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Community-based approaches in preventing child maltreatment

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In the past, efforts to prevent child maltreatment have been hampered by a failure to address the structural social forces and the community-level factors that impact on children, families and the propensity for maltreatment. This paper provides a review of the theoretical constructs underpinning recent efforts to prevent child maltreatment holistically, and identifies a current emphasis on health promotion strategies and efforts to develop healthy, resilient communities. Three major interventions, perceived to be key components of any attempt to reduce maltreatment at the societal and community levels, are described: early intervention projects, cross-sectoral collaboration, and 'whole of community' initiatives. Overall, the authors support the adoption of a developmental prevention approach, where effective child abuse prevention requires acknowledgement of the inter-relationship between risk and resiliency, and solutions are developed to address the former and to promote the latter.

The African proverb, *'It takes a village to raise a child'*, epitomises the importance of the role of the wider community in raising children and young people. The larger socio-economic system in which child and family are embedded can influence family functioning, child development and the availability of helping resources, such as universal child and health services, within communities and neighbourhoods, (Martin 1976; Garbarino 1977; Garbarino & Sherman 1980; Schorr 1988; US Advisory Board on Child Abuse and Neglect 1993; Hashima & Amato 1994).

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

Until recently, despite the development of ecological theories of child maltreatment¹ (for example, Garbarino 1977; Belsky 1980), researchers, policy makers and practitioners

working to prevent child maltreatment have often perceived such structural forces as being beyond the scope of prevention. The tendency has been to tailor prevention activities to run within environmental or structural constraints (Parton 1991; Garbarino 1995). However, there has been growing recognition that truly to prevent child maltreatment requires the development of the means to address the societal factors underpinning child maltreatment and other family violence (Altepeter & Walker 1992; Tomison 1997a). This in turn, has led to the adoption of holistic prevention strategies with a focus on 'whole of community' approaches and early intervention strategies designed to influence a broad network of relationships and processes within the family and across the wider community (Wachtel 1994; Hay & Jones 1994; US Advisory Board

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on Child Abuse and Neglect 1993; Tomison 1997a; NSW Child Protection Council 1997; National Crime Prevention 1999).

It is the aim of this paper to describe some of the current trends in child abuse prevention and some of the key components of an holistic framework for the prevention of child maltreatment. Specific attention is devoted to describing some of the current innovations in practice – in particular, early intervention and ‘whole of community’ approaches designed to enhance the health and wellbeing of children via the development of healthy communities², which attempt, in part, to counter some of the structural societal forces that negatively impact on families and child rearing.

THEORETICAL CONSTRUCTS

In this section, three theoretical constructs that underpin the development of an holistic approach to child abuse prevention are discussed: first, ecological theories of child maltreatment causation; second, the identification of key risk and protective factors that influence children, family and community vulnerability to child maltreatment and other social ills – that is, risk and resiliency; and third, the recognition of the importance of the local community and the development of the concept of social capital.

Ecological framework

Current theories of the causes (or etiology) of child maltreatment draw heavily on Urie Bronfenbrenner’s ecological theory of human development (Bronfenbrenner & Mahoney 1975; Bronfenbrenner 1979). Underpinning the various theories is recognition of the complex, multidimensional nature of child abuse and neglect (Garbarino 1977; Belsky 1980; National Research Council 1993).

Belsky’s (1980) model of the etiology of child maltreatment integrates a number of diverse single factor approaches, including psychological disturbance in parents, abuse-eliciting characteristics of children, dysfunctional patterns of family interaction, stress-inducing social forces, and abuse-promoting cultural values. He offers a conceptualisation of child maltreatment as a ‘social-psychological phenomenon’ where maltreatment is determined by the mutual influences of the individual child or parent, family, local community, and the wider culture or society.

The essence of Belsky’s multi-level modelling approach is the interaction of protective and risk factors. That is, the overall likelihood of child maltreatment results from the combination and interaction of complex constellations of factors, some enhancing and some minimising the potential for maltreatment, whose influence may increase or decrease over different developmental and historical periods (Holden, Willis & Corcoran 1992; National Research Council 1993).

Implications for prevention

Until recently, most child abuse prevention strategies have focused on addressing child, parent and family-related factors that are associated with a greater propensity for child maltreatment, with scant attention paid to the societal and community factors that cause harm to children, or that impact on the lives of children and families (Hay & Jones

1994; Korbin & Coulton 1996; Reppucci, Woolard & Fried 1999).

The eminent US psychologist James Garbarino (1995) has argued that there is currently a toxicity of the social environment similar to the toxicity of the physical environment, and that the contemporary social environment, wider society, local communities and neighbourhoods, is particularly toxic for children. Garbarino identified a series of toxic factors including violence in all its forms, poverty, unemployment, poor housing and an under-resourced education system, that may be presumed to lead to an increased potential for abusive or neglectful behaviour in families, or higher incidences of other social ills. He asserted that the management of socially toxic environments should be analogous to the management of the physically toxic environment – requiring a similar, if not greater, level of perceived urgency by the public.

To be truly effective, consideration must therefore be given to the means to remedy the socially toxic factors that underpin child maltreatment and other family violence via the adoption of community or neighbourhood and society-wide approaches (Parton 1985; Seagull 1987; Limber & Hashima 1992; Harrington & Dubowitz 1993; Rayner 1994; Thompson 1994; Cox 1997). Greater recognition that ‘programs focused solely on the individual seem destined to failure if they do not take into account community context’ (Reppucci et al. 1999:411) has led to the perception that child abuse and neglect cannot be overcome through ‘administrative, legal, technical and professional measures which leave social values, structures and dynamics unchanged’ (Gil 1979:1).

Concomitantly, there has been a move to develop multi-level prevention efforts that typically maintain an individual or family-level component, but which also address the socio-cultural context within which children and families live (Cox 1997; Reppucci et al. 1999).

Risk and resiliency

Researchers investigating the risk factors that may heighten children’s vulnerability to various social ills, such as child abuse and neglect, have consistently identified some children who are able to achieve positive outcomes in the face of adversity – children who are ‘resilient’ despite facing stressful, high risk situations (Kirby & Fraser 1997).

Resilience appears to be determined by the presence of risk factors in combination or interaction with the positive forces (protective factors) that contribute to adaptive outcomes (Garmezy 1985, 1993). The interaction of risk and protective factors occurs at each stage of child development and within each ecological level (that is, it is affected by a child or parent’s internal characteristics, aspects of the family, and of the wider social environment) (Kirby & Fraser 1997). A number of studies, particularly those by Werner (Werner & Smith 1989; Werner 1989, 1993; Rutter 1987; Garmezy 1985, 1993), have led to further investigation of the interaction of risk factors and the buffering, or protective factors, that may protect a child from risks and enhance

resilience (Bowes & Hayes 1999). However, research is still required to determine precisely the ways in which interactions between risk and protective factors may influence child outcomes (Kaufman & Zigler 1992).

Three types of resiliency have been identified and described. First, *overcoming the odds*, where positive outcomes are attained, despite high risk status; for example, an infant born pre-term is considered to be at high risk because of an association with poor health outcomes. Second, *sustained competence under stress*, where in environments high in stress and conflict children display an ability to cope well. Third, *recovery from trauma*, where children function well after experiencing severe trauma – for example, war, severe violence or a natural disaster (Kirby & Fraser 1997).

It is important to note that just as risk factors may be unique to particular populations, resiliency is also culturally determined. Behaviour considered adaptive and normative in one culture may not be perceived in the same way in other cultures. A second potential source of variation in childhood resilience is associated with the nature of children's developmental processes. That is, children respond differently to risk over time, with vulnerability or resilience shifting as a function of 'developmental or maturational changes' (Kirby & Fraser 1997:15).

Garnezy (1985) identified three main types or constellations of protective factors which contribute to the level of resilience or positive outcomes that are achieved.

Dispositional attributes of the child – the personal characteristics or skills that may foster resilience, such as rapid responsiveness to danger, precocious maturity, the use of relationships for survival, the conviction of being loved, and a sense of optimism (Mrazek & Mrazek 1987; McQuaide & Ehrenreich 1997).

Positive family relationships – resilience is associated with, among other factors, high levels of parental monitoring and high levels of support from at least one parent, a history of good parenting, effective interpersonal communication between family members, and low socio-environmental stress (Herrenkohl et al. 1994; Fantuzzo & Atkins 1995; McCubbin et al. 1997; Resnick et al. 1996; Pharris, Kirby & Fraser 1997; Pharris, Resnick & Blum 1997).

External social supports from the community – good social and cultural supports, a strong religious affiliation, few stressful life events, positive life expectations, and ongoing opportunities for positive connections from families, schools, and communities are protective factors associated with more positive developmental outcomes (Langeland & Dijkstra 1995; Benard 1993; Vinson et al. 1996; Pharris et al. 1997).

These findings reinforce the importance of the socio-cultural context of the child's situation and the ecological nature of child development, vulnerability and resilience.

Implications for prevention

As part of the adoption of approaches where the enhancement of protective factors or 'strengths' are valued as part of a policy of promoting healthy communities, there has been some government interest in further developing the concept of resilience and using it as the basis for Australian community-level interventions. Professor John DeFrain, a US

researcher with 20 years experience in developing population-based assessments of family strengths, will be working in collaboration with the University of Newcastle's Family Action Centre to develop a measure of resiliency for the Australian population in 1999 (see DeFrain 1999 forthcoming).

Similarly, in Victoria, the Department of Human Services has contracted the Centre for Adolescent Health, Royal Children's Hospital to pilot and run a Victorian adaptation of Hawkins and Catalano's (1992) *Communities that Care* model (see below) as a means of identifying risk and protective factors for Victorian adolescents. A pilot study has been completed and the Centre is currently undertaking a statewide survey of almost 13,000 secondary students which will enable the development of regional and local government area profiles of risk factors, protective factors, and the incidence of social problems.

Developmental prevention

In order to prevent child maltreatment more effectively, strategies are required that focus on both reducing risk factors and strengthening protective factors that foster resiliency. As Cox (1997:253) notes: 'Truly ecological approaches that are developmentally attuned demand concurrent programs that work on protective as well as risk factors and that reflect and impact on processes working within and across various domains of the child's world.'

Such an approach has been adopted in order to prevent other social ills. For example, Tremblay and Craig (1995:156-157) describe *developmental prevention*, a key component of crime prevention strategies, as 'interventions aiming to reduce risk factors and increase protective factors that are hypothesised to have a significant effect on an individual's adjustment at later points of . . . development.'

Prevention or promotion?

Such a developmental approach (Tremblay & Craig 1995) has implications for the development of child abuse prevention strategies, and more specifically, the terminology employed. Child abuse prevention has commonly been classified into three main levels under a 'public health' model – primary, secondary and tertiary prevention (Helfer 1982). Most prevention initiatives have taken a problem-focused approach, where the objective is the prevention of a social ill and a reduction in risk rather than the promotion of positive, life-enhancing strategies (protective factors), such as good interpersonal relationships, appropriate parenting and pro-child policies (Tomison 1997a).

The term 'child abuse prevention' may also tend to focus attention on the problems of individual parents or families, without adequate recognition of the connection between individuals' problems and the influence of the wider social context (NSW Child Protection Council 1997). Thus, any models framed around *prevention* without *promotion* may be considered to offer a somewhat restrictive means to address social ills (NSW Child Protection Council 1995).

Taking an example from an allied health field, the prevention of mental disorder in the community is generally described as mental health promotion (encouraging the development of positive mental health) rather than mental illness prevention (the prevention of a social ill). Competence

building and mental health promotion efforts are perceived as among the most promising strategies for preventing mental illness (Reppucci et al. 1999).

It appears that a similar 'revolution' has begun among professionals working in the child protection and child welfare arenas. In family support work, many agencies have begun to re-focus their work with families to empower clients, focusing on a family's potential for change rather than on their problems, and attempting to engage family members in a truly cooperative venture to find solutions to their issues. A 'strengths-based' or 'solution-focused' approach to practice is based on the development of an effective collaborative relationship with children and their families (De Jong & Miller 1995).

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

Specific child abuse prevention programs have also adopted a 'positive' approach to ensuring children are cared for adequately. For example, the Positive Parenting (Triple P) Program developed by Associate Professor Matt Sanders at the University of Queensland is a parenting education program where, as the title suggests, the focus is on the enhancement of good parenting rather than the minimisation of bad parenting.

Last, following research undertaken in Western Sydney, I'Anson and Litwin (1996) identified the need for a re-examination of the role of health services in addressing child abuse and neglect concerns. They advocated the adoption of a health-promoting framework where the focus is on the opportunities available to health services to promote the health and wellbeing of children, young people and their carers.

Overall, it appears that associated health fields (World Health Organisation 1986; Australian Health Ministers Conference 1995; NSW Child Protection Council 1997; National Crime Prevention 1999) and elements of the child welfare/family support system have moved to adopt a prevention philosophy (and associated terminology) which promotes healthy, positive practices rather than those which merely signify the minimisation of social ills. As Reppucci et al. (1999: 401) noted: 'In the 1990s principles of community mobilisation and development have increasingly been used in health and wellness promotion efforts . . . concentration of effort on at-risk populations has been de-emphasised, in favor of promoting healthy behaviors in all people within a community.'

As no specific health *promotion* term has as yet been devised or embraced by the professional community working in the

child protection or child welfare field, the term *child abuse prevention* shall continue to be used throughout this paper.

Social capital

The practice of economic rationalism, adopted by governments of different political orientations in the United States, United Kingdom and Australia, has dominated economic and social policy agendas in these countries for much of the last 15 years. Economic rationalism has been deemed partially responsible for the development of a cult of individualism – that is, the pursuit of individual interest and the associated promotion of individual autonomy at the expense of social values and commitment to the broader community (Dalton, Draper & Weeks 1996; McGurk 1997).

One result of economic rationalism has been that social issues have often been discussed in economic rather than social terms (Rees 1994). For example, the utility of the welfare system is often framed in terms of cost-effectiveness and efficiency criteria, rather than the health or wellbeing benefits reaped by the individual, familial or wider community. There is growing recognition however, that to develop a true assessment of the health of a community requires an assessment of social capital as well as economic capital (Fegan & Bowes 1999).

'Social capital' may be defined as 'social relations of mutual benefit that are characterised by norms of trust and reciprocity' (Winter 1999 forthcoming). Specifically, it is the quality of the linkages and the supports or resources that communities provide to children and families (Fegan & Bowes 1999), and the processes between people which lead to the establishment of interpersonal networks, social norms, and social trust that may facilitate coordinated and collaborative action for mutual benefit (Coleman 1988).

Communities possess varying degrees of social capital. In his theory of social capital, Coleman (1988) characterised communities high in social capital as encompassing a myriad of complex interpersonal relationships. These included broad and ongoing connections to family and extended family members, linkages to the local school system, employment, peer relationships, and involvement in local community activities (Argyle & Brown 1998). Communities high in social capital were also characterised by their accessible, helpful information networks; relatively clear-cut norms and sanctions about parental and child behaviour; perceived opportunities for advancement (that is, employment opportunities, the potential to become a valued member of the community); and the perception that the community had a relatively stable residential pattern (that is, low residential mobility).

Neighbourhood cohesion and the quality of social relationships that exist between community members and between individuals and organisations have been found to help the parenting function, and reduce the stress associated with maltreatment (Vimpani et al. 1996; McGurk 1997). The connections made with family, friends, neighbours and local professionals, positively influence the ability to cope when problems arise, providing opportunities to seek advice and assistance (Fegan & Bowes 1999).

Being part of a healthy community that is strong in social capital may also provide benefits via 'collective socialisation'

(Fegan & Bowes 1999), where children and young people are taught norms and sanctions regarding acceptable social behaviour and are positively affected by the community's expectations for children (for example, the importance of education, of obtaining a 'good job'). Communities may also prevent maltreatment by setting norms of appropriate parenting behaviour, supporting parents who are under stress, and by providing additional professional and lay resources (Garbarino & Crouter 1978). Importantly, people who feel part of a vibrant, healthy community are themselves more likely to see that they can contribute something worthwhile to that community (Kaufman & Poulin 1994). This, then, is the beginning a cycle of positive support and enhanced community life where individuals and the wider social group reap the rewards.

Social isolation and social connectedness

However, just as a strong, positive community may promote positive, healthy development, a lack of connectedness or supports may have very real effects on community members' quality of life and ability to cope. Non-involvement in the community, being disconnected, can have serious social consequences such as alienation, loneliness, low self-esteem, boredom, intolerance of others, lack of motivation, and may negatively impact on family functioning or impair child development (Fegan & Bowes 1998). Numerous studies have shown that social isolation is associated with a greater risk of child maltreatment (Garbarino 1976; Gelles & Straus 1979; Wolock & Horowitz 1979; Straus 1980; Salzinger et al. 1983; Tomison 1996c; Chalk & King 1998; Repucci et al. 1999).

For example, prospective studies conducted by Hunter and Kilstrom (1979) and Egeland, Jacobvitz and Papatola (1987, as cited in Egeland 1993) investigated the effect of extensive social supports on the potential for maltreatment. In comparison with maltreating mothers, non-abusing mothers were reported having extensive social supports, were less likely to have been maltreated by both of their parents, and were more likely to report a supportive relationship with one parent while growing up.

Living in an environment plagued by various social ills may adversely impact on the quality of life of community members. Residing in a community of high unemployment, high crime rates, poor transport facilities and poor access to professional services, where the social interactions that take place are predominantly with others who are also struggling to cope with life's pressures, is less likely to produce favourable social outcomes. Considerable research has demonstrated the association of stressful, negative community conditions with maladaptive coping and social dysfunction (Jencks & Peterson 1991; Garbarino 1992; Garbarino & Kostelny 1992; Hay & Jones 1994; Thompson 1995; Garbarino 1995; Cox 1997, 1998).

Providing social support and promoting the development of 'caring communities' are therefore seen as important ways of preventing child maltreatment for socially isolated families in particular (US Advisory Board on Child Abuse and Neglect 1993; Melton & Barry 1994). However, societal changes over the past 30 years have made it more difficult for people to establish and/or maintain social links, even in the same local community. Since the 1950s, technological

innovation, changes to women's roles in the workforce and in society as a whole, family breakdown, the increased geographical distances between family members, and the higher mobility of families, among other things, have resulted in substantial changes to the local neighbourhood. A result has been a higher degree of social isolation; many people no longer have the resources of extended family, friends or neighbours to turn to for advice, company or support as part of everyday life (Bowes & Hayes 1999; Fegan & Bowes 1999).

Garbarino noted that: 'Families are on their own. Family privacy, economic prosperity, and mobility patterns all separate parents and children from traditional sources of support and feedback . . . Isolation is contagious, we become estranged from each other and all families lose the social support of close and caring loved ones' (Garbarino & Abramowitz 1992:94).

Vinson, Baldry and Hargreaves (1996) conducted a study of two adjoining neighbourhoods in Western Sydney, both economically depressed but with contrasting rates of child maltreatment. Their intention was to determine why the difference in the rate of child maltreatment existed and whether this could be attributed to differences in the characteristics of the neighbourhoods as social entities.

The neighbourhoods were matched in terms of population, size and measures of social disadvantage. Based on analysis of demographic data and parents'/carers' ratings of their social environment, the locality as a place to raise children, transport and communication patterns, and specific aspects of each carer's support network, it was apparent that the one outstanding difference between the neighbourhoods was the structure of the social networks. The area with the higher rate of abuse suffered from a relative lack of connection between more immediate parts (familial) and more distant parts (usually peers) of the social network. These parents had a quite insular existence, with much less contact with the wider community.

The researchers concluded that the degree of network connectedness enabled them to distinguish between not only clinical and non-clinical populations (high abuse and low abuse) but also high and low risk localities. This has implications for the effective prevention of child maltreatment in that it indicates the importance of social support and social networks. They also suggested that the prevention of child maltreatment may be enhanced by programs that attempt to simulate some of the 'helpful child-rearing functions attributed to naturally occurring networks' (Vinson, Baldry & Hargreaves 1996:540).

These *devised social networks* are organised to fulfil functional roles, such as parent education, child care, parent enrichment courses and mutual support groups, and act as the means to improve the social connectedness of participants. Vinson, Baldry and Hargreaves (1996) describe the Child and Neighborhood Program (Powell 1987, as cited in Vinson, Baldry & Hargreaves 1996), which fulfils the role of the devised social network. This program provides parent education, emotional support, role models and information and referral services.

The US National Commission on Children (1991) concluded that enhancing a sense of community and invigorating

informal systems of social support for children and families should be a primary goal of social policies at all levels of government. This was greeted with less enthusiasm by government leaders who had worked with neighbourhood development programs in the 1960s, in that it appeared to be a return to a policy, planning and resource allocation model that had been judged to be unsuccessful (Wilson & Ward 1997). However, the 'failure' of these earlier approaches may not have been due to flaws in the overall concept.

These values underly a relatively new development which has begun operating in Australia, *Child and Family Centres*, which were described in the last Issues Paper (Valuing Parent Education, Tomison 1998). The centres, frequently referred to as 'one-stop shops', adopt an holistic approach to preventing child maltreatment and promoting healthy communities.

Similar programs, known as *Family Resource Centers*, have been operating in the United States for some time (US Advisory Board on Child Abuse and Neglect 1993). Designed to be easily accessible, the centres offer highly integrated services that can promote parental competence, meet the diverse needs of children and families, and facilitate a sense of community and the development of social support networks within neighbourhoods.

COMMUNITY-LEVEL COMPONENTS

Using the tenets of ecological theories and a developmental prevention approach, a number of comprehensive frameworks have been produced that recognise the need to address the problem of child maltreatment holistically (US Advisory Board on Child Abuse and Neglect 1993, Melton & Flood 1994, Fraser & Galinsky 1997, Tomison 1997a, NSW Child Protection Council 1997). As the NSW Child Protection Council notes, 'prevention on a broad scale requires a web of complementary programs and strategies. No single program or service can be expected to solve the problem on its own, but each can make its own contribution to an environment which is safe for children and supports their development' (1997:31).

In their assessment of family violence prevention and treatment programs, the US Committee on the Assessment of Family Violence Interventions (Chalk & King 1998) identified three separate but complementary initiatives that have emerged to address the 'complex interactions of risk and protective factors, multiple problems, and environmental effects on family violence: (1) service integration, (2) comprehensive services focused on separate problems that share common risk factors (also called cross-problem interventions), and (3) community-change interventions that target social attitudes, behaviors, and networks' (Chalk & King 1998: 260).

Although the overall goals and characteristics of these three initiatives are similar, they employ different strategies in order to effect positive change and to improve the quality and range of prevention, treatment and supports available in community settings. The first strategy is based upon the enhancement of interagency communication and collaboration, such that the response to a social ill, such as child maltreatment or domestic violence, is enhanced. The second strategy relates to the adoption of cross-sectoral collaboration to address children and families problems

comprehensively. The third strategy addresses the community or society itself as the subject of the intervention and involves the adoption of 'whole of community' responses.

The Committee concluded that although the research is recent and largely descriptive, it is apparent that there is substantial interest and enthusiasm for these new approaches by community leaders, and for the government and non-government agencies that sponsor family violence prevention programs (Chalk & King 1998).

While interagency collaboration is vital to effective prevention, in the remainder of this paper the focus will be on describing cross-sectoral collaborations and 'whole of community' responses, in conjunction with a discussion of the role of early intervention strategies in the development of healthy communities.

Type of maltreatment

Most holistic frameworks and/or community-based approaches aimed at preventing child maltreatment or the promotion of healthy children, families and communities have, until recently, focused predominantly on physical abuse and neglect (Cox 1997). With the relatively recent recognition of the pervasiveness and destructive consequences of emotional abuse (Garbarino & Vondra 1987; O'Hagan 1993), emotional abuse issues have been widely incorporated into community education campaigns, parent education and family support programs. Typically, the approach is to provide positive parenting alternatives rather than merely focusing on the prevention of harmful behaviour (Tomison & Tucci 1997; Tomison 1998).

For example, the Victorian Board of Studies has developed the *Healthy Families Project*, a school-based community education program with an underlying message that cycles of behaviour are not unchangeable. Adopting a proactive, health promotion approach, the educational program at the centre of the project both implicitly and explicitly strengthens children's natural resilience. It teaches children that individuals have the power to change their lives and to develop more constructive forms of parenting than they themselves experienced as children.

The program is firmly located within the mainstream primary school curriculum to ensure it reaches all children, and is intended to achieve three related sets of outcomes: (1) a cultural and attitudinal change in the wider community, particularly among primary school teachers and parents, via media publicity, publications, workshops, seminars and conferences; (2) structural improvements in the organisation of support services provided by the educational system and primary care agencies, to improve the coordination of services at the local level; and (3) personal improvements in the quality of family relationships for participating children and parents. Preventing emotional abuse, physical abuse and neglect are primary objectives that are achieved via positive parenting and health promotion approaches.

Sexual abuse

However, the key community-level factors that are likely to be related to child maltreatment, such as poverty, neighbourhood, culture and parenting practices, apply more to physical abuse, emotional abuse and neglect than to the

sexual abuse of children. Community-level approaches, particularly those designed to create healthy communities, focus on the forms of maltreatment that can be remedied or prevented by the use of social support or parent education via the promotion of 'positive parenting' strategies. Such strategies are not designed to prevent sexual abuse.

Unlike the other forms of child maltreatment, sexual abuse is generally believed to occur as one part of the range of violence perpetrated by men against women and children (O'Hagan 1989). Under such a 'social power' framework, sexual abuse is perceived by feminist theorists to be an outcome of societal values, resulting from women and children's inferior social status under the current patriarchal social structure and as a function of male dominance (Tomison 1995; Goddard 1996). As a result, sexual abuse prevention programs 'must target victimisation, sexually abusive behaviour and the changing of community attitudes which allow the sexual abuse of children to occur' (Crime Prevention Committee 1995:265).

The application of holistic or community-based approaches to the prevention of child sexual abuse is limited to primary-level community education of parents and the education of school-aged children to teach them the means of avoiding or seeking assistance with unwanted sexual or physical advances. Currently the major school-based initiatives are personal safety and Protective Behaviours programs (Tomison 1997b). Personal safety programs have the aim of educating school-age children to protect themselves from sexual abuse. The programs attempt to involve the children's parents in order to raise community awareness of sexual abuse and to teach parenting skills related to protecting children and detecting signs of abuse (Plummer 1993). Protective Behaviours programs focus on teaching children to avoid a wide range of potentially unsafe situations, only some of which involve child maltreatment.

However, as part of a coordinated approach to the prevention of violence it is also necessary to develop primary prevention education campaigns which challenge gender stereotypes and promotes positive social interactions across all strata of society. Given that recent research has identified a link between child sexual abuse, child physical abuse and spousal violence (Goddard & Hiller 1993; Tomison 1995), such campaigns need to address male physical and sexual violence against both women and children. A number of mass media campaigns addressing community violence have been developed in Australia, including one which featured prominent Australian men making anti-violence statements (Michaux 1996).

Early intervention programs

Much of the current approach to child abuse prevention results from a re-visitation and extension of the programs and tenets of generic early intervention programs that were first begun 30 years ago.

Social competency

In the United States in the 1960s, the Civil Rights movement provided the impetus to develop new ways of thinking and to overhaul the existing social structure. Education was seen as the key to eliminating social and economic class

differences (Zigler & Styfco 1996; Ochiltree 1999) and resulted in attempts to improve the cognitive and social competence of disadvantaged young children. Two programs that have significantly shaped current attitudes and early intervention strategies are the Perry Preschool and Head Start projects. These programs were effectively secondary prevention programs, given that they targeted specific 'at risk' populations for service provision; more accurately however, their focus is one of health promotion and the development of resiliency.

Perry Preschool Project

The Perry Preschool Project was a small experimental program begun in the early 1960s, designed to enable children to participate in an active approach to learning, facilitated by well-trained teachers. The emphasis throughout the program was on problem-solving, choice and decision making, taking responsibility, and maintaining consistent daily routines. The key areas of the curriculum were: creative representation, language and literacy; social development and personal initiative; motor development and movement; music; classification of similarities and differences; and basic mathematical skills and concepts. The focus of the program was preschool education, although there was a home visiting component to enable parents to reinforce the curriculum in the home. Unique in the field, the graduates of the project have been followed until the age of 27 years and it was found that over half of the 58 predominantly African-American, three to four year old children who participated in the project subsequently had better life outcomes as adults compared with a matched group of non-participants.

Initial findings indicated that the program produced immediate increases in participants' IQ test scores, although these were not permanent and dissipated over time. A reduction in grade retention was maintained however. Significantly, as adults the Perry graduates showed better social competence, measured across a series of indices relating to criminality, use of welfare services, family structure and career success (Schweinhart et al. 1993). Barnett (1993) was able to calculate that by the age of 27 years, for every dollar taxpayers spent on the preschool program, there was a subsequent saving of over seven dollars.

This cost-benefit analysis resulted in a revitalised attitude towards the effectiveness of early intervention programs (Zigler & Styfco 1996), given that they were able to assist the nation to attain educational targets, and were 'lucrative social investments' (Zigler & Styfco 1996:144).

Head Start

Head Start was one of the earliest and largest early intervention programs, developed before there was an established knowledge base that could indicate the positive effects that early intervention could have on children's development (Zigler & Styfco 1996). It was designed to combat the disadvantages children faced as a result of living in poverty and to improve child developmental outcomes, particularly intelligence (IQ) scores, and social competence (Zigler & Styfco 1996; Ochiltree 1999). The intention was to give poor preschool children, aged three to five years a 'head start' that would ensure that they began elementary schooling with a level of competence similar to that attained by their middle class peers. The program,

begun just as the Perry Preschool project was finishing, opened in the United States summer of 1965 with an initial enrolment of over 500,000 children.

Head Start was based on a 'whole of child' philosophy, and embraced a number of goals. Each Head Start preschool centre was designed to improve children's mental and physical health, enhance their cognitive skills, encourage their social and emotional development, self-confidence, healthy relationships and social responsibility, and foster a sense of dignity and self-worth for both the child and family. Parents were involved as teacher aides and although the major focus was on improving the educational outcomes for children, there were also parent education and other classes for parents, and access to family support services was provided through referrals (Condry 1983).

Overall, the primary aim of the Head Start program was to develop children's overall social competence through the comprehensive provision of services (Zigler & Styfco 1996:136): 'By far the most unique theme set forth in the planning document was the central role accorded to parents. Up to this time, poor people were treated as passive recipients of services dispensed by professionals . . . Head Start parents were to be involved in the planning, administration, and daily activities of their local centers.'

This occurred, in part, because of the influence of Urie Bronfenbrenner who was beginning to develop his ecological model of human development and who advocated an intervention focusing on the broader ecology of the child's environment. 'Today the involvement of parents as well as communities is recognised as crucial to Head Start's success' (Zigler & Styfco 1996:136) and it has provided a model for the development of partnerships with the local community to develop healthy communities.

Despite the program's aim of improving both social and cognitive competencies, initial evaluations of the program focused predominantly on changes to IQ scores and, like the Perry Preschool Project, immediate increases in participants' IQ test scores were identified, and these also dissipated over time. There were other lasting program effects, such as being less likely to fail a grade or to require special education classes, benefits which lasted until many children had reached the age of 12 years or more (Zigler & Styfco 1996). There was also strong parental approval for the program and the effects it had had on their children (Ochiltree 1999).

Over time, the program has taken a two-generational approach to enhancing competence, in that many of the adults from low-income families that have been involved with the program have subsequently become project staff, and/or received training and qualifications through the program, thus improving their own level of competence and subsequent ability to achieve better-paying employment (Ochiltree 1999).

A number of positive outcomes identified in the Perry Preschool Project, (which was later described as 'Head Start-like'), particularly the benefits-costs findings, were later generalised to the Head Start program, as well as to other early intervention initiatives. Head Start and other early intervention programs were subsequently assigned the tasks of reducing welfare dependency, crime, and low educational attainment, although these goals were inspired

more by 'politicians' campaign promises than by scientific findings' (Zigler & Styfco 1996:132).

Programs that could reduce social ills and save money were particularly welcomed in the harsh economic times of the past 15 years. As a result, since 1990 there has been a rejuvenation and expansion of Head Start programs in the United States. Initially with a duration of eight weeks, and run over the summer, Head Start programs are now run as a half-day programs for the duration of the school year, although some children attend for two years (Zigler & Styfco 1996; Ochiltree 1999).

Home visiting programs

Home-visiting programs are an important facet of a cohesive child abuse prevention strategy, ideally offering a universal primary preventative service with the flexibility to cater for the needs of 'at risk' or maltreating families (Vimpani et al. 1996). Such services have had some success carrying out an 'early detection' role and identifying families at risk before family dysfunction reaches a level requiring protective intervention (Olds et al. 1986a; Olds et al. 1986b; Olds et al. 1997; Chalk & King 1998).

Typically involving infant welfare nurses or antenatal services, such programs are able to divert or refer families to the most appropriate support and can often alleviate the family situation without involving child protection services (National Research Council 1993; Vimpani et al. 1996). Most Australian states and territories have some form of postnatal home-visiting program, albeit usually of limited duration.

Prenatal/Early Infancy Project

The most scientifically rigorous program evaluation of a comprehensive home-visiting program, and arguably the most rigorous evaluation of a child abuse prevention program, is the Prenatal/Early Infancy Project developed by David Olds and colleagues (Olds et al. 1986a; Olds et al. 1986b; Olds et al. 1997). Professionally trained nurses were used as home visitors for a sample of 400 Caucasian expectant mothers and their families in Elmira, a rural area of New York State. Elmira County was part of an area rated in 1980 as the worst in the United States in terms of economic conditions, and it had the highest rates of reported and substantiated child maltreatment in New York State from the early 1970s until the mid-1980s.

Participants were randomly assigned to one of four conditions: a control group that did not receive services; a minimal intervention group that received transportation to medical appointments; a group that received extensive prenatal home visiting and transportation; and a group that received extensive prenatal and postnatal home visiting and transportation. The nurses provided parent education and attempted to enhance parents' linkages to both formal and informal social supports (Olds et al. 1986a). The project evaluated a series of prenatal, birth and postnatal outcome variables, such as length of gestation, birth weight, quality of maternal-child interactions, disciplinary behaviours, child maltreatment reports and postnatal emergency room visits.

The major finding was that the home-visiting nurses significantly reduced the number of subsequent child maltreatment reports in comparison with the control group. The finding was particularly salient for families judged to

be at high risk for child maltreatment. However, the service was also found to affect prenatal health behaviours significantly in terms of factors such as improved maternal diet, less smoking and greater social support. In addition, there were increases in the length of gestation and infant birth weight, including a 75 per cent reduction in pre-term deliveries (Olds et al. 1988).

However, four years after completion of the intervention no significant differences existed between control and treatment groups in terms of behavioural or developmental outcomes or rates of child maltreatment (Olds, Henderson & Kitzman 1994). This was attributed to a selection bias in the original sample – nurses and other professionals who continued to have contact with mothers in the treatment groups might have been more sensitive to, and more likely to report, signs of child maltreatment. In contrast, Olds et al. (1997) reported at a 15-year follow-up that prenatal and early childhood home visitation had a significant impact on behavioural and developmental outcomes. In addition, there was a reduction in subsequent pregnancies, the use of welfare, child maltreatment rates and criminal behaviour on the part of low-income, unmarried mothers.

Overall, home-visiting programs are clearly an important facet of a cohesive child abuse prevention strategy, ideally offering a universal, primary preventative service with the flexibility to cater for the needs of ‘at risk’ or maltreating families (Vimpani et al. 1996).

Universal services – the Scandinavian model

In some countries of Western Europe, universal early intervention programs drive strategies to prevent social ills via the development of a series of universal public health services in combination with a capacity to intervene with individual cases of child maltreatment (Clark 1997).

The cornerstone of this approach, as exemplified by Sweden, is: antenatal/postnatal parent education and health checks at maternity health centres; maternal and child health services, which play a significant role in the protection of infants and preschool children; and the provision of a universal day care service for preschool children. The long-term needs of children are taken care of via the education system (Kahn 1990).

Finland and Denmark have similar national family support programs which, together with Sweden’s, demonstrate significantly better outcomes for families on a number of indicators (Clark 1997): the rate of child abuse notifications in the Scandinavian countries is eight times lower than in the United States and four times lower than in Australia; 5 per cent of pregnant mothers begin prenatal care before the end of the fourth month of pregnancy, compared with 85 per cent in the United States; less than 4 per cent of mothers are under the age of 20, compared with 10 per cent in the United States; infant mortality and birth rates are among the lowest in the world; the prevalence of mild intellectual disability is 8–10 times lower than in the United States.

Pransky (1991:59) notes the social and political appeal of such Scandinavian family support programs which strengthen and promote ‘well functioning, independent, self-supporting families that produce children who, in turn, will become independent, self-supporting adults.’ Yet there must be some recognition of the cultural context within

which the programs operate. Like any preventative or health promotion initiative, the programs and their benefits may not be readily transferred to other cultures without modification and tailoring for the social norms and needs of the host community.

Overall, while it is difficult to establish a causal relationship between a family support system and improved child and family wellbeing, such a population-based assessment produces compelling results (Clark 1997). It has been contended that the findings result not as a consequence of the support system, but because of underlying differences in the socio-economic status of countries (Clark 1997). However, Bronfenbrenner (1979) has argued that the relationship between socio-economic status and child development may be altered when appropriate social policies are in place to ease the impact of social class on families. Miller (1987) supports this contention in a comparative study using the low infant mortality rates of some of the poorer European countries, such as Ireland and Spain, where the mortality rates were found to be lower than those among the poor communities in the United States.

Universal services are often closely linked with early intervention strategies which are, as already noted, one of the most effective ways to ameliorate the effects of maltreatment (Widom 1992). The prenatal/perinatal period, in particular, is a period of developmental transition which provides an ideal opportunity to enhance parental competencies and to reduce risks that may have implications for the lifelong developmental processes of both children and parents (Holden, Willis & Corcoran 1992).

However, population-wide efforts may not be intense enough to help those families who are most in need of services, and this may be exacerbated by the generally limited resources available to develop and maintain universal services (Reppucci et al. 1999:399). There is a need therefore, to maintain services that are able to provide more intense support for families in need, who are at risk of maltreating (secondary prevention), or who are maltreating their child (tertiary prevention). For example, Widom (1992) highlighted the need also to target specifically children exhibiting behavioural problems as part of a crime prevention strategy. She found that these children had the highest risk of later juvenile and adult arrest, and for engaging in violent criminal behaviour.

The *Resilient Peer Training Project* was a three-year project designed to reduce parent and child social isolation, to promote pro-social interactions, to evaluate the effectiveness of the child- and parent-resilient peer training (RPT) interventions, and to assess the integrity and replicability of Head Start and parent and child RPT interventions (Fantuzzo & Atkins 1995). The development of the project involved establishing links among university researchers, Head Start teachers and Head Start parents to determine outreach strategies for socially isolated, low-income, maltreating parents and their children.

Results of a social competency assessment show that maltreated children displayed more adjustment problems, general social competence difficulties, and problems in peer play interactions than non-maltreated children, supporting the need for a social competence intervention

targeted for maltreated children. Field tests of the child and parent RPT interventions reveal that children assigned to the RPT intervention showed higher levels of positive interactive play behaviour at post-test than control children and that parents assigned to the RPT intervention were less socially isolated and displayed lower levels of perceived stress and higher levels of parental supports.

Implications for prevention

The evaluation of these and other early intervention projects has resulted in the development of some guiding principles for the development of effective programs. Of primary importance, programs must be comprehensive in scope and attend to the various factors underlying social problems like child maltreatment (Emens et al. 1996; Zigler & Styfco 1996; Hayes & Bowes 1999; Reppucci et al. 1999). This best result appears to be achieved via the adoption of a cross-sectoral response to ensure that the needs of child and family are met, and works best where a partnership is developed between program staff, other professionals working with the child or family, and with the family itself (Powell 1982), what in this paper is described as a 'whole of community' response.

However, it is apparent that early intervention programs in isolation cannot transform disadvantaged children and parents' lives. No program can enable children to develop optimally when their larger child rearing environment is not conducive to healthy development, supporting calls for greater attention to the structural societal forces that impact on the quality of children's and families' lives (Emens et al. 1996; Zigler & Styfco 1996; Tomison 1997a; Hayes & Bowes 1999). As Zigler and Styfco note: 'Thirty years of experience with early intervention have yielded a clear but unwelcome truth: such programs cannot overpower poverty in shaping a child's developmental outcome . . . Although children do better than they would have without the experience, they still do not approach the achievements of middle-class students' (1996:152).

Yet early intervention programs like Head Start and Elmira have demonstrated some improvement in disadvantaged children's lives, and may reduce the number of 'at risk' or maltreating families who will require more intensive support in order to reach an adequate level of parenting and overall functioning. Early intervention remains a vital component of any holistic approach to preventing social ills or promoting social competence (Emens et al. 1996; Zigler & Styfco 1996).

Cross-sectoral prevention

Child maltreatment is now recognised as a complex phenomenon that may reflect the degree of underlying social problems in a family, community or society (Melton & Flood 1994). Child maltreatment is associated with the occurrence of other individual, family and societal problems (poverty, mental illness, substance abuse, domestic violence, unemployment, lack of social support) (Mulroy 1997). A holistic approach must therefore be adopted to address what are often multi-problem, disadvantaged, dysfunctional families (Tomison 1997a).

An integral component of such a strategy is the development of partnerships between the various professions and agencies involved in child protection, child welfare, family support, education and community health (Powell 1982;

Tomison 1996b). In the past decade there have been a number of links made between agencies or sectors working with families. For example, the New South Wales Department of Community Services, which has the statutory responsibility for child protection, is required to consult at the highest levels with the Police Service, Education and Health departments and peak family support and child welfare bodies when developing policies, contemplating changes to service delivery, and in order to develop effective, coordinated cross-sectoral case practice. In Queensland child protection reports are dealt with by multidisciplinary SCAN (Suspected Child Abuse and Neglect) teams. There has also been some recognition of the need to incorporate cross-sectoral issues in both treatment and prevention programs.

In addition, the Victorian Government has recently commenced a reform of primary health and community support services, which are usually delivered in community-based or non-institutional settings. One of the key objectives of the reform is that service providers establish strong partnerships with clients, a high degree of collaboration with other local service providers, and greater integration of services at the local community level (Department of Human Services 1999).

Service provision

There has been a concomitant reform of direct service provision. For example, Hayes and Emshoff (1993:281) note that, in attempts to prevent child maltreatment and/or substance abuse, 'multidisciplinary collaborative approaches to these issues are developing in response to the understanding that violence may lead to substance abuse, substance abuse may lead to violence, and environmental pathologies may result in either or both behaviors.'

A similar trend is evident when considering the relationship between child maltreatment and domestic violence. Research examining battered women populations in refuges has indicated that domestic violence and child abuse are strong predictors of each other (Stark & Flitcraft 1988). Until recently however, research into family violence has been fragmented, with the various types of violence investigated independently of one another (Stanley & Goddard 1993; Tomison 1995). For the most part, programs have either focused on preventing child maltreatment or preventing marital violence, without much consideration of other forms of familial violence (Straus & Smith 1990, as cited in Rosenberg & Sonkin 1992). However this appears to be changing.

In Tomison's (1997b) audit report of New South Wales child abuse prevention programs it was apparent that a large number of programs submitted for audit had taken an holistic approach to family violence, in particular, linking domestic violence and child maltreatment. Approximately 43 per cent of family support programs incorporated prevention strategies targeting both domestic violence and child maltreatment. These programs were being run by domestic violence groups and sexual assault services, as well as by generalist family support services and child-focused agencies where child maltreatment was the predominant concern.

A role for governments

In 1994, Rayner undertook an assessment of the Commonwealth Government's role in the prevention of child

maltreatment. A major finding from Rayner's (1994) assessment of the Commonwealth Government's role in the prevention of child abuse was the frequent failure in communication, coordination and cooperation within and between levels of government and between government departments, between the government and non-government sectors, and within the multitude of non-government agencies that have adopted a prevention role. Overall, the prevention of child maltreatment appeared to be a very fragmented exercise, with many institutional structures not geared towards perceiving or identifying aspects of their work which had a preventative role. Rayner recommended that the Commonwealth take a lead in the development of a cross-sectoral partnerships.

Signalling Commonwealth, State and Territory government acknowledgment of the need for a national, coordinated approach to prevention, in 1993 the Commonwealth Government developed the first National Child Protection Council. The current National Council for the Prevention of Child Abuse and Neglect was announced in 1997 to provide community perspectives, advice and recommendations on the prevention of child maltreatment. Presently comprised of representatives from various non-government health and welfare agencies, the Commonwealth government, and the State Governments of New South Wales, Victoria and Western Australia, it is particularly concerned with the development of primary and secondary child abuse prevention strategies. The recent creation of a Commonwealth Family and Community services portfolio also presents an opportunity to enable a 'whole of government' approach to the prevention of child maltreatment and other social ills.

Rayner also proposed a number of strategies as the possible means of improving the level of coordination and communication between agencies and departments with a role in preventing child maltreatment.

Office for Children and Children's Commissioners

Following the recommendations laid down in the United Nations Convention on the Rights of the Child, a number of reports in the last few years have advocated for the development of Offices for the Children and Children's Commissioners at the State and Commonwealth levels (Rayner 1994), some of the more recent being the Australian Law Reform Commission (1997) report, *A Matter of Priority: Children and the Legal Process*, and the recommendations arising from the 1998 National Children's Summit, convened by the Coalition for Australia's Children.

The Offices for Children are proposed to provide the coordination of all child-related policies and programs at the State or Federal levels. Often such Offices are given a role in the promotion of child rights and thus the empowerment of children in society. Children's Commissioners fulfil similar roles, but generally focus on the promotion of child rights, acting as an advocate for children and determining the extent to which the UN Convention has been implemented within her/his sphere of influence. Queensland has subsequently appointed a Commissioner for Children, albeit with a role focused predominantly on the investigation of complaints against statutory child

protection services. In addition, New South Wales recently appointed a Commissioner and established an Office of Children and Young People.

Action Plans

Another commonly mooted option to enhance government response to the prevention of maltreatment relates to the development of mandatory Action Plans across all levels of government. Such Plans are designed to ensure that governments develop and implement cohesive strategies to address the needs of children and families, with particular reference to child abuse prevention.

As part of ongoing policy development, the then Commonwealth Department of Health and Family Services (now Family and Community Services) developed Action Plans for specific 'at risk' populations, such as the *Action Plan for Children with Disabilities* (The Wallis Group 1996), based around a comprehensive, collaborative framework for action. This Plan noted the need for the development of policies and protocols for the investigation and reporting of suspected maltreatment of children with disabilities; the importance of regular cross-program policy development and coordination between protective services and disability services; and the need to ensure effective interagency cooperation (Authier 1987; The Wallis Group 1996).

Child Impact Statements

Rayner also proposed the implementation of mandatory Child Impact Statements (Rayner 1994). At present, government departments are required to produce environmental impact statements which outline the effects of particular actions on the environment. It is argued that Child Impact Statements would fulfil a similar function, forcing government departments or non-government agencies to consider the effect of particular actions on children, thus keeping child rights and role of the child in society at the forefront of debate around social issues.

Apart from the potential benefits for children and families and a possible reduction in child maltreatment or associated social ills, Action Plans and/or Impact Statements may have economic benefits for governments. Taking the needs of children into account as part of the development of all policies may actually reduce the need for specific child-focused programs over time as many childhood needs will subsequently be met under more general program policies.

Cross-sectoral promotion

Finally, there is presently a general acceptance among stakeholders involved in the prevention of a variety of social ills such as child maltreatment, violence prevention in general, crime prevention, mental illness prevention (or mental health promotion), of the need to adopt an ecological approach, to incorporate a holistic response that takes account the effects of the wider social environment, to both prevent social ills and perhaps more importantly, to promote general resiliency and the development of healthy communities. Consideration should therefore be given to developing cross-sectoral health promotion collaborations.

The role of schools in the prevention of social ills and general health promotion provides a possible model of such a collaboration. There is currently a general reliance on the school system to provide the prime access for health

promotion and the prevention of child maltreatment and other social ills. As a result, many schools currently teach courses on a number of social problems, but there is only a limited level of support available to resource such programs. A possible solution advocated by Conte and Fogarty (1990) was based on the premise that many of the different health/life-skills programs share some basic goals: the encouragement of independent thinking; resistance to peer pressure; the development of decision making; assertiveness and effective communication skills.

Conte and Fogarty perceived some benefit in developing a general prevention curriculum, primarily promoting mental health and empowering individuals, but with a secondary focus on applying the generic skills to specific problems and situations. In theory, the adoption of such an holistic approach to prevention would encourage cooperative ventures between a number of professional fields, such as drug and alcohol services and child protection services. Such an approach appears to lend itself to the development of overarching, cross-sectoral health promotion strategies.

Extending Conte and Fogarty's model at the global level would lead to the development of generalist community education programs, universal services and other vehicles for health promotion that could be implemented in schools, the workplace and local neighbourhoods. The aim would be to develop or enhance some of the key protective factors that underlie resiliency. It would require extensive cross-sectoral collaboration and pooled resources, but has the potential to produce a cost-effective means of developing healthy communities via the reduced duplication of effort. The pooled funds and expertise resulting from a cross-sectoral promotion strategy would ensure that there was a greater ability to develop extensive programs that could achieve greater positive social impact over longer periods of time.

However, it should be noted that there would still be a need for truly preventative initiatives targeting specific social problems, like child maltreatment. Cost-effective cross-sectoral health promotion may, in the longer term, also result in a freeing up of resources within each sector that could then be employed in targeted prevention initiatives.

'Whole of community' approaches

Begun in the late 1980s and early 1990s, 'whole of community' approaches, better known in the United States as 'comprehensive community initiatives' (CCIs) represent the most recent generation of a long line of community-level interventions (Kahn & Kamerman 1996; Pawson & Tilley 1998; Kubisch et al. 1998). Such an approach is founded upon the formation and strengthening of partnerships between families, governments, child welfare, family support, health and education agencies, business, unions, religious organisations, as a means of integrating private and social responsibilities for families (Cass 1994).

Although these initiatives may take a variety of structures and forms, they are all based around the adoption of a comprehensive approach with the aim of empowering community members to participate in a partnership with government and the professional sector as a means of promoting the development of healthier communities. That is,

promoting positive change in disadvantaged neighbourhoods for individuals, families and the community as a whole, by improving physical, social and economic conditions (Kubisch et al. 1998).

In the 1990s the approach became advocated widely in the United States. For example, in 1993 the US Advisory Board on Child Abuse and Neglect (1993:3) recommended that: 'We must strengthen our neighbourhoods, both physically and socially, so that people care about, watch, and support each other's families. Child protection must become a part of everyday life, a function of all sectors of the community.'

The Board also advocated for the development of *prevention zones*, model neighbourhoods in which intensive efforts were made to facilitate 'neighbors helping neighbors' and to promote social and economic development as a means of preventing child maltreatment at the structural level.

So popular has CCI become in the States that a Roundtable on Comprehensive Community Initiatives for Children and Families has been convened regularly since 1992. It currently has 30 members, including foundation members, program directors, experts in the field and public servants engaged in 'cross-system, geographically targeted initiatives' (Kubisch et al. 1998). These forums provide a venue to share the lessons that have been learned, to receive updates on innovations and to work on common problems facing program providers and evaluators.

'Communities that Care'

Communities that Care, developed by Hawkins & Catalano (1992), is one of the more widely recognised 'whole of community' crime prevention programs, taking the slogan 'building safer communities where children and young people are valued'. This program has been implemented widely across the United States, and more recently, has received significant attention in Australia, and the United Kingdom (Farrington 1997).

The project provides a good example of the various phases of CCIs. The initial phase revolves around community mobilisation and the identification of key leaders of each community (for example, local government representatives, and professionals from the health, welfare, police and business sectors). These people are brought together to agree the goals of a prevention program, and to pledge their involvement in implementing it. A Community Board is then set up by the leaders with representation from a variety of professional agencies, community groups and the media.

The Board has the responsibility for overseeing a detailed community assessment designed to identify key risk and protective factors in the local community, and for the development of a prevention plan specifically tailored to enhance the protective factors and to reduce the risks evident in the local community. The Board is also expected to identify sources of funding and support (or opportunities to redirect funds) in order to enable a plan of action to be implemented. Technical assistance is usually provided to the various Community Boards throughout this process by the United States Government, and typically involves the training of frontline professionals and community members to implement the proposed plan. A range of interventions may be undertaken, focusing on the whole community,

and/or targeting specific sectors for more intensive intervention.

Australian initiatives

In Australia, recognition of the benefits of adopting a 'whole of community' approach has been a much slower process. In 1994, the International Year of the Family provided a forum for a discussion of social provision for individuals and families in Australia (Smith & Herbert 1997). A conclusion of the National Council was that social provision 'should occur in a framework of partnerships between individuals, families, and the private and public sectors' (Smith & Herbert 1997:5).

Unlike Europe and OECD countries, Australia's adoption of interventionist strategies to facilitate the greater participation of people in an active society has largely been confined to the promotion of participation in the labour market (Smith & Herbert 1997). In the past few years however, Australia has begun to incorporate 'whole of community' approaches into frameworks designed to prevent child maltreatment (NSW Child Protection Council 1997) and a number of other social ills, such as crime (National Crime Prevention 1999) and youth homelessness (Prime Ministerial Youth Homeless Taskforce 1998).

For example, a key recommendation of the Prime Ministerial Youth Homeless Taskforce report 'Putting Families in the Picture' (1998) was that as part of the development of early intervention responses to youth homelessness, an aim should be 'to re-engage young homeless people or those at risk of homelessness in family, work, education, training and community' (1998:32). The results of pilot projects have indicated that half of the young people in the programs reported that their level of engagement with the community had improved, particularly in terms of access to accommodation, income and relationships with significant adults.

Crime prevention

The National Crime Prevention (1999) report, *Pathways to Prevention*, written by a consortium convened by Professor Ross Homel, identified the need for a local, community-based approach to crime prevention. The Report recommendations exemplify the current convergence in thinking in the prevention of social ills, with much of the report advocating early intervention and 'whole of community' approaches.

For example, the consortium concluded that future prevention initiatives should include: 'a neighbourhood or small area intervention targeting multiple risk and protective factors at multiple life phases and transition points. The focus should not only be on individual children and families, but, more generally, on the functioning of both local and non-local institutions, policies and aspects of social organisations that affect the quality of the local environment for children. The overall aim should be to create a more supportive, friendly and inclusive environment for children, young people and families that better promotes healthy, pro-social development' (National Crime Prevention 1999:99).

The core component of such a demonstration project, or *prevention zone*, was perceived to be a process of community building that promoted the creation of an inclusive 'child

friendly' or 'family supportive' environment, and that promoted the normal, pro-social development of children' (National Crime Prevention 1999). However, the consortium also noted that mounting a large-scale community-based program in Australia would not be quickly achieved because of the current tendency of 'funding agencies and the political system [to be] mostly oriented to short term "quick fix" initiatives that fit within the three year election cycle' (1999:100).

As mentioned above, Victoria has recently begun an Australian adaptation of the first stages of Hawkins and Catalano's Communities that Care program. However, another Australian initiative that is currently operating and receiving much attention is the New South Wales Inter-agency School Community Centres Pilot Project.

Inter-agency School Community Centres Pilot Project

As mentioned above, there has been a general reliance on the school system to provide the prime access for child abuse prevention purposes to children, young people and their families. Clearly the time demands on the school curriculum are increasing. In addition, there is a growing recognition that child abuse and child abuse prevention are too complex for schools, or any one sector, to manage alone (Tomison 1996b).

In the United States a number of communities have developed programs that link a number of services to schools through school-linked Family Resource Centers (Dupper & Poertner 1997). This has eventuated as a function of the opportunity schools provide to access children and families, and the 'seemingly intractable problems with the current US network of social services . . . which has been characterised as disempowering, fragmenting and confusing for families (Lerner 1996)' (Dupper & Poertner 1997:416).

The Inter-agency School Community Centres Pilot Project has used schools as venues to access children and families in an effort to involve the wider community in the development of healthy families and communities and the prevention of child maltreatment and other social ills. In a cross-sectoral collaboration, the NSW Departments of School Education and Community Services and Health have worked together to fund a two-year pilot program to establish four interagency school community centres. Administered by the NSW Department of School Education and located at public schools, the aim of the program is to develop and trial models of interagency coordination, and to support families with children of five years and under with a view to preventing disadvantage at school entry.

The project objectives are to: encourage and support families in their parenting role; to identify needs, knowledge gaps and issues in the local community; to promote community involvement in the provision and coordination of services for children and families; and to promote the school as a community centre. Managed by an interagency management committee, a full-time facilitator appointed to each site works closely with a community advisory group to identify needs and issues for families. The types of local initiatives developed under the project include: play groups; parenting groups; before school screening; literacy programs; transition to school programs; home visiting; and nutrition programs.

An interim evaluation report based on interviews with parents, community members, organisations involved in the local projects, school personnel and various management staff concluded that each of the four pilot centres had met its objectives (Social Systems and Evaluation 1996). In particular, parents whose children attended transition or preschool programs identified benefits to their children in terms of readiness for school and general socialisation; such benefits were also noted by principals and preschool staff. Parents reported that the project had lessened their own social isolation and provided them with opportunities for self-development.

Health professionals perceived the projects as contributing to the health and wellbeing of children, particularly at two centres which introduced Before School Screening Programs; and there was enhanced interagency cooperation between government departments and with local community agencies. Finally, the report indicated a high level of community support for the continuation of the project, and a strong level of community involvement. Community representatives noted the positive impact of the local centres on the communities' perceptions of themselves: 'People have begun to feel good about their community and to take action to improve amenities' (Social Systems & Evaluation 1996:2).

Community participation

The crux of a 'whole of community' or CCI approach is the development of an effective partnership between professionals and the local community, such that participants are more likely to have some control of decision making and a sense of mutuality and common purpose (Smith & Herbert 1997). Participation leads to a greater sense of empowerment when addressing a problem such as child abuse and neglect, with participants having a greater sense of ownership of the plans and activities that result from such a process (Kaufman & Poulin 1994; Smith & Herbert 1997). An underlying aim of the approach may be the development of a level of self-sufficiency and independent action such that the local community eventually take a greater role in the development of activities and ventures aimed at improving the health and wellbeing of community members, with less involvement by the government or the professional sector.

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

Natural helpers

In most neighbourhoods, people reap the benefits of some form of 'neighbourhood-based natural helping network' – that is, they have a range of local professional and non-professional supports (friends, family, neighbours) they can turn to. 'Natural helpers' are those members of the community who, often without prompting, provide support to others. They may help friends, family, neighbours on ongoing relationships; but more importantly, many natural helpers

provide assistance across the community, to people with whom they have no prior link. These people may have a special concern or cause; an altruistic desire to help or support others; some special skills or expertise they wish to use to help others; they may be very resourceful or merely have a strong conviction regarding people's obligations and responsibilities as part of a community (Fantuzzo et al. 1998).

Clearly, there is a need to encourage people in the local community to become 'natural helpers', to provide them with development and training, and perhaps as a means of indicating the value of such work to society, by paying them for their time. Fantuzzo et al. (1998:215) note that under a 'whole of community' approach, an effective way to mobilise community resources is to ensure the program is run in natural settings within the targeted community, and that it is 'designed to engage natural helpers in the development of strategies'.

North America's *Front Porch Project* (Farestad & Harper 1998) is an example of a community-based intervention that engages community members in the prevention of child abuse and neglect. The name of the project reflects a desire to return to a time when people spent time sitting on their front porches, interacting with neighbours and contributing to the wellbeing of the local community. The project is designed to facilitate a return to neighbourhood problem solving and productive caring, with an emphasis on identifying or preventing child maltreatment and offering assistance to parents in need of support.

Volunteers undertake community-based training that provides knowledge and skills about child maltreatment and its prevention. They are taught specific actions they may take when they witness child maltreatment in public, or have concerns for the safety of a child, including culturally appropriate materials that assist them to become confident about employing intervention strategies. Post-training evaluation revealed that training participants in Washington State, followed over sixty days using an evidence-based assessment process, reported increased actions and documented successful interventions with families in the community.

The utilisation of natural helpers in 'whole of community' approaches has much promise. However, given the relative dearth of research that has investigated the mechanisms and processes by which neighbours are most effective in preventing child maltreatment (Korbin & Coulton 1996), or in community-building, there is a need to conduct further research to delineate the most effective means of community participation.

Intergenerational helping

A particularly untapped resource of natural helpers who have a strong role to play in building connectedness are older people. The population is ageing and people are living healthily for decades after their retirement from full-time employment. There needs to be recognition of not just what services are required to support these people, but what they can offer society, and especially the younger members of society.

Promoting positive contacts across the generations – for example, older mentors for young people or older supporters for young parents, adopt-a-grandparent programs,

agencies where skilled tradespeople pass on their craft to the young, youth as lay-visitors to the elderly – are valuable community services of benefit to all parties. Such contact promotes intergenerational communication and learning, it may teach mutual respect, it enhances the social linkages for both groups, and for the young, there is an opportunity to gain wisdom, and perhaps employment and life skills; all of these enhance community connectedness and social capital.

Role of paraprofessionals

An evaluation of home visitor programs (Cox 1998) has provided some evidence that the use of paraprofessional home visitors is very successful when targeting the general population under a universal service model, provided they engage with families for more than six months. The general population was defined as including those who were generally disadvantaged, but excludes groups identified as particularly high risk (Cox 1998). For shorter durations however, paraprofessionals were only successful with families where there was no disadvantage.

For example, the *Resilient Peer Training Project* (RPT) was a three-year project targeting maltreating families, that was designed to reduce parent and child social isolation and to promote pro-social interactions. The evaluation of the project assessed the effectiveness of child and parent RPT interventions, and the integrity and replicability of Head Start and parent and child RPT interventions (Fantuzzo & Atkins 1995). One finding was that parents were much more effective in attempts to engage with isolated parents and to successfully enrol them in Head Start than graduate psychology students.

Paraprofessionals appear to be less successful when targeting very high risk groups (Cox 1998), whereas professionals rarely targeted the general population, but managed quite successful interventions with very high risk groups (Huxley & Warner 1993; Olds et al. 1997). These findings would appear to indicate the value of using trained lay volunteers in 'whole of community' activities, but ensuring there are professional supports available for families requiring greater support to achieve healthy development.

Role of fathers

Child protection and child welfare practice has traditionally tended to focus interventions on the mother as assumed primary caregiver, and the children, with less effort spent in engaging other caregivers or close family members. Similarly, research to date has been overly focused on mothers without an in-depth investigation of the roles of other adult family figures (Warren 1983b; McBride & Darragh 1995; Tomison 1996a). This has implications for effective protection and also the prevention of maltreatment.

The failure to engage male caregivers in addressing or preventing child maltreatment or other family violence concerns may, in itself, constitute a form of systems abuse of both mother and child (Tomison 1996a). It is contended that greater attention needs to be paid to the broader family context within which maltreatment may occur (for example, father figures, grandparents, parents, siblings) (Langeland & Dijkstra 1995), and attempts made to engage with fathers in prevention work.

In the last two decades in particular, there has been an increased emphasis on the role of the father in the prenatal/perinatal period of development (May & Perrin 1985), although the role fathers fulfil during this time is not entirely understood (Holden, Willis & Cocoran 1992). More recently, the role of fathers has begun to change, with society encouraging men to adopt a more active role in child-rearing (Harris & Morgan 1991).

The *Fitting Fathers into Families* project (Russell et al. 1999), funded by the Commonwealth Department of Family and Community Services and led by Professor Graeme Russell from Macquarie University, investigated the role of Australian fathers in parenting and identified the key principles that underlie effective parenting programs for fathers. The project involved a national survey of the diversity and level of involvement of men in parenting and included an assessment of what men saw as their current needs as parents; children's perceptions of their fathers; and the key elements of successful men's parenting programs. Russell et al. recommended the development of a cross-sectoral policy to address the needs of men as fathers and the development of proactive strategies to involve and support men in health promotion and prevention activity.

Role of children and young people

With regard to the development of healthy communities, there is a need to identify, access and engage with young people as equal partners in collaborative ventures to build healthier communities and to prevent maltreatment (Tomison 1997a). Programs where youth have a powerful voice in decision making and work in partnership with professionals and other adults result in enhanced pro-social development of young people and improves their connectedness to the wider community (Finn & Checkoway 1998).

The need for youth participation has already been recognised in the child welfare sector, with progress in giving a voice to children and the empowerment of young people arising predominantly from attempts to empower children and young people in the out-of-home care system (O'Brien 1997). Although involving children and young people in community partnerships will involve 'altering adult institutionalised ways of behaving to accommodate the difference inherent in contributions by children' (Mason & Steadman 1997:36), the potential benefits to young people and the wider community make this a priority.

The issue of children and young people's role in child abuse prevention will be discussed in more detail in a future Issues Paper.

CONCLUSIONS

In the past, efforts to prevent child maltreatment have been hampered by a failure to address the structural social forces and community-level factors that impact on children, families and the propensity for maltreatment (Tomison 1997a). This paper has provided an extensive review of the theoretical constructs underpinning recent efforts to prevent child maltreatment holistically, and has described three major strategies that are currently perceived as key components of any attempt to reduce maltreatment at the societal and community levels.

It is apparent that in Australia, like other western countries, that there has been recognition of the need to develop efforts that enhance the protective factors and increase children, family and the community's resiliency to social ills and the benefits arising from the adoption of a health promotion approach. It has been further suggested that health promotion approaches lend themselves particularly to cross-sectoral collaboration and the pooling of resources, given the apparent universality of protective factors and approaches that foster resiliency.

However, as Zigler and Styfco's (1996) concluded, despite being able to make observable improvements, no program or activity has been entirely successful in enabling children and young people to develop optimally when their larger child rearing environment is not a conducive one, giving rise to a number of recommendations.

First, various community development approaches have been trialled in the past, but have not been perceived as successful by governments or policy makers (Wilson & Ward 1997). Although this failure may be attributed to implementation and process issues, rather than flaws in the overall concept, in order to ensure the success of the current generation of 'whole of community' approaches, with their emphasis on the empowerment of the community to facilitate the creation of healthier communities, it is vital that research is undertaken to delineate the mechanisms of successful comprehensive initiatives.

Second, in spite of the likely positive effect of health promotion campaigns, there will still be a need for the continuation of primary, secondary and tertiary *prevention* activities for each specific social ill. Specifically, there will be a need to promote child maltreatment-specific or 'positive parenting' messages and to provide specific services for those 'at risk' or maltreating families for whom early intervention approaches and/or health promotion have not been enough to entirely overcome a risk of maltreatment.

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

Notes

¹ The terms *child abuse and neglect* and *child maltreatment* are used interchangeably throughout this paper. Unless otherwise stated, the term *child abuse prevention* encompasses the prevention of all forms of child abuse and neglect.

² Although the term *community* and *neighbourhood* are often used interchangeably, in this paper the term *community* refers to a definable political jurisdiction (for example, a township, metropolitan area, or local government area) that includes a governing structure that controls the resources available for children, families and neighbourhoods. A *neighbourhood* is defined as a relatively small geographic area where people reside and with which they identify (Bruner, Bell & Brindis 1993).

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