) and neglect were the primary predictors that decreased the likelihood of reunification, while children whose parents had some form of incapacity (physical or mental illness) were significantly more likely to be reunited with their parents than other children. A mother's improved ability to cope led to reunification in 40 percent of the cases studied (Delfabbro, Barber, & Cooper, 2003). Panozzo,

[64] In New Zealand, the term 'family reunification' is often used in an immigration context (eg, referring to reuniting refugee families who have been separated).

[65] Based on data held in the Multistate Foster Care Data Archive (maintained by the Chapin Hall Centre for Children at the University of Chicago). This archive holds data from 12 states and accounts for approximately 55 percent of children in foster care across the US.

Osborn and Bromfield (2007) suggest that it may be inappropriate to attempt reunification between families and children who have been removed due to chronic neglect: "children in these circumstances may be better served by early identification and early efforts to secure permanent placements" (p. 9).

A number of the studies suggested family reunification programmes are more successful in returning children home where the family is not dealing with co-occurring problems (Child Welfare League of America, 2002; Marsh et al, 2006; Stein, 2009). Marsh et al (2006) examined the role of multiple problems experienced by the family (in particular domestic violence, housing and mental health) in combination with substance abuse. Using survival analysis,[66] the study of 724 families found:
35 percent were dealing with three or more problems simultaneously, while 8 percent were dealing *only* with substance abuse
families are significantly more likely to be reunified where they are not experiencing co-occurring problems (21 percent).
Both Marsh et al (2006) and Farmer, Sturgess and O'Neill (2008) found that very few of the families in their studies had made complete or even substantial progress in addressing all of their problems. Only one-quarter of the families in the Farmer et al (2008) study had done so, and the authors reported that unresolved issues (particularly parental substance misuse and family violence) could jeopardise successful reunifications. Marsh et al (2006) noted that some families were reunified despite a lack of progress.
All three of the studies (Child Welfare League of America, 2002; Marsh et al, 2006; Stein, 2009) suggest that services that enable families to meet their basic needs (adequate housing, income and family support) and are targeted at changing specific and multiple issues (domestic violence, mental health and substance misuse) are more likely to facilitate a child's return home:

The service [needs to be] targeted to a specific problem area and effective enough to ensure client progress. (Marsh et al, 2006, p. 1085)

Successful integrated service programmes must identify the range of specific problems that clients are dealing with and ensure that they can address and resolve these problems in order to increase the likelihood of family reunification… Providers must ensure that clients receive the comprehensive services they need and that they participate in these services to make progress in resolving the range of specific problems they are designed to address. (Marsh et al, 2006, p. 1086)

Other factors associated with return stability (Farmer et al, 2008) were thorough assessment, clear expectations, adequate preparation for the child's return and good monitoring of children before and after return:
Assessment and case planning need to specify from the outset what needs to change, over what timescales (having regard to children's developmental needs) before return is possible and how this is to be supported and monitored. The consequences and contingency plans if changes are not achieved need to be spelled out. Using written contracts which agree clear goals with parents and which are regularly reviewed can be useful, alongside the provision of tailored services addressing parents' and children's'

[66] Analysing time until occurrence of an event of interest (eg, time until reunification).

difficulties… Reunification practice in cases where parents misuse alcohol or drugs needs to … introduce clear expectations [of] parents. (Farmer et al, 2008; p. 3).
The implications for children coming into families who have had children removed are: the safety of the subsequent child may be enhanced by thoroughly assessing their needs, establishing clear expectations of what needs to change, effectively 'treating' each 'problem', demonstrating real change regarding each problem, planning well for the child to be in the home and monitoring that placement.

Effective interventions in families with a previous child removed

We were able to identify very little literature focusing specifically on this group of families. Most studies focused on effective interventions with complex/vulnerable families, or effective interventions with a particular 'problem' (eg, substance abuse). As outlined earlier, one of the few directly related studies we found was a multiple case analysis informing a child death inquiry conducted in Victoria (Australia) in 2001 (Department of Human Services, Victoria, 2001). This explored the relationship between the sibling's protective history and the impact of this history on conducting a risk assessment for the new baby.

Fourteen cases were examined, a literature review was conducted and consultation was undertaken with 15 experts and practitioners.

Regarding effective interventions, the study noted:

Many of the issues confronting practitioners when working with these families are consistent with other cases involving young children. While strategies to address the broad range of issues can be applied, the Panel believes that the specific issues relating to the introduction of a new baby into already proven inappropriate environments requires more intensive risk assessment and case management to ascertain if any changes that would alleviate the risk to the baby had occurred. (p. 14)

In addition to comprehensive risk assessment and intensive case management, the study noted the importance of engaging successfully with families; this should take place as early as possible, before a serious incident occurs.

As noted earlier in this review, the Department of Human Services, Victoria study (2001) found a high percentage of cases were characterised by long-term neglect. It recommended adequate resourcing for long-term interventions for parents with limited capacity to parent, as well as research into programmes that are proven to be effective in creating 'positive, sustainable change' for families demonstrating long-term neglect.

Summary

Based on the literature, principles of effective practice with families who have had children removed and complex families have emerged. These are:
careful assessment, including thorough reading of all files, consideration of parental history (abuse, domestic violence, maltreatment, care, substance misuse, mental health issues) and listening to the child
assessment of evidence of change (including role of fathers/partners) and progress, and the family's capacity to sustain change
successful engagement balanced with critical questioning (avoiding 'start again syndrome', collusion and professional dangerousness)

intensive casework
effective, regular supervision of workers
effective multiagency assessment and intervention
a mix of intervention lengths and intensities
support should be culturally responsive and mindful of families' strengths and capabilities
programmes need to be effectively targeted and when they are manualised[67],
programme integrity is required to ensure programmes are working as intended
referral for specialist treatment (eg, to mental health services), if indicated.

These principles hold true for all forms of intervention.

Only one study in this review considered interventions specifically intended to prevent maltreatment of subsequent children in families where previous children had been removed. This study suggested that these families need more intensive risk assessment and long-term case management than other families, alongside interventions to effectively address chronic neglect. However, both this and other studies acknowledge there is little evidence of what works to address neglect, and suggest further research is required. Families who have had previous children removed are likely to suffer intense feelings of loss and may go on to have a 'replacement child' (Baum & Burns, 2007; Jordan & Sketchley, 2009; Turner, 2006). To tackle this issue, families need help to address their grief, and long-acting birth control could be discussed. However, little is known about the effectiveness of such approaches.

Because of the dearth of literature around interventions specifically tailored to families who have children removed, we also explored the effectiveness of interventions for a broader grouping: 'complex families'. We reviewed a wide range of programmes aimed at resolving problems within the family and consequently preventing future child abuse and neglect. These included intensive family preservation services, multi-component programmes, home visitation services, parent education programmes, therapeutic programmes, strategies during pregnancy, interventions after a child has been removed (including family reunification programmes) and programmes targeting parents with particular characteristics (eg, intellectual disabilities, substance abuse issues).

The evidence regarding the effectiveness of these programmes is mixed. While some programmes contribute to reducing child abuse, enhancing parent education and improving parent–child relationships, many of these programmes are less effective in addressing adults' needs or the family's broader social needs (including housing, income, mental health, family violence, substance abuse) in the longer term. Chronic neglect is also a significant issue for complex families, and we were unable to identify any programmes showing evidence of effective interventions to address neglect in the longer term. Family reunification programmes also do not appear effective with families where neglect exists. As Thoburn (2009) notes:

We are still some way away from having a menu of methods known to be effective, particularly with complex families who are hard to reach and hard to change. (p. 1)

These findings have a range of implications; most importantly, that while a programmatic approach may help address some parent–child relationships, resolving a complex

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[67] A standardised set of practices is followed for each programme participant.

family’s full range of needs requires a more comprehensive approach, utilising a mix of intervention types, lengths and intensities.

Considered from an ecological perspective, such approaches include addressing problems with parental functioning (eg, drug and alcohol abuse, mental health problems, family violence) and remedying more systemic issues (eg, poverty, housing, discrimination). Interventions need to be complementary, and support addressing the full range of issues should be sought not only from professionals but also from the family themselves, and their communities. A team-around-the-family casework or multi-component approach, supported by effective universal policies (eg, regarding prevention of family violence, reducing child poverty), could potentially work at all of these levels.

The issue of neglect is challenging. Findings suggest a need for improved research about what types of interventions are effective in preventing recurrent and chronic neglect. Given that chronic neglect indicates that successful reunification is less likely, the literature implies that careful decision-making is needed when considering whether to allow subsequent children to enter homes where chronic neglect has previously been demonstrated and remains unchanged.

It is important to note that while we have assumed families who have had children removed are a subset of complex families, none of the studies reviewed in this section (including those that included our target group in their samples) reported on findings specifically for families where previous children have been removed. Consequently, these findings need to be tested with families who have had previous children removed before being considered conclusive. A retrospective study of families who have had subsequent children removed or who have retained subsequent children could provide insight into these families’ characteristics and the effectiveness of the ‘interventions’ they have experienced.

PART FIVE: PREVENTING SUBSEQUENT CHILDREN COMING INTO FAMILIES

As one component of this review, we were asked to explore what could be done to prevent subsequent children coming into families (in which parents have lost custody of previous children) and being put at risk while parents are still addressing their complex issues.

This section of the review focuses on family planning as a pathway to prevention, exploring two key areas:
family planning education
'coerced' contraception and sterilisation.

We were unable to locate any research literature specifically focusing on family planning approaches for families where previous children have been removed. We focus instead on family planning approaches to complex families who demonstrate some of the characteristics of families who have subsequent children removed.

Family planning education and advice

The provision of age-appropriate sexual and reproductive health education may lead to men and women being better informed as they make decisions about parenthood.

Pregnancies may be intended or unintended and there are diverse reasons why subsequent children are born into families (eg, a desire for children to have siblings, wanting to have children with a new partner, contraception failure). As noted in a previous section of the review, research suggests that parents who have had their children removed may experience a range of emotions, which they may need support to deal with. 'Replacement children' may also be at risk of being removed if the reasons their sibling was removed have not been addressed. Knowledge about and access to contraception may delay the birth of subsequent children, allowing parents more time to address their complex issues.

Research literature refers to general links between unintended pregnancies and child maltreatment (Brown, 2006; Ministry of Social Development 2008, citing McCormack et al, 2006 and WHO/ISPCAN, 2006). Women living in poverty (and their children) are more likely to experience negative consequences of unintended pregnancies (Brown, 2006); these begin pre-natally if the mother has inadequate healthcare (and if she continues to smoke or drink).

Brown cites work carried out by Forrest and Samara (1996), in the US. For every dollar spent to provide publicly-funded contraceptive services, they estimated that an average of $3 was saved in Medicaid[68] costs associated with pregnancy- and delivery-related

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[68] A means-tested health and medical services programme in the US for eligible individuals and families with low incomes and few resources. See http://www.medicalnewstoday.com/info/medicare-medicaid/

healthcare and medical care for newborns. Brown argues that contraception should be considered a public health issue, not a moral issue:

Everyone should have knowledge of, and access to, safe contraceptives to be protected from unwanted pregnancy and sexually transmitted infections. (Brown, 2006, p. 13)

Dailard (1999) and others emphasise the benefits of access to effective contraception. It allows pregnancies to be spaced or avoided, and helps to avoid the adverse health, social and economic consequences associated with unintended pregnancies. Providing family planning advice and contraception may go some way towards preventing child maltreatment; there appears to be a link between maltreatment and large families, multiple births or children close in age (Ministry of Social Development, 2008).

Factors that can limit the uptake of family planning advice and contraceptive use include: lack of awareness of available options; lack of access to information and/or supplies (eg, in places where access to advice and supplies is limited or doctors are unwilling to prescribe contraceptives); cost;[69] partner resistance; and religious and cultural beliefs. Amongst the adolescent mothers participating in her New Zealand study, Guild (2010) reports that a common barrier to accessing sexual health services is the young woman's feeling that she may be judged or looked down on.

New Zealand women can choose between these contraceptive options:[70] the combined pill and progesterone-only pill (mini-pill); condoms; diaphragms and caps; and long-acting contraceptives (eg, intra-uterine devices or implants). Some women opt to use natural family planning.

After unprotected sex there are two forms of emergency contraception available: the emergency contraceptive pill (ECP)[71] or the intra-uterine device (IUD). An IUD can be inserted up to five days after ovulation, to prevent implantation (Family Planning, 2010).

Sterilisation (eg, through vasectomy or tubal ligation) is a permanent form of birth control. For women who have unplanned pregnancies (which may result from contraceptive failure), termination (abortion) is an option.

Currently, long-acting and highly effective reversible contraception is only available for women, although there have been clinical trials overseas of long-acting contraception for men (von Eckardstein et al, 2003). The effectiveness of long-acting reversible contraceptive (LARC) methods does not depend on daily adherence, unlike other methods (eg, oral contraceptives) that depend on correct and consistent use. Clinical

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[69] New Zealand aims to keep costs low: access to family planning clinic consultations are free for New Zealand residents aged 21 and under; subsidies are available to people aged 22 and over who hold a Community Services Card.
[70] In some other countries there are more choices available; for example, the contraceptive patch, which is applied to the skin and releases hormones to prevent pregnancy.
[71] The ECP is often known as the 'morning after pill'; this is misleading as it can be used up to 72 hours after unprotected sex. However, the sooner it is taken, the more effective it will be.

opinion[72] suggests that increased use of LARC methods could help to reduce the number of unintended pregnancies.

While we were unable to identify research on specific approaches to providing family planning and contraceptive advice to families who have had previous children removed, we did find articles relevant to complex families.

Substance-abusing parents

Substance-abusing parents are at high risk of unplanned pregnancy. Sharpe and Velasquez (2008) reported findings of a survey administered to 2,672 women (18 to 44 years old) in settings working with low-income women, including a drug treatment facility. They note that greater proportions of drug users (27 percent) failed to use contraception compared with non-users (19 percent). High proportions of drug users (91 percent) and non-users (82 percent) reported unplanned pregnancies. Sharpe and Velasquez found that women living in poverty who had used more than one illicit drug were at greater risk for having an alcohol-exposed pregnancy. They recommend that such women likely require enhanced education about the hazards of drinking during pregnancy and methods to reduce unplanned pregnancies.

Lester, Andreozzi and Appiah (2004) note the literature agrees that programmes for substance-dependent women should be comprehensive, with a broad range of components, including family planning. They suggest that tertiary prevention efforts should include developmentally and culturally appropriate education and treatment, to enhance protective factors and minimise risk factors. Efforts should capitalise on women's motivation to change and their desire to keep or be reunited with their child. Wells (2009) also recommends comprehensive programmes for substance-abusing women, offering education, treatment and support services—including family planning.

Teen parents

There is a body of literature that notes barriers to young people's access to health services, including family planning advice and contraception (Adolescent Health Research Group, 2008). Although becoming parents at a young age is considered a risk factor for child maltreatment, most young parents do not abuse their children.

The Department of Corrections (2001), in considering how to slow/reduce the growth of inmate numbers, outlined reducing high-risk births as one option; in particular, births to young women between the ages of 13 and 18 years who enter the youth justice system, the child protection system or the adult justice system. The report recommends that these young women be further supported by a sexual and reproductive health strategy, including advice on contraception, and that young men receive parenting advice and training. The report argues such an approach may yield a benefit/cost ratio of 50:1, an estimate of the crime prevention return per dollar spent on intervention.[73] Multiple benefits are anticipated:

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[72] http://www.nice.org.uk/nicemedia/live/10974/29912/29912.pdf

[73] This estimate is based on five assumptions, including that one in 15 interventions prevents the birth of a child who might subsequently become a serious offender as an adult.

An effective intervention in this area would also reduce future demand for income support, child protection, youth justice services, and possibly psychiatric services, which would increase the estimated return per dollar spent. (p. 29)

The Teenage Pregnancy Strategy (2010) in the UK indicated that the two measures for which there is the strongest evidence of impact on teenage pregnancy rates are comprehensive information advice and support (from parents, schools and other professionals), combined with accessible, young people-friendly sexual and reproductive health services.

The provision of universal, accessible and youth-friendly family planning services *may* help prevent teen pregnancy, and targeted family planning interventions with highly vulnerable young people *may* contribute to reducing not only child maltreatment but also crime and social costs.

Parents with learning/intellectual disabilities

James (2004) suggests that many women with learning disabilities may be poorly informed about contraception and the significance of changes in their menstrual pattern; consequently, they may not make informed decisions about family planning and some may not realise at first that they are pregnant. Appropriate support, including access to ante-natal services, can have positive physical and psychological benefits for both mothers and babies.

The Scottish Good Practice Guidelines for Supporting Parents with Learning Difficulties (2009) recommend that parents with learning difficulties who have had a child removed should be supported "to avoid the situation where they conceive another child without their parenting support needs being addressed" (p. 44). They suggest that repeated removals of children can be avoided if support is provided to their parents. This can include health workers and others working cooperatively to help parents access family planning, as well as other health services.

In New Zealand, the Contraception, Sterilisation and Abortion Act 1977 provides that, with regard to 'mentally subnormal females' a parent, guardian or medical practitioner may administer a contraceptive if it is considered in the best interests of the woman (s4(1)).

Who should provide family planning education?

Consideration should be given as to who would broach the topic of contraception with women (and their partners) who have previously had children removed, and how and when the topic should be raised. For example, should contraception be raised by child protection workers, health professionals or others supporting the parent? Cultural factors may mean that sexual topics, and other related topics, must be sensitively discussed. Other factors, including consideration of language barriers or parental disability, should also be taken into account.[74]

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[74] For example, British guidelines regarding the effective and appropriate use of LARC advise that healthcare professionals have access to trained interpreters for women who are not English speaking, and advocate for women with sensory impairments or learning disabilities. http://www.nice.org.uk/nicemedia/live/10974/29912/29912.pdf

Midwives and other professionals such as GPs are ideally placed to offer contraceptive advice following childbirth. In New Zealand, a Lead Maternity Carer (LMC)[75] is responsible[76] for ensuring that a range of services are provided to both the mother and baby following birth, including advice regarding contraception. However, not all women who have had children removed will have recently had a baby.

Some studies suggest that post-partum education about contraception leads to more contraceptive use and fewer unplanned pregnancies; however, many post-partum women may have unmet contraception needs (Lopez, Hiller, & Grimes, 2010). Ross and Winfrey (2001) suggest that women who have recently given birth need better access to information about family planning and reproductive health, proposing that it can be provided during pre-natal visits as well as in the post-partum period.

Coerced contraception and sterilisation

In some countries, coerced contraception and sterilisation have been proposed as a 'solution' to ensure that parents who have abused or neglected their children do not have more children (see discussion about Project Prevention later in this section). The term 'coerced' is used within the research literature to refer to legislative proposals that mandate or provide incentives for women (particularly women on welfare) to undergo sterilisation or use long-acting birth control methods (eg, long-acting reversible contraceptives). Thurber (2005) describes the case for 'coerced contraception' as one option that judges (in the US) can impose upon parents for whom other options such as counselling and persuasion to voluntarily use contraception have not been successful.

Thurber suggests that the reasons why a state would have a compelling interest in coerced contraception are to protect the vulnerable, prevent harm, reduce economic and social burdens and promote general welfare interests. However, he notes that coerced contraception should not be seen as a substitute for addressing poverty, discrimination and limited access to healthcare; there is still a compelling need for education about parenting skills and voluntary contraception.

He refers to ethical issues related to government interests in controlling contraception, citing historical concerns about the eugenics movement in the US and Europe. Powderly (1995) urges ethical and policy issues around the use of long-term contraceptives to be considered from an historical perspective. She cautions that efforts to empower women to manage their fertility and make their own reproductive choices must be mindful of previous debates about controlling fertility, including themes of racism and eugenics. Stace (2008) describes the historical influences of the eugenics movement within New Zealand; advocates of eugenics were vocal from the turn of the 20th century until at least the Second World War, with some women's groups suggesting a range of

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[75] A Lead Maternity Carer (LMC) is a person who—(a) is—(i) a general practitioner with a Diploma in Obstetrics (or equivalent, as determined by the New Zealand College of General Practitioners); or (ii) a midwife; or (iii) an obstetrician; and (b) is either—(i) a maternity provider in his or her own right; or (ii) an employee or contractor of a maternity provider; and (c) has been selected by the woman to provide her lead maternity care.
[76] According to the Notice Pursuant To Section 88 of the New Zealand Public Health and Disability Act 2000 (Maternity Services; effective July 2007).

measures to address perceived social problems, including segregation, sterilisation and castration.

There are human rights issues associated with coerced sterilisation and contraception. New Zealand is a member state of the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW requires states to ensure, on a basis of equality of men and women:
access to healthcare services, including those related to family planning (article 12(1))
appropriate services in connection with pregnancy and post-natal care, as well as adequate nutrition during pregnancy and lactation (article 12(2))
the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights (article 16(1)(e)).

Thus, in accordance with CEDAW legislation, parents who have had children removed have the right to have subsequent children. They also have the right to access information and education about contraception, so that unintended pregnancies can be avoided.

In the US the controversial Project Prevention[77] programme offers $US300 to current and former drug users to encourage them to be sterilised or to use certain long-acting birth-control methods. The project has recently been introduced to the UK, although without payment for sterilisation; it is now also operating in parts of Kenya, with women living with HIV paid $US40 to have an IUD inserted.[78] In all three countries, the project's approach has been criticised (eg, because offering payment for women to use contraception could be seen as bribery).

The programme's developers believe that their approach addresses a range of problems, including unwanted pregnancies and child welfare issues. We have been unable to find any reference to an evaluation of the programme being undertaken. Thus, there is no evidence of the effectiveness of this programme in preventing children entering families who have previously had children removed.

Critics of the programme (eg, Paltrow, 2003) argue that the project's approach is a violation of informed consent, is exploitive, coercive, racist and a form of eugenics:

While CRACK claims to have a broad-based mission applicable to men and women and people of all races and classes, its mission might be better understood as one designed to stigmatise certain people and to make them seem appropriate targets for sterilisation and other forms of population control. Even the suggestion that a particular group of people needs a financial incentive to take responsibility for their reproductive lives is arguably stigmatising in and of itself. (Paltrow, 2003, p. 23)

Paltrow also suggests that programme practices indicate class- and race-based targeting. For example, a billboard campaign was located in "predominantly poor neighbourhoods and neighbourhoods of color" (p. 92). She cautions that programmes and political philosophies that start out as private ideology can become government-

[77] Previously known as Project CRACK (Children Requiring A Caring Kommunity).
[78] http://medicalkenya.co.ke/2011/04/money-for-sterilisation-project-keen-on-nation/

enforced law, citing the eugenics movement as an example. She argues that focusing attention on ‘terrible mothers’ may be at the expense of adequate funding of programmes that could help them, including the provision of family planning services.

The crux of this debate is the balance between parental rights to reproduce and responsibilities to ensure the safety and wellbeing of their (potential) children. Coerced contraception may be a heavy-handed (and possibly unviable, as well as unethical) approach to ensuring parental responsibility; a better starting point may be enhancing access to voluntary contraception for parents who have had children removed.

Summary

Family planning education may help prevent unintended pregnancies, and offer parents control over the spacing and number of children they have. We know that unplanned pregnancy is linked to child maltreatment and some groups of vulnerable women are likely to have unplanned pregnancies; this may include our target group. We know that there are links between maltreatment and large families, and those with children close in age—some of our target group may also fit this description.

The literature suggests that some parents who have had children removed may go on to have ‘replacement children’, who may also be at risk. Access to contraception may delay the birth of subsequent children and allow parents more time to address their complex issues. In particular, wider availability and uptake of long-acting reversible contraceptives could help to reduce the number of unintended pregnancies.

Because there are barriers to some women accessing family planning and contraceptive services, we must consider how access can be improved, how services should be delivered, what they should look like, who should deliver them and what underlying policies and protocols may be needed—particularly to ensure appropriate referrals within or across agencies. Currently, Lead Maternity Carers are responsible for providing information about contraception following childbirth, but women may benefit from receiving this information at other times of their lives as well.

There may be scope for targeting family planning education to families who have had children removed, as part of the package of child maltreatment interventions delivered to them.

Coerced contraception and sterilisation raise human rights, legal and ethical issues that make them unlikely to be a viable option.

PART SIX: DISCUSSION AND CONCLUSIONS

In New Zealand in 2010, 1,895 (45 percent) of the 4,238 children recorded by CYF as being in out-of-home care had siblings who had previously been removed from their parents/caregivers by CYF.[79] In this review, we have explored a broad range of national and international literature to consider what might be done to prevent and/or protect these subsequent children coming into families while parents may still be addressing their complex issues.

Conclusive evidence on effective practice with this specific group of families is scarce. Literature on the broader grouping of complex families (Fauth et al, 2010; Thoburn, 2009) suggests prevention of child maltreatment and its recurrence requires effective identification of these children, clear referral pathways, sound assessment to inform decision-making and supportive and effective interventions. Knowledge about and access to family planning options, such as contraceptives, may also contribute.

Our literature review has concentrated on these areas, and has considered the characteristics of these families. A number of key themes were identified in the literature and these are explored here.

Enhancing pathways

Becoming aware of new children entering into families who have had children removed can be challenging. The research suggests that children can be more readily identified when cases are still active with social services; if files are kept open, new referral pathways are not required.[80] While keeping files open would allow ongoing monitoring and support to be provided, this would raise issues around resourcing, and the privacy and/or empowerment of families. Exploration of longer-term support and monitoring may be worth considering, and community agencies may be able to play a role. There are implications for a range of CYF policies which would need to be further explored.

If there is no active file for a family in which a previous child has been removed, clear referral pathways are needed when agencies or individuals learn that a subsequent child will be entering the family.

Within the literature we identified a range of tools aimed at improving referral pathways:
professional and public education
alert systems (predominantly health systems, reporting on unborn or recently born children)

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[79] Noting the parents from whom the previous child had been removed may differ from those from whom the subsequent child was removed, in the case of blended families.
[80] The Independent Experts' Forum also explored the concept of an 'always-open' file, meaning that management or monitoring would not automatically cease, and the case be closed and records archived, when a child dies as a result of abuse. The forum recommended that, once an incident of abuse or neglect has been confirmed, the child or family/whānau concerned does not become a 'closed case'.

mandatory reporting
improved relationships between health and social sector agencies
enhanced interagency information sharing.

A comprehensive approach to identifying child abuse is likely to include a combination of these tools. However, there is no evidence that these tools prevent recurrent maltreatment and further evaluation is needed.

Mandatory reporting may help safeguard referrers, and protect existing relationships with parents, as informers can explain that they are compelled to report (Goddard, 1994, in Tomison, 2002). Automated approaches (such as alert systems) may prevent some families from 'falling through the gaps'. Both require significant investment[81] and raise ethical and legal issues related to privacy, confidentiality and human rights.

In considering how to improve referral pathways, it is also important to consider those groups who may be potential referrers. From an ecological perspective, responsibility for looking out for vulnerable children ranges from individuals to agencies, to policies which enable or disable vigilance. Families and communities may become aware of subsequent children entering families before professionals do. People within all systems need to know what to look for and how to intervene if they have concerns. Improving public understanding of recurrent child maltreatment may encourage a culture of collective responsibility, where people act when they believe a child's safety and wellbeing are at risk. Such work could build on CYF's "Five Eyes on Under Fives" concept and the "It's Not OK" campaigns.[82]

Effective assessments also assist in identifying the strengths and risks within families who have had previous children removed. The literature suggests that as well as ensuring staff are well trained and supervised in completing assessments, assessments themselves should consider not only discrete risks and strengths, but also the cumulative and interactive effects of these factors.

Neglect

Neglect has been identified as a key issue for families who have previously had children removed, so this could be an area where assessing and intervening with such families should be focused. The literature highlights the challenges involved in identifying, assessing and defining neglect (which may be one-off or chronic), which suggests that better tools and training may need to be developed to complement the existing range of assessment practices. This may involve, for example, increased education about the characteristics of families most likely to be at risk, including indicators of chronic neglect and consideration of intergenerational patterns of neglectful behaviour.

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[81] For example, in training professionals to recognise and refer families in our target group, in resources, in use of the system.
[82] Research on the effectiveness of a public education approach in enhancing referrals and reducing recurrent maltreatment is not covered by this report but needs to be considered; refer to Horsfall et al (2010) (http://www.aifs.gov.au/nch/pubs/issues/issues32/index.html).

We were unable to identify any specific programmes showing evidence of effective interventions to address neglect in the longer term. Home visitation and parenting programmes may help to address some of the underlying factors associated with neglect through parenting education; specific programmes for substance misuse and mental health issues that lead to neglectful parenting may also contribute. In all of these instances, adults must demonstrate evidence of change. As there are links between poverty and neglect (eg, children may live in unsafe or overcrowded housing because their parents are unable to afford alternatives), interventions beyond the family level (eg, welfare support) may affect outcomes for the child. For example, research on family reunification suggested that resolving practical issues such as housing and inadequate income can enhance outcomes for children.

More research is needed to determine whether neglect is the *most* significant factor/characteristic of these families, or whether there are other, more influential factors.

Effective interventions

The review has outlined a range of interventions available to complex families. These aim to resolve problems and, in doing so, prevent future child abuse and neglect. However, the evidence regarding the effectiveness of these programmes is mixed. While some programmes show a reduction of child abuse and improved parent–child relationships, many of these programmes are less effective in addressing adults' needs or the family's broader, social needs in the longer term.

While there was a shortage of literature regarding practices with families who have had previous children removed, suggestions for working with complex and resistant families consistently recommend:
comprehensive assessment (thorough reading of files, consideration of full parental and family history, assessment of evidence of change and capacity to sustain change)
continual efforts to sustain change
a range of service lengths and intensities (including intensive casework), tailored to the needs of individual families
successful engagement (with critical questioning/scepticism balanced with empathy)
multiagency, multidisciplinary assessment and intervention
complementary interventions, rather than single-focus programmes
inclusion of fathers/male partners in assessment and intervention.

An ecological analysis suggests that multiple sources of support from within a family's ecological system may help improve outcomes for children, and support parents to deal with complex issues. Improved public education may also encourage family and community involvement, ensuring that families receive the support they need, including during the pre-natal period.

Adult issues

Several interventions reviewed in this report only improved single outcomes; often, parenting behaviour or the parent–child relationship. While any improvement is positive, to ensure the future safety of a child within their family, sustained change in all 'problem' areas, including those affecting parental capacity, is necessary. As many problems co-occur, the full range of issues that families are dealing with must be recognised and responded to. Chronic adult issues in particular (eg, substance misuse, mental health problems, family violence) must be addressed, alongside issues (eg, grief, depression) that may have emerged as a result of a previous child being removed. Complex families, who often have limited resources, require a range of solutions that consider external

environmental conditions (eg, housing, low income) that may contribute to the issues they face.

Questions remain about the ideal mix of support providers. As CYF is primarily focused on the child, what role/s might adult-focused agencies play in supporting parents whose children have been removed? Bromfield et al (2010, citing Scott, 2009) suggest that in developing better responses for complex families it is important to build the capacity of adult-focused services (eg, drug and alcohol and mental health services), making them child-sensitive, and that child-focused services be more parent-sensitive. This suggests implications for the way all agencies involved with the family work.

Prevention

In considering how to prevent children coming into families, we have drawn primarily upon family planning and related literature. We know that some groups of vulnerable women are likely to have unplanned pregnancies; this may include our target group. There are known links between unplanned pregnancy and child maltreatment; knowledge about, and access to, contraception can help prevent unintended pregnancies (Robertson, Rogers, & Pryor, 2006).

With regard to our target group, access to contraception may delay the introduction of subsequent children and allow parents more time to address their complex issues. Several factors can limit the uptake of family planning advice and contraceptive use, including lack of access to information and/or supplies, cost, partner resistance and religious and cultural beliefs. Some of these barriers may be addressed by improving access to services (including subsidies for services; Robertson et al, 2006).

Current law (largely) prevents the state from making contraceptive decisions for (prospective) parents, or from forcing parents to act in a certain way. Coerced contraception and sterilisation raise human rights, legal and ethical issues and are unlikely to be a viable option.

Changes across ecological systems

The literature covered in this review has primarily focused on changes within microsystems (eg, services that agencies provide) rather than changes within broader systems, which should also be considered. For example, given the harmful and pervasive effects of neglect and its known link to poverty, steps to counteract the effects of poverty may be indicated (eg, reviewing the adequacy of health and housing benefits). Applying an ecological approach to the research questions, we conclude that responsibilities for 'keeping an eye on' vulnerable children (ie, knowing what to look for and who to contact in case of concern) range across systems—from within families, to agencies and communities—and underlying policies should encourage and support this. An assessment should consider not only individual child/adult/family characteristics, but also systemic factors, such as the availability of support within the community and from government. Interventions and support can be provided from within all levels of ecological systems: by immediate and extended families, agencies, communities and government. Raising awareness about signs that a child may be at risk, as well as educating people about who to contact with concerns, and how, may help to engender a culture of collective responsibility.

Families' futures must also be kept in mind. Interventions need to address the family's wider circumstances and ongoing needs. Parental issues must be confronted in order to protect children both present and future. The balance between ensuring a child's safety

and meeting adult needs, as interpreted within current child protection policies and practices in New Zealand, may need to be further considered.

Conclusion

Although themes have emerged in the research literature, there are significant gaps regarding the needs of families where previous children have been removed, and how to protect subsequent children. Studies do not tell us what alert systems or programmes are working specifically with families who have previously had their children removed, either to prevent maltreatment or to support parents. Nor does the literature yield firm evidence about how assessments should be conducted, what tools should be used or what practices should be followed when working with families who have had previous children removed.

Support for families after a child has been removed should ensure the original reasons for child removal (including any adult issues) are addressed. Long-term, sustainable change is required, but more evidence is needed about the most effective supports to enable such change. What has been effective in supporting families who have had their first child removed, but who did not go on to have a second or subsequent child/ren removed? What made a difference to ensure the safety and wellbeing of these subsequent children within the same family? A retrospective study of families who have had subsequent children removed, and those who have not, may be worth considering.

Having more information about the reasons why children have been removed would assist in developing and targeting support for these families.

It is also important to note that, even with the most effective systems and practices in place, experts agree that some situations cannot be predicted or prevented:

Herein lies a harsh but inevitable reality in terms of child protection practice: not all violence towards children can be anticipated, nor is it appropriate to treat all families who struggle to adequately care for their children as potential child killers. (Connolly & Doolan, 2007)

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APPENDICES

Appendix 1: Data request to Child, Youth and Family

The table below describes the custody orders which were included and excluded from our data request to CYF.

Included orders		Excluded orders	
s78	Custody of child or young person pending determination of proceedings	S139	Temporary care agreement (voluntary)
S101	Custody order	S140	Extended care agreement (voluntary)
S102	Interim custody order	S39	Place of safety warrant
s110(2)(a)	Sole guardianship order	S40	Warrant to remove child
s238(1)(d)	Custody of child or young person pending hearing in youth court		
s345	Interim custody order pending appeal		
s311	Supervision with residence order		

Appendix 2: Literature search strategies

Literature searches for this report were conducted by the Ministry of Social Development's Knowledge Services Enterprise Content Unit, and by Family Planning (New Zealand).

Ministry of Social Development search

A systematic search of multiple databases was undertaken to locate relevant national and international literature. Search parameters were derived from the project brief (see search strings identified below). As some of the terms/strings were further adjusted during entry into database search fields, the words and phrases identified should be considered indicative rather than absolute.

The databases and other sources searched were National Bibliographical Database, Index New Zealand, ChildData, Social Care, InfoTrac, Master FILE Premier, E-Journals, The Australia/NZ Reference Centre, SocINDEX, Australia/New Zealand Reference Centre, EJS E-Journals, SocINDEX, Social Services Abstracts, Sociological Abstracts, ERIC, ProQuest Psychology Journals, ProQuest Social Science Journals, Knowledge Services Database (MSD) and the internet.

Titles and abstracts from the searches were reviewed and selected by the research team based on their relevance to their project. Full reports were accessed either electronically or in hard copy.

Search strings

1. Preventing and/or protecting additional children coming into families who have had children removed:
mother*
pregnan* or unborn or baby or babies or infant* or subsequent or new or additional or step* or newborn*
terminat* or lost or loss* or lose* or remov* or take* or previous*
Infant* OR baby OR babies OR preverbal OR (young ADJ child*)
custod* or noncustodial or noncustody or guardian* or right* or child* or older siblings or older children or older child or older sibling or previous*
protect* or welfare
services or child protection or child welfare
(TI=(pregnan* or unborn or baby or babies or infant* or subsequent or new or additional or step or newborn) AND AB=(custod* or noncustodial or noncustody or guardian* or right* or child* or older siblings or older children or older child or older sibling or previous*) AND AB=(protect* or welfare))
Social Care Database**:** (topic="mothers" or topic="pregnancy" or topic="babies") and (topic="guardianship" or topic="custody" or topic="death") and (freetext="lost*" or freetext="loss*" or freetext="remov*" or freetext="lose*" or freetext="take*") and publicationdate>1999.

2. Parental intellectual disability and child protection:
(parent* OR mother*) SAME (disab* OR (learning ADJ difficulties)) SAME (child* OR infant*) SAME (protect* OR welfare)
search strings above adjusted to suit the search engines of other databases (eg, Ebscohost, InfoTrac)

Social Care Database: (topic="parents with learning disabilities") and (topic="child abuse" or topic="child neglect" or topic="child sexual abuse" or topic="children in need" or topic="vulnerable children" or topic="child protection registers" or topic="child protection services" or topic="child development") and publicationdate>1999.

3. Support for parents dealing with complex issues:
(mother* OR parent*) SAME ((complex ADJ needs) OR troubled OR vulnerable OR (high ADJ risk*))
(supporting parents with complex issues) and (reunification)
search strings above adjusted to suit the search engines of other databases (eg, Ebscohost, InfoTrac)
Social Care Database: (title="mother*" or title="maternal*" or title="parent*") and (freetext="troubled" or freetext="high risk" or freetext="complex") and (topic="access to services" or topic="intervention*" or topic="risk management" or topic="preventive practice" or topic="intervention" or topic="good practice") and publicationdate>1999 OR (topic="mothers" or topic="parents") and (freetext="troubled" or freetext="high risk" or freetext="complex") and (topic="access to services" or topic="intervention*" or topic="risk management" or topic="preventive practice" or topic="intervention" or topic="good practice") and publicationdate>1999.

Family Planning search

The databases and journals searched were the Cochrane Library, Medscape, Opposing Viewpoints Resource Centre, Pubmed, Proquest, IDS Bulletin, Perspectives in Reproductive Health, Google Scholar.

Search strings used:
(pregnancy prevent*) (abus* child*)
pregnancy
prevent*
child*
abus*
(birth control) & (child* abus*)
(substance abuse) & (child welfare)
(child abuse) & (social welfare)
+ mental health
pregnancy prevention/abuse/child removal
coercive contraception
Cochrane Database of Systematic Reviews: (pregnancy prevent*) (birth control) **and** (substance abuse) (mental health) **and** child welfare.

Appendix 3: Legislation, conventions, rights and responsibilities

Legislation and conventions that govern the care and protection of New Zealand children, and establish parental, child and state rights and responsibilities:

New Zealand Bill of Rights Act 1990 (NZBoRA)
United Nations Convention on the Rights of the Child 1989 (UNCRoC)
Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
Contraception, Sterilisation and Abortion Act 1977 (CSAA)
Care of Children Act 2004 (CoCA)
Children, Young Persons and Their Families Act 1989 (CYPFA).

The Care of Children Act (2004) shifted from parents' rights towards parents' responsibilities. The Act emphasises that the welfare and best interests of the child is the first and paramount consideration in any dispute about them. The Act sets out the following principles in section 5:
the child's parents and guardians should take the main responsibility for looking after them and making arrangements for their care, development and upbringing
there should be continuity in the arrangements for the child's care, development and upbringing and the child's relationships with their parents, wider family and whānau should be stable and ongoing
there should be co-operation between parents, guardians and others who are involved in looking after the child
relationships between the child and their family and whānau should be preserved and strengthened
the child must be kept safe and protected from all forms of violence
the child's identity, including their culture, language and religion, should be preserved and strengthened.

Children have the following rights:
to life (NZBoRA, UNCRoC)
to know and be cared for by their parents and family (UNCRoC)
to maintain contact with their parents (UNCRoC)
to express their views and be heard (UNCRoC)
to have their treatment reviewed if they have been removed from their family (UNCRoC).

Parents have the following responsibilities:
day-to-day care, upbringing and development of their children (CoCA, CYPFA, UNCRoC)
contributing to the child's intellectual, emotional, physical, social, cultural and other personal development (CoCA)
determining their child's name, where they live, medical treatment, culture, language and religion (CoCA)
preventing children from suffering harm (CYFPA).

Parents also have the following rights:
to determine number and spacing of children (CEDAW)
access to healthcare services, including those related to family planning (CEDAW)
to direct and guide their children (UNCRoC)
to administer a contraceptive to a 'mentally subnormal female' (CSAA).

The state has the following responsibilities:

recognise that parents have primary responsibility for the upbringing and development of their children (UNCRoC)
respect the rights and responsibilities of families to direct and guide their children (UNCRoC)
provide parents with information, support and assistance, including pre- and post-natal care, preventive healthcare, family planning education (CEDAW, UNCRoC, CYPFA)
protect children from harm (UNCRoC, CYPFA)
assist families in their responsibilities to prevent their children and young persons from suffering harm, or where their relationship is disrupted (CYPFA)
promote the physical and psychological recovery of children who have been abused or neglected (UNCRoC)
encourage and promote co-operation between organisations engaged in providing services for the benefit of children and young persons and their families and family groups (CYFPA).

The state also has the following rights:
removal of children from parents when abuse or neglect has occurred (CYPFA)
determine who children shall live with (CYPFA)
deprive parent of guardianship (CoCA).

Appendix 4: Interagency protocols

Section 7(2)(ba)(ii) of the CYPF Act addresses the development and implementation of interagency protocols:

in relation to child abuse:
(i) promote, by education and publicity, among members of the public (including children and young persons) and members of professional and occupational groups, awareness of child abuse, the unacceptability of child abuse, the ways in which child abuse may be prevented, the need to report cases of child abuse, and the ways in which child abuse may be reported, and
(ii) develop and implement protocols for agencies (both governmental and non-governmental) and professional and occupational groups in relation to the reporting of child abuse, and monitor the effectiveness of such protocols.

Appendix 5: Summary of intervention studies

Intervention practices

Protective Issues for Newborn Siblings of Children Taken into Care: Department of Human Services, Victoria (2001)	Case analysis of 14 cases (including administrative data/file reviews), literature review, consultation with 15 experts and practitioners.	Yes—all those included had previous children removed.	**More intensive risk assessment and case management required:** Maltreatment issues are consistent with other cases with young children and similar strategies can be applied, but the cases require a decision about whether any changes could alleviate risk to the child (and prevent it also being removed). Importance of **successful engagement**—ideally pre-birth. **Long-term neglect:** High percentage of cases were characterised by long-term neglect. Resources are required for **long-term interventions for parents** with limited capacity to parent. **Better interventions for dealing with neglect** may also be needed—additional research is needed to identify proven interventions for creating 'positive, sustainable change' for families demonstrating long-term neglect. **Assessment:** The study made substantial recommendations around the assessment of families: Assessments should occur before a child is born. Tools are needed for pre-birth assessments, to assess whether the situation has changed, assess parents' capacity to care and their ability to sustain change. Role and capacity of (adult) males within the family should be

			assessed. Tools should be used across the health and community sector. Practice: Workers should read case files in their entirety. Workers should be well supervised when undertaking thorough risk assessments. Workers should consult a specialist infant protection worker.
Multiple studies, particularly Thoburn (2009) and Fauth et al (2010)	Literature reviews and practice literature were reviewed.	Studies focused on complex and resistant families, not those where previous children removed.	No specific findings re: effectiveness for families where children previously removed. Effective practice for complex/resistant families requires: good engagement critical questioning intensive casework inclusion of fathers good supervision coordinated multiagency approach ability to recognise and work with chronic neglect observation of parent–child interaction; listening directly to the child.

Intervention programmes

Intensive Family Preservation Studies	Short-term, intensive services designed to	Not specified.	Range of studies and methods, including	No specific findings re: effectiveness for families where children previously

(International/US)	prevent out-of-home care by addressing parental shortcomings.		those with experimental design.	removed. Not overly effective with families exhibiting multiple/complex problems. May have some effect reducing out-of-home care, but less evidence of effect on improved family functioning.
Hi Risk Infants Service Quality Initiatives: Parenting Assessment & Skill Development programme (Australia) (Campbell et al, 2001)	Multi-component programme, aiming to improve parenting capacity. Delivery varies across sites (residential, day-stay, in-home) and comprises assessment (evidence-based), in-home programme (integrating health and welfare), voluntary involvement variable duration and intensity.	Study included 8/46 families where a child had previously been removed or died as result of maltreatment/neglect.	Evaluation, mixed methods. Retrospective case analysis, document analysis and stakeholder interviews.	No specific findings re: effectiveness for families where children previously removed. No outcomes findings (process focused).
Family Recovery Programme Westminster (UK)	'Team around the family' approach targeted at top 3% of families likely to lose their liberty, home or children. Follows a cost recovery model. Develops a voluntary contract of consequences with the family. Uses single, multiagency care plan.	Not specified.	In early stages of monitoring and evaluation including of cost effectiveness.	Evaluation not complete. Programme shows promise in working with high-needs families in that it encompasses many of the approaches effective in working with complex families (Fauth et al, 2010; Thoburn, 2009).

	Uses an 'information desk' to gather 'intelligence' about all family members and their circumstances/agency involvement.			
Family Help Trust (NZ)	Early intervention child protection programme for Christchurch families who are considered ultra-high risk for child abuse and family dysfunction. Provides intensive, long-term services through home visitation.	1/59 families had previous child removed. 44% had CYF involvement at time of entry to programme, 61% had previous CYF contact or involvement, 75% of those with older children had previous CYF involvement and 3.4% had children who were subject to orders (eg, custody or support orders).	24-month outcomes evaluation of the programme was completed in 2009. Prospective longitudinal design, following 59 families over time: at baseline, 12 months and 24 months. Data collection entailed interviews with mothers (comprehensive questionnaire including structured, semi-structured and open-ended questions). Quantitative analyses of the data used Friedman and Cochran's tests. No control group, resulting in inability to establish	No specific findings re: effectiveness for families where children previously removed. For the group overall: statistically significant improvements in some parenting behaviours trends toward reduction in mothers hitting children (14% at baseline to 0% at 24 months) downward trends in adult substance use, offending and experiences of domestic violence (from 25.4% to 6.8%) but overall no statistically significant reductions of adult issues (maternal mental health, substance abuse, poverty).

			a direct causal link between the programme and outcomes for families.	
Healthy Families Alaska Home Visitation Programmes (US)	Home visitation using paraprofessionals. Aims to decrease occurrence of child abuse and neglect among high-risk families. Highly manualised.	Not specified	Retrospective cohort design, nine-year follow-up of 985 children under 2—examined maltreatment outcomes following intervention.	No specific findings re: effectiveness for families where children previously removed. Experimental group had more child protection outcomes than control and no difference with other high-risk groups. No statistically significant change in number of CPS outcomes over time (ie, home visiting made little difference). Children on programme moderately less likely than other high-risk groups to have a substantiated neglect outcome.
Early Start (Christchurch) (Fergusson et al, 2005)	Intensive, long term (up to five years), voluntary home visitation programme. Modelled on Healthy Start (Hawaii). Aims to improve child health; reduce child abuse; improve parenting skills, support parental physical and mental	While one in seven of the mothers involved in the experimental group (ie, those involved with Early Start) reported having a previous child enter foster care, the effectiveness of Early	Randomised control trial, n=206 families in Early Start group, n=221 families in control group.	Improved healthcare and health outcomes. Increased exposure to early childhood education. Increased exposure to positive parenting practices. Lower rates of severe/very severe physical assault by parents. 36 months on, 11.7% of the control group had experienced severe physical child

	health; encourage family economic and material wellbeing; and encourage stable positive partnerships (Fergusson et al, 2005). Range of services include Listen, Love, Play Parenting Programme; Triple P Positive Parenting programme; Get Ready for School programme; Young Mothers Breastfeeding group; Assisted Drivers Licence course; Te Puna Oraka—partnership between Barnardos and the Early Start Project. Uses qualified staff.	Start specifically for these families was not explored.		assault compared to 4.4% of the Early Start group. There was no difference between the Early Start and the control group in rates of agency contact for child abuse and neglect. Reduced rates of externalising and internalising behaviour problems. No evidence of improvements to: maternal health and wellbeing family stability, family relationships and family violence family economic and material wellbeing family exposure to stress and adversity. Māori: Results suggest programme benefits were similar for Māori and non-Māori, but noting the programme was evaluated using mainstream measures of health and wellbeing (Fergusson et al, 2005, p. 74).
Family Start (multiple evaluations undertaken)	Intensive, voluntary home visiting service. Aims to “improve health, education and social outcomes for children; improve parents’ parenting capability and	Not specified	2001 process evaluation exploring programme logic; 2005 impact/outcomes evaluation; 2007 scoping evaluation; 2008 indicators report.	Average length of involvement with families was 13–15 months. Not all children received immunisations when scheduled at each age period. Rates of mothers fully or partially breastfeeding at six months were

	practice; improve children's and parents' personal and family circumstances". Mix of qualified and unqualified staff. Offers Born to Learn/Ahuru Mowai programme (Māori dimension of PAFT).		Findings reported here are from 2005 evaluation. No control group; not possible to say findings were caused by programme. Based on information from four sites rather than national results.	lower than national statistics. Increase in the rate of children seen by a Well Child provider (2002–3) Increase in the rate of children attending some recognised form of early childhood education. Increase in the rate of caregiver participation in an educational or training programme. Increase in the rate of caregivers in paid employment. No reported significant change in child problem behaviours. 79% reported progress on their goals; 20% reported achieving their goals. Transience a key challenge.
Anger Change Programme (CAPS) (NZ)	Therapeutic group programme for mothers using psychoanalytic approach to reduce abusive behaviours.	Not specified (but seven families were involved with CYF)	Evaluation, n=11, interviews before and after programme, over 5 months. No control group.	No specific findings re: effectiveness for families where children previously removed. 8 families reported increased tolerance with children after programme.
Attachment Centred Intervention (US)	Therapeutic group programme aiming to enhance adult/child attachment; uses psychoanalytic and cognitive approach.	Not specified		No specific findings re: effectiveness for families where children previously removed. Claims to show some evidence of improved attachment although no baseline measures were taken.

	Targets high-risk families with children 0–3 years. Isolated parents with their “own history of multiple adverse childhood experiences and ongoing exposure to poverty, domestic and neighbourhood violence”. Group-based, twice-weekly, 90-minute therapeutic sessions.			
Family reunification programmes	Planned process to reconnect children who are in out-of-home care with their families. These programmes are likely to involve a range of services and supports provided to parents, as well as children, and may involve siblings, whānau, foster parents and other caregivers.	Not specified—studies apply to families where a child has been removed but it may be that family’s first child rather than subsequent.	Multiple studies reviewed.	No specific findings re: effectiveness for families where children previously removed. Farmer et al (2008) found issues leading to removal had only been addressed in 25% of cases prior to reunification. Ryan et al (2008) study found some effect when substance-abusing parents were linked to their own recovery coach rather than child’s social worker, and concluded that progress in ancillary problems (domestic violence, housing and mental health) is more likely to lead to positive child welfare outcomes. Reunification programmes may not be

				effective in addressing chronic neglect.
Ante-natal care	Education for parents about newborns/children; health screening; offering intervention/support.	In Hatters Friedman et al (2009) study.		No specific findings re: effectiveness for families where children previously removed. Some evidence ante-natal care can be beneficial in educating parents, screening for health and socio-economic risks, providing treatment (eg, drinking) or opportunities to do so. But single women, women having subsequent births (target group), men, Māori and Pacific peoples have lower access rates. Found no research about link between ante-natal care and prevention of maltreatment; but did find research about association between lack of ante-natal care and child removal (Brandon et al, 2009; Hatters Friedman et al, 2009). Some research into how ante-natal care should be provided to complex families (Victoria) and how to improve access for men, Māori and Pacifica peoples (Dwyer, 2009; Luketina et al, 2009).