Inverting the pyramid

Enhancing systems for protecting children

Australian Research Alliance for Children & Youth

Working together to enhance the wellbeing and life chances of children and young people.

The Allen Consulting Group

The Allen Consulting Group Pty Ltd
ACN 007 061 930, ABN 52 007 061 930

Melbourne
Level 9, 60 Collins St
Melbourne VIC 3000
Telephone: (61-3) 8650 6000
Facsimile: (61-3) 9654 6363

Sydney
Level 12, 210 George St
Sydney NSW 2000
Telephone: (61-2) 8272 5100
Facsimile: (61-2) 9247 2455

Canberra
Empire Chambers, Level 2, 1–13 University Ave
Canberra ACT 2600
GPO Box 418, Canberra ACT 2601
Telephone: (61-2) 6204 6500
Facsimile: (61-2) 6230 0149

Perth
Level 21, 44 St George's Tce
Perth WA 6000
Telephone: (61-8) 6211 0900
Facsimile: (61-8) 9221 9922

Online
Email: info@allenconsult.com.au
Website: www.allenconsult.com.au

Acknowledgments

The authors wish to acknowledge the Australian Research Alliance for Children and Youth for funding the research for this report.

The authors wish to thank the project reference group members who provided valuable input and advice throughout the project:

Dr Fiona Arney — Australian Centre for Child Protection, University of South Australia

Mr Brian Babington — Families Australia

Ms Gillian Calvert — Commissioner for Children and Young People, NSW

Dr Judy Cashmore — University of New South Wales

Dr Lance Emerson — Australian Research Alliance for Children and Youth (ARACY)

Dr Maria Harries – University of Western Australia

Dr Nathan Harris — Regulatory Institutions Network, Australian National University

Dr Daryl Higgins — Australian Institute for Family Studies

Dr Geoff Holloway — Australian Research Alliance for Children and Youth (ARACY)

Ms Lone Keast — Department of Child Safety, Queensland

Dr Stephen Lake — Department of Child Safety, Queensland

Ms Kathryn Mandla — Department of Child Safety, Queensland

Ms Fiona Smart — Department of Families and Housing, Community Services and Indigenous Affairs

Dr Clare Tilbury — Griffith University

The authors also wish to thank staff from state and territory departments who provided input into the stocktakes and to the many people from around Australia who provided information and ideas through the consultation process.

The final draft of this report was reviewed by Professor Dorothy Scott, Foundation Chair of Child Protection and the Director of the Australian Centre for Child Protection at the University of South Australia, and Associate Professor Maria Harries, University of Western Australia. We are grateful for their comments and guidance.

This report has been prepared under the auspices of ARACY, which holds copyright and responsibility for this publication.

Contents

Executive summary

Introduction

Current systems for protecting children in Australia are failing in their primary objective: to protect children. Substantiation rates have increased significantly across Australia in the past decade although the rates in Victoria, Western Australia and South Australia have remained relatively stable (AIHW 2008). Indigenous children are more than five times more likely to be the subject of a substantiation (AIHW 2008). In addition, the Australian Institute of Health and Welfare reports that the number of children in out-of-home care in Australia has increased by 102 per cent in the last 10 years. For Indigenous children, the national average in out-of-home care was substantially higher than the non-Indigenous population (AIHW 2008).

The statutory child protection system is overburdened with notifications of alleged child abuse and neglect almost tripling nationally between 1999–2000 and 2006–07 (AIHW 2008). This represents huge demand on the resources within child protection agencies to assess and investigate these reports, and more broadly on government resources. Further, the growth in child protection services is unsustainable from a system capacity perspective regardless of available resources — for example, the numbers of children in care is escalating whilst the number of foster carers is declining due to ageing (Wood 2008). In addition, persistent workforce shortages for child protection workers evident now will only be exacerbated by increased notifications.

There is widespread consensus that the best way to protect children is to prevent child abuse and neglect from happening in the first place. There is also widespread consensus that this requires a robust primary and secondary system for protecting children that provides families with the assistance they need before they come into contact with the statutory child protection system.

Background

The Australian Research Alliance for Children and Youth (ARACY) commissioned the Allen Consulting Group to develop a report based on national and international experience of best practice in organisational change strategies and processes for protecting children, while reducing demand on tertiary child protection services. ARACY anticipates that by advancing preventive strategies, the report will ultimately assist in reducing the incidence of child abuse and neglect in Australia (ARACY 2008).

Project objectives

The report has two key objectives:

- to describe the current service systems for protecting children across Australia in terms of primary, secondary and tertiary prevention — addressed in Appendix C of this report
- to identify the organisational strategies and processes that could lead to more effective approaches to prevent child abuse and neglect — addressed in Parts II and III of this report through the systems analysis and the case studies of systems change.

Methodology

The methodology for this project involved five phases:

Phase 1: Developing a conceptual framework

The first phase was to develop an overarching conceptual framework to guide the project. This phase included an affirmation of the public health prevention model as the 'change goal' and the development of a conceptual model to move the system from tertiary dominated interventions to a more preventive focused model.

Phase 2: Literature review

The literature review for this project involved investigating the literature to better understand:

- ways in which systems for protecting children are arranged in selected other countries in systems and organisational terms and the ways in which they collaborate in order to reduce the incidence and prevalence of child abuse and neglect
- ways in which shifts towards prevention strategies have been, or can be, managed within systems, in order to reduce the need for tertiary service interventions and associated expanding costs.

Three case studies were selected for detailed analysis in this phase of the project. Each of the chosen case studies used collaborative strategies and demonstrated a movement towards a preventive model for protecting children. The case studies include one from Australia (every child every chance and Child FIRST from Victoria), the UK (Every Child Matters), and the US (Community Partnerships for Protecting Children).

In addition, key sources from the academic literature were reviewed, which informed the analysis throughout the report.

Phase 3: Stocktakes of service systems for protecting children

In this phase we developed stocktakes of the service systems for protecting children in Australia based primarily on publicly available information. The stocktakes are organised around a public health model of primary, secondary and tertiary prevention. Systems were characterised by sectors, namely:

- health
- family support
- education and care
- child safety
- specialist services for parental risk factors
  - substance abuse
  - mental health
  - family violence.

Phase 4: Stakeholder consultations

The Allen Consulting Group conducted a number of face to face and telephone consultations to inform the review using a targeted consultation strategy. The primary arm of this strategy involved meeting with *key strategic thinkers* in the child protection and child wellbeing field and informants including:

- key government and non-government stakeholders with significant experience and expertise in child wellbeing and/or child protection
- academics working in child protection and/or child wellbeing
- the children's commissioners in most states and territories, namely the Australian Capital Territory, Victoria, Tasmania, Queensland, Western Australia and the Northern Territory.

These strategic thinkers provided insights and observations into the functioning of the systems for protecting children *as a whole* including the interactions between the various systems.

In addition, the Allen Consulting Group conducted a limited number of consultations with key providers of services to children and families. These consultations particularly focused on government and non-government providers of children's and family support services, namely:

- child and family health services
- education services
- family support services
- statutory child protection services.

Consultations with providers were in no way intended to comprehensively cover all of the services involved in preventing child abuse and neglect. They were designed to elicit broad insights at the operational level on system enablers and barriers to a preventive model for protecting children.

Phase 5: Systems analysis

The systems analysis phase of this project incorporated findings from the:

- consultations
- case studies
- literature review.

A framework for systems analysis was adopted from the work of Foster-Fishman et al. (2007) on organisational and systems change in the human services. This framework assisted in structuring the analysis and providing a firm foundation from which to identify levers for change.

Main summary points

The project takes a *systems-based approach* to child protection by examining the ways that systems and organisations can collaborate to deliver the best outcomes for children. The report does not attempt to answer the question 'how do we prevent child abuse?' in terms of evidence-based interventions or policy direction. Instead it focuses on describing *how* to move to a collaborative *system,* which uses a public health model of primary, secondary and tertiary prevention to ultimately assist in reducing the prevalence of child abuse and neglect in Australia.

The change goal — the public health model

The public health model provides a conceptual model which, if realised, would shift child protection systems to a more preventive and collaborative model by accessing three levels of prevention: primary, secondary *and* tertiary.

Under a public health model, child protection interventions that aim to prevent the occurrence or re-occurrence of child abuse and neglect are classified into these three levels.

- *Primary (or universal) interventions* are strategies that target whole communities or all families in order to build public resources and attend to the social factors that contribute to child maltreatment.
- *Secondary or targeted interventions* target vulnerable families or children and young people who are at risk of child maltreatment — that is, those with special needs or those who are in need of greater support.
- *Tertiary interventions* target families in which child maltreatment has already occurred. Tertiary interventions seek to reduce the long-term implications of maltreatment and to prevent maltreatment recurring. They include statutory care and protection services (Holzer 2007).

Child protection — a wicked problem

Complex policy problems are sometimes called 'wicked' problems — not in the sense of evil, but as an issue highly resistant to resolution. Wicked problems share a range of characteristics — they go beyond the capacity of any one organisation to understand and respond to, and there is often disagreement about the causes of the problems and the best way to tackle them.

Attempts to address wicked problems are hindered by the uncertainty they generate. Our overarching perspective in this report is that child protection is a wicked problem in its nature and would respond best to approaches that are appropriate for these highly complex problems — collaborative approaches. We argue that current approaches are largely authoritative, rather than collaborative, and that systems change is required to overcome barriers to collaboration.

The report acknowledges that *systems change* to advance collaborative strategies will not alone solve this wicked problem. New and systematic ways of thinking about the problem to identify solutions and drive *policy change* and the development of evidence-based programs and interventions is also required. While these issues are beyond the scope of this project, our approach argues that collaboration will enhance the policy-making process.

A conceptual framework

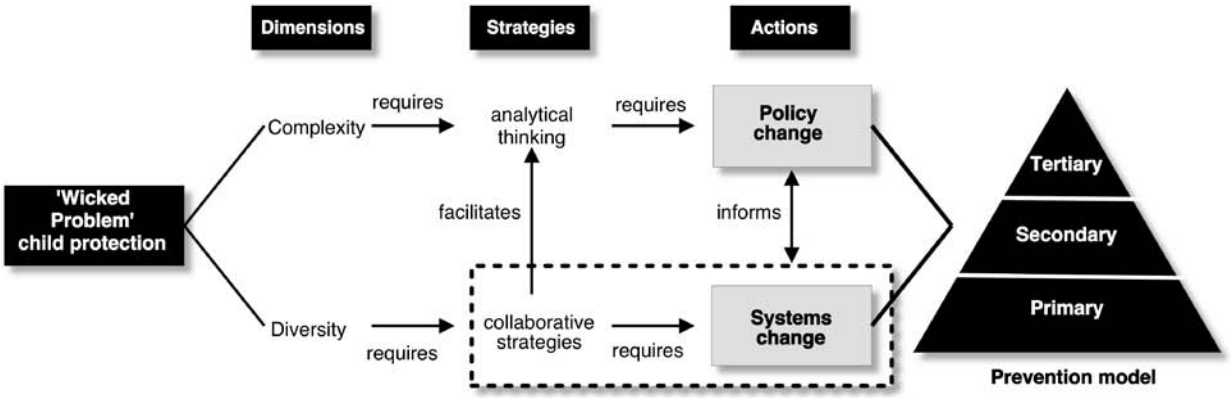
In the conceptual framework for this project, child protection is characterised as a 'wicked problem', as described above. There are two dimensions to wicked problems — complexity and diversity — which require different strategies:

- responding to the *diversity* dimension of wicked problems — the number and range of stakeholders involved — requires collaborative approaches and systems change (the focus of this report)
- responding to the *complexity* of wicked problems requires analytical thinking and policy change.

Clearly, policy change and systems change are interlinked as the system will need to reflect the policy, and the policy will need to reflect the system realities and constraints. A diagram representing the conceptual framework for this project is in Figure 1.

Figure 1

CONCEPTUAL FRAMEWORK



Source: Allen Consulting Group.

Our conceptual framework also assumes agreement that the best way to protect children is to prevent child abuse and neglect from occurring in the first place — the public health model is our change goal. However, there may be a range of policy options for achieving this goal.

Key elements of a collaborative model

Some critical changes are required to enhance systems for protecting children in Australia. These changes need to centre on shifting the focus to prevention and early intervention. This will require increased coordination and collaboration across the range of primary, secondary and tertiary services that aim to prevent the occurrence or re-occurrence of child abuse and neglect (Allen Consulting Group 2003). Additionally, strategies for preventing child abuse and neglect need to be multifaceted and span a variety of systems across organisational, jurisdictional, and government and non-government lines. Sustainable change can only be achieved if there is long-term collaboration and coordinated delivery of services across all organisations and systems that effect children and youth.

The recent Report of the Special Commission of Inquiry into Child Protection Services in NSW supports the premise of shifting child protection to a prevention approach that utilises a range of services to achieve that goal. The report states:

> child protection systems should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion. They should be delivered by a mixture of the non-government sector and state agencies, with DoCS being a provider of last resort.
>
> Wood 2008, p. v

This project has identified a number of key elements required to move the system to a more preventive focus. These key elements include:

- articulation of a shared vision
- building a supportive culture
- integrated governance arrangements
- legislative support.

Articulation of a shared vision

A shared vision provides a platform for building shared responsibility and accountability for protecting children. A shared vision would enhance collaboration and coordination between organisations and sectors by facilitating integrated governance for joint planning of policies, programs and services among and between government agencies, non-government organisations (NGOs) and others who have responsibility for providing services and supports to children and families.

Articulating a shared vision should include identifying desired outcomes for children and families, as well as common goals and strategic objectives for the 'whole' system. An outcomes-based approach provides the opportunity to redefine goals and objectives in terms of actual improvement in children's lives (for example, improved life chances for all children, and ensuring families get the right help at the right time) as opposed to measurement of system processes and outputs.

This review found that in all case studies of systems change *common outcomes or a shared vision* were articulated to build shared responsibility for protecting children. In addition, all case studies also had a strong focus on *clarifying and defining the roles and responsibilities* of system players to improve accountability for protecting children.

Building a supportive culture

A preventive model for protecting children requires a supportive culture. This is a culture that is embodied by:

- collaboration between organisations and services
- mutual respect and trust between professional groups and providers
- shared responsibility for vulnerable families and children rather than risk aversion
- focus on the needs of the child and working with — rather than on — families.

The findings from this project indicate that in order achieve the change goal significant cultural change would need to occur within organisations. The concept of shared responsibility for protecting children needs to be translated into action through this cultural change. This requires consideration of which system players are best placed to deliver strategies — some system players will need to 'step up' whilst others may need to 'let go' and transfer responsibility.

Stakeholders reported a number of mechanisms that were effective in building a collaborative culture between agencies and services. These are:

- liaison officers who are embedded in another agency and can reflect the values, practices, concerns and ideas of their home agency
- joint training between professionals
- training from child protection agencies to other professional groups that work with children and families to showcase their role and practices
- common assessment frameworks and integrated case management
- co-location and integrated services — such as wraparound child and family centres which bring together a number of key services (including child protection officers in some cases).

In addition, building shared responsibility and overcoming a culture of risk aversion will require the development of shared responsibility for protecting children using integrated governance arrangements (discussed below). The media and political response to child protection crises also plays a significant role in shaping culture. Strong leadership can assist in providing responses that support the change goal, rather than erode it.

Integrated governance arrangements

Establishing integrated governance structures to provide oversight of a comprehensive system for protecting children is an important step in moving towards the change goal. Integrated governance is described as:

> the structure of formal and informal relations to manage affairs through collaborative (joined-up) approaches, which may be between government agencies, or across levels of government (local, state and Commonwealth) and/or the non-government sector.
>
> IPAA 2002

Integrated governance arrangements permit, support and facilitate cooperation and collaboration among different agencies. The concept of integrated governance incorporates an element of 'mutuality', as opposed to individual action. This is mutuality in terms of consultation as well as shared responsibility and accountability for policy and program development, planning, implementation and evaluation.

Integrated governance is supported by structures and processes that encourage collaboration. The structures and relationships that are appropriate in a particular case should be determined by what is necessary to achieve the agreed shared vision, outcomes and objectives, taking into account the specific local conditions. That said, there are some elements that are consistently reported by stakeholders and in the literature as critical to integrated governance arrangements. These are:

- leadership
- funding and accountability arrangements.

Legislative support

Legislative support *may* be required to give effect to collaborative relationships among the relevant government and non-government agencies. In consultation, there were differing views as to whether legislation would help or hinder the establishment of collaborative relationships for protecting children. Victorian stakeholders reported that legislation was key to implementing their Child FIRST reforms. The *Children, Youth and Families Act 2005* incorporates child protection and community services for children into one Act and the role of secondary family support services is embedded in legislation. Victoria stakeholders reported that this provides assurances to the NGO sector of their role in protecting children. It also delivers a unifying legislative framework for protecting children that went beyond the tertiary system.

The elements outlined above are not necessarily sequential, although several stakeholders suggested that a strategic framework is a necessary precursor to change. The elements also interact and overlap — for example, culture is influenced by, and influences, the effectiveness of integrated governance arrangements. A detailed discussion of each of these elements is included in Part II and III of the report.

Levers for change

Levers for change are either system characteristics that support the change goal and therefore should be enhanced, or characteristics that do not support the change goal and need to be changed if systems reform is to be successful.

The levers for change represent system parts that could be used by policy-makers in bringing about systems change. This highlights the point that the weight of change required to achieve the change goal does not fall on systems change alone. Systems change will be significantly directed and influenced by — and in turn influence — policy change. Thus, the relative importance of the levers would depend in large part on the chosen policy approach.

The levers in Table 1 reflect the full list of barriers and enablers that stakeholders reported to this project in relation to system norms, system resources, system regulations, and system power and decision making. As such, not all levers apply to all jurisdictions although the themes were highly consistent. The table only includes levers for change at a *whole-of-system level*. Detailed discussion of these levers is included in Part II of the report.

Table 1

LEVERS FOR CHANGE

	Elements that are incompatible with the change goal and need to be shifted	Elements that support the change goal that could be strengthened
Norms	Values underpinning the statutory child protection process are not conducive to identifying families 'in need' even with differential responses	Values underpinning the universal and family support systems are compatible so change should be driven in these, subsystems but this would require — some system players to 'step up' (e.g. universal systems to accept the more complex cases and an expanded role) — some system players to 'let go' (e.g. statutory services relinquishing some control of family support services)
	A culture of systemic risk aversion in protecting children needs to change to build shared responsibility and accountability among organisations	
	Media coverage and the politicisation of child protection contributes in large part to the risk averse culture surrounding child protection	
	The culture of mistrust between professional groups makes building shared responsibility and accountability difficult	There is shared understanding of the problem but shared responsibility needs to be built. Shared understanding can be leveraged to build shared responsibility
	Resistance from some professional groups to accept that family support is part of their 'core business'	Broad *sentiment* of shared responsibility and a willingness to be part of the solution
		Strong commitment from some system members for an increased role in protecting children
		Australian Government commitment to play a role in the solution
Resources		
	Weaker capacity (knowledge and skills) in some professional groups for an enhanced role	Strong capacity (knowledge and skills) in some professional groups for an enhanced role
	Perception of lack of capacity in the NGO sector for an increased role in secondary prevention	NGO skills and expertise working in the community and a commitment for expansion of role in secondary prevention
	Skills and capacity for collaboration need to be built	
	Information and data sharing arrangements	Formal commitment to interagency working
	Capacity for collaboration	Good (albeit mostly isolated) experiences of collaborative interagency working in most states and many models in implementation
	Poor relationships between NGOs and government in some states (culture, consultation and resourcing)	
	Professional values and philosophies	
	Resources available to the secondary system	Possible reallocation of resources from tertiary subsystem
	Inadequate coverage of universal services	
Regulations	Mandatory reporting	Overarching principles in policy and legislation
	Privacy legislation	Differential intake responses
	Siloed funding and accountability arrangements	Broad stakeholder support for community-based intake models or dual pathways
	Competitive tendering	
	Referrals for support through tertiary system	
Power	Fragmented governance and funding arrangements	Models of formal integrated planning in place in all states and territories
	Lack of engagement with NGOs	Proliferation of integrated service delivery models that require joint governance

Source: Allen Consulting Group.

Next steps

This report provides ARACY with a solid foundation to move forward with a systems change agenda for protecting children. However, as the future work progresses we believe that additional research should occur. Specifically further research is needed to explore:

- the broader family, community and societal influences (and strategies) that have a significant role to play in shifting to a preventive model for protecting children
- the appropriateness of the proposed systems change in relation to Indigenous children and families.

Following release of this report ARACY is planning to identify and consult with appropriate stakeholders able to implement a sustainable systems change for protecting children. This plan offers the opportunity to work with many provider groups including those consulted during this project and others involved in protecting children.

Part 1

Introduction and background

Chapter 1

Introduction

1.1 Context

Current systems for protecting children in Australia are failing in their primary objective: to protect children. Substantiation rates have increased significantly across Australia in the past decade although the rates in Victoria, Western Australia and South Australia have remained relatively stable (AIHW 2008). Indigenous children are more than five times more likely to be the subject of a substantiation (AIHW 2008). In addition, the Australian Institute of Health and Welfare reports that the number of children in out-of-home care in Australia has increased by 102 per cent in the last 10 years. Of note however is the wide variation between jurisdictions in the proportion of children in out-of-home care; Victoria has the lowest proportion and NSW the highest (AIHW 2008). For Indigenous children, the national average in out-of-home care was substantially higher than the non-Indigenous population (AIHW 2008).

There is much debate about the extent to which these figures reflect changes in policies and processes, as well as increasing community awareness of child protection, rather than an actual increase in child abuse and neglect. In addition, definitions of child abuse and neglect have evolved over time and reflect cultural interpretations. The definition of what constitutes child abuse and neglect has broadened in the past ten years and this has translated to an increase in notifications and substantiations by 'widening the net' (Cashmore 2001 in AIHW 2008). Further noted by the AIHW:

> Each state and territory has its own legislation that provides a definition of 'in need of care and protection'. In some states and territories, the definition in the legislation covers a wide range of factors that may lead to a child being considered in need of care and protection, such as truancy or homelessness. In other jurisdictions, the legislation defines the need for care and protection more narrowly to refer to situations where the child has been abandoned or where the child's parent(s) are unable to protect the child from significant harm.
>
> AIHW 2008, p. 35

Regardless of the extent of growth in child abuse and neglect, there is now significant evidence that engagement with the child protection system, and particularly being in out-of-home care, does not protect children from poor long-term outcomes. In fact, it appears that out-of-home care contributes to rather than protects from poor long-term outcomes for children, particularly where placements are not stable (Doyle 2007; Rubin et al. 2007).

The statutory child protection system is also overburdened with notifications of alleged child abuse and neglect almost tripling nationally between 1999–2000 (107 134) and 2006–07 (309 517) (AIHW 2008). This represents huge demand on the resources within child protection agencies to assess and investigate these reports, and more broadly on government resources. Based on stakeholder consultations conducted for this project and submissions to inquiries such as the recent Special Commission of Inquiry into Child Protection Services in New South Wales (the Wood Inquiry), there is agreement building that the current system is not the most effective or efficient way to protect children.

Further, the growth in child protection services is unsustainable from a system capacity perspective regardless of available resources — for example, the numbers of children in care is escalating whilst the number of foster carers is declining due to ageing (Wood 2008). In addition, persistent workforce shortages for child protection workers evident now will only be exacerbated by increased notifications.

The nature of child abuse and neglect is also evolving. The majority of the reports that relate to parental and family incapacity — rather than intentional or physical harm (AIHW 2008) and statutory child protection services — may not be the appropriate response to these issues (DHS 2002). For example, the Wood Inquiry noted:

> Most reports to DoCS concern domestic violence, psychological abuse, neglect, carer substance abuse, carer mental health and/or sexual abuse. There is little reliable research to guide effective interventions for children and young people who are neglected
>
> Wood 2008, p. ii

There is widespread consensus that the best way to protect children is to prevent child abuse and neglect from happening in the first place. There is also widespread consensus that this requires robust primary and secondary systems for protecting children that provides families with the assistance they need before they come into contact with the statutory child protection system.

1.2 The change goal — the public health model

The public health model provides a conceptual model which, if realised, would shift child protection systems to a more preventive and collaborative model by accessing three levels of prevention: primary, secondary *and* tertiary.

Under a public health model, child protection interventions that aim to prevent the occurrence or re-occurrence of child abuse and neglect are classified into the three levels:

- *Primary (or universal) interventions* are strategies that target whole communities or all families in order to build public resources and attend to the social factors that contribute to child maltreatment.
- *Secondary or targeted interventions* target vulnerable families or children and young people who are at risk of child maltreatment — that is, those with special needs or who are in need of greater support.
- *Tertiary interventions* target families in which child maltreatment has already occurred. Tertiary interventions seek to reduce the long-term implications of maltreatment and to prevent maltreatment recurring. They include statutory care and protection services (Holzer 2007).

The public health model definitions of primary, secondary and tertiary interventions can be used to classify child protection intervention services. The two defining factors are the target and timing for the services and the purpose of the services (Table 1.1).

Table 1.1

CLASSIFYING CHILD PROTECTION INTERVENTION SERVICES

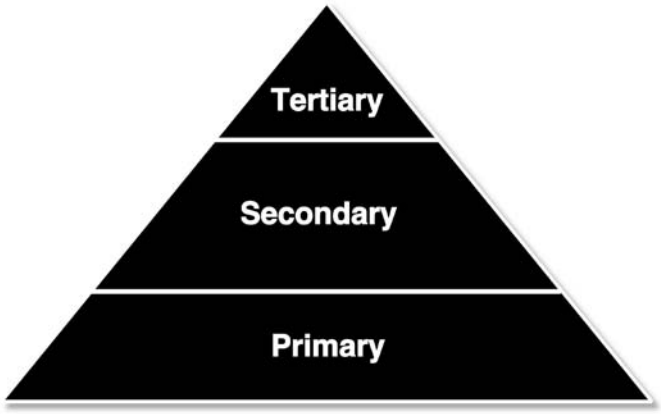
Child protection intervention services	Target and timing	Purpose
Primary	Whole communities or all families — before problems arise	To prevent child maltreatment through support and education
Secondary	Families and/or children/young people at risk of maltreatment occurring	To address risk factors, alleviate problems and prevent escalation, with a focus on early intervention
Tertiary	Families and/or children/young people where maltreatment has occurred	To reduce long-term implications of maltreatment and prevent maltreatment re-occurring

Although the public health model can be useful in characterising services, there are limitations with using the model that should be noted. First, some services may provide interventions at the primary, secondary and tertiary prevention levels, so distinctions between the levels are artificial in many cases. For example, a maternal and child health service may deliver health promotion activities to all families, work with parents with an identified risk factor such as those experiencing family violence, and may also actively treat serious neglect such as failure to thrive, which is a tertiary prevention strategy. Second, prevention strategies are broader than just 'services' and can include community-wide measures such as social marketing campaigns, and policy contexts such as paid parental leave.

The public health model uses a pyramid to describe how systems ideally should be 'weighted' and provided for protecting children (Figure 1.1). The large lower part of the pyramid represents primary prevention strategies and services provided to *all* children and families, the middle part of the pyramid represents secondary prevention strategies for children and families who need more support than what the primary prevention strategies can offer them, and the smallest part at the top of the pyramid represents the tertiary prevention strategies which should be provided only to those few children and families who need intensive intervention. Under a public health model, statutory child protection services are just *one component* of the system for protecting children (Scott 1995).

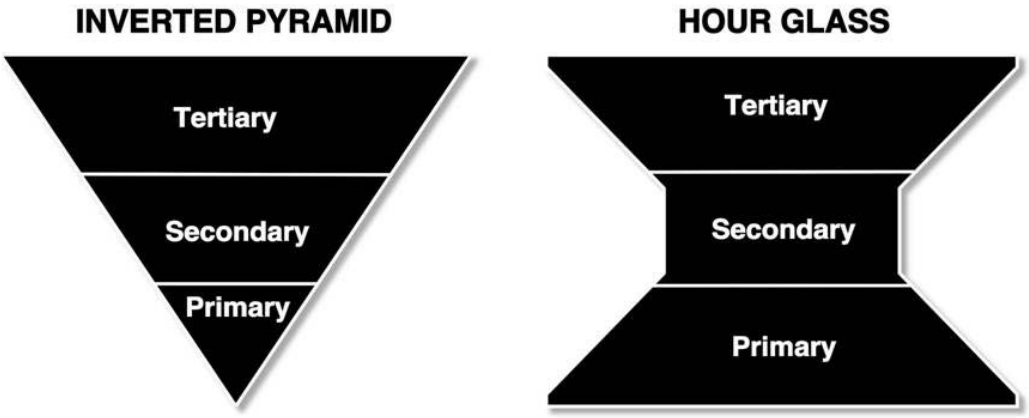
Figure 1.1

THE PUBLIC HEALTH MODEL



Stakeholders reported that current systems for protecting children resemble an inverted pyramid, or an hourglass shape rather than the public health model pyramid. Figure 1.2 describes these deviations from the traditional public health model. As one senior government child protection officer noted in consultations for this project, 'we need to turn the system on its head. The statutory child protection system needs to live behind the secondary system and be accessed through that door'.

Figure 1.2



There is consensus by the Australian, state and territory governments and community organisations in Australia of the need to reduce the burden on the tertiary end of the system and to enhance primary and secondary supports and services in line with the public health model. This was also a key finding of the recent Wood Inquiry — 'the child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the largest proportion' (Wood 2008, p. v).

The figures above show that realising the public health model for protecting children represents a significant shift in the current system. But *how* can a shift to prevention be managed within and across service systems for protecting children? What *organisational and systems change* is required to achieve this goal? This project seeks to answer these questions.

1.3 This project

The Australian Research Alliance for Children and Youth (ARACY) has commissioned the Allen Consulting Group to develop a research report on *Enhancing Systems for Protecting Children*.

The research report has two key objectives:

- to describe the current service systems for protecting children across Australia in terms of primary, secondary and tertiary prevention
- to identify the organisational strategies and processes that could lead to more effective approaches to prevent child abuse and neglect.

This project takes a *systems-based approach* to child protection by examining the ways that systems and organisations can collaborate to deliver the best outcomes for children. The report does not attempt to answer the question 'how do we prevent child abuse?' in terms of evidence-based interventions. Instead it focuses on describing *how* to move to a collaborative *system,* which uses a public health model of primary, secondary and tertiary prevention to ultimately assist in reducing the prevalence of child abuse and neglect in Australia.

Report structure

This report comprises four parts.

Part I — Introduction

This part consists of three chapters:

- Chapter 1 (this chapter) — provides background to the project and defines the change goal.
- Chapter 3 — introduces the conceptual framework guiding the project.
- Chapter 4 — provides an overview of the project methodology including an overview of the project phases and a discussion on system boundaries.

Part II — Systems analysis

This part provides an analysis of the current systems for protecting children in Australia in the context of our change goal — developing a system for protecting children that prevents child abuse and neglect based on the public health model. Chapter 4 describes the methodology and the framework for the system analysis. Chapter 5 to Chapter 8 analyse key system parts:

- system norms — attitudes, beliefs and values that underpin the system
- system resources — human, social and economic resources that reflect the capacity of the system to perform its functions
- system rules and regulations — rules and practices that govern the system operations

- system power and decision-making — that influence system functioning.

Part III — Case Studies

Chapter 9 introduces the matrix that was used to evaluate each case study against key systems and organisational features. It then provides three detailed case studies relevant to systems change for preventing child abuse and neglect in Chapter 11 through Chapter 12. The cases presented include:

- every child every chance — Victoria (Chapter 10)
- Every Child Matters — UK (Chapter 11)
- Community Partnerships for Protecting Children — USA (Chapter 12).

Each case study ends with concluding comments regarding the applicability of the case to the Australian context.

Part IV — Conclusions

Part IV outlines a model for systems change that brings together findings from the system analysis and identifies levers for change within the system. The summary also includes key lessons learned from the national and international case studies in the Australian context.

Appendix C — Stocktakes

The appendix includes the stocktakes of service systems for protecting children in each state and territory. There is also a discussion of the limitations inherent in the stocktakes.

1.4 Acknowledgement of previous work

There has been a tremendous amount of work done in the past several years related to shifting the focus of child protection towards prevention. This report draws on and has been influenced by that work. The following reports/papers have been particularly helpful in describing the current state of child protection systems in Australia and the systems change process needed to meet the goal of preventing child abuse and neglect:

- *Protecting Children — the Child Protection Outcomes Project*, Final Report for the Victorian Department of Human Services (Allen Consulting Group 2003).
- *Child abuse and neglect — is it time for a public health approach?* (O'Donnell et al. 2008).
- *A national approach for child protection — project report for the Community and Disability Services Ministers' Advisory Council* (Bromfield and Holzer 2008).
- *Putting the system back into systems change: a framework for understanding and changing organisational and community systems* (Foster-Fishman et al. 2007).
- *Tackling Wicked Problems: a public policy perspective* (APSC 2007).

Chapter 2

The conceptual framework

2.5 Introduction

Our overarching perspective is that child protection is a wicked problem in its nature and would respond best to approaches that are appropriate for these highly complex problems — collaborative approaches. We argue that current approaches are largely authoritative, rather than collaborative and that systems change is required to overcome barriers to collaboration. We then draw on systems change models and public sector management literature on collaborative or 'joined-up' approaches to establish a framework for analysing the root causes of current system problems and to identify levers for systems change.

We acknowledge that *systems change* to advance collaborative strategies will not alone solve this wicked problem. New and systematic ways of thinking about the problem to identify solutions and drive *policy change* and the development of evidence-based programs and interventions is also required. While these issues are beyond the scope of this project, our approach argues that collaboration will enhance the policy-making process.

2.6 Child protection — a 'wicked problem'

In a recent paper, the Australian Public Service Commission (APSC) discusses the challenges involved in dealing with very complex problems. These problems share a range of characteristics — they go beyond the capacity of any one organisation to understand and respond to, and there is often disagreement about the causes of the problems and the best way to tackle them.

These complex policy problems are sometimes called 'wicked' problems — not in the sense of evil, but as an issue highly resistant to resolution. Attempts to address wicked problems are hindered by the uncertainty they generate. Koppenjan and Klijn (2004) identified three forms of uncertainty that are clearly relevant to child protection:

- substantive uncertainty — gaps and conflicting understandings in the knowledge base so that there is no clear, or shared, understanding of the nature of the problem
- strategic uncertainty — many stakeholders, each with their own preferences, are involved
- institutional uncertainty — relevant stakeholders are attached to a variety of organisational locations, networks and regulatory regimes so that processes for reaching decisions about wicked problems are messy and uncoordinated (Koppenjan and Klijn 2004 in Head and Alford 2008).

Using the APSC framework, the characteristics of wicked problems are set out in Box 2.1, which we have related to the problems and issues of child protection. Wicked problems such as child protection cannot be addressed with traditional approaches to policy-making and program implementation.

Box 2.1

CHARACTERISTICS OF WICKED PROBLEMS

From the literature, several key characteristics of 'wicked' problems emerge. Generally, 'wicked' problems:

- *are difficult to clearly define* — the nature and extent of the problem depends on who has been asked, i.e. stakeholders have different versions of the problem. For example, in child protection, practitioners from primary systems conceptualise the problem very differently from those providing tertiary services.
- *have many interdependencies and are often multi-causal* — stakeholders may disagree based on the different emphasis they place on casual factors and how to focus efforts. Child protection is interrelated with other similarly complex policy problems including poverty, mental health, and drug and alcohol use.
- *are often not stable* — the context and/or evidence base is often changing as policy-makers are attempting to address the problem. In child protection, changes in legislation and political responses to crises have the ability to change the operating environment significantly.
- *usually have no clear solution* — solutions to wicked problems are often not right or wrong, but rather better or worse or good enough. Wicked problems also have no 'stopping rule' i.e. the problem can never be completely solved.
- *are socially complex and hardly ever sit conveniently within the responsibility of one organisation* — the social, rather than technical, complexity of wicked problems generally overwhelms traditional problem-solving and project management approaches. Solutions to wicked problems generally involve coordinated effort by a range of stakeholders including government organisations (at several levels), non-government organisations and individuals.
- *involve changing behaviour* — solutions to wicked problems often involve changing the behaviour of individual citizens and organisations. This is certainly true for preventing child abuse and neglect, where the solutions involve building capability in vulnerable families.

In addition, some wicked problems are characterised by *chronic policy failure.*

Source: Adapted from APSC 2007.

Head and Alford (2008) propose that a problem's 'wickedness' is determined by two dimensions:

- complexity — difficulties in acquiring knowledge about the problem and therefore its solution. Complexity is driven by a 'patchy knowledge base; complex interdependencies of processes and structures; and uncertainties arising from the contingent and dynamic nature of social issues and processes'
- diversity — the number and variety of stakeholders involved.

They combine these two dimensions to form a typology of problem types that have different levels of 'wickedness' and require different solutions. In their typology, we propose that child protection has both high complexity and high diversity and is therefore a 'very wicked problem'.

Table 2.1

TYPOLOGY OF PROBLEMS

Diversity ▸ Complexity ▾	**Single party**	**Multiple parties, each having only some of the relevant knowledge**	**Multiple parties, conflicting values or interests**
Both problems and solutions known	Tame problem		
Problem known, solution not known (relationship between cause and effect unclear)			Wicked problem
Neither problem or solution known		Wicked problem	Very wicked problem

Source: Head and Alford 2008, p. 10.

2.7 Tackling 'wicked problems'

Wicked problems pose particular problems for public management systems. Traditional hierarchical systems are characterised by a focus on inputs and processes and organisational 'silos'. Newer forms of public management that are focused on management and contracting out have also failed to adequately address wicked problems. These have created further systems problems such as competition between providers, program silos and a culture of narrow approaches in line with performance management processes (Head and Alford 2008).

The APSC report provides three main 'coping strategies' for wicked problems to bring about substantive change, predominately from the work of Professor Nancy Roberts (APSC 2007). These are:

- authoritative strategies — the problem is given to some group or individual (identified by their knowledge, organisational position in the hierarchy, or their coercive power) who 'solves' the problem and others abide by it. These approaches are efficient and quick but have a high likelihood of alienating stakeholders and adopting a solution that relates to the individual or group's narrow perspective. Authoritative strategies are useful in emergency situations.
- competitive strategies — organisations or governments compete for power, influence and/or market share. These strategies are useful for stimulating innovation between providers but are not generally useful in other situations.
- collaborative strategies — collaboration is premised on the idea that more can be achieved by joining forces than by individual action. It is particularly relevant where the solution involves behavioural change from stakeholders and/or systems change (APSC 2007; Roberts 2000).

The choice of strategies depends on how power to influence the problem is dispersed among stakeholders. If power is concentrated in a small number of stakeholders then the authoritative approach is appropriate to identify the problem and develop solutions. If power is dispersed and contested a competitive approach is appropriate. And finally, collaborative strategies are likely to be most effective when there are many stakeholders with dispersed power and where commitment is required from multiple stakeholders (Roberts 2000).

There are many players involved in protecting children — many government agencies, non-government organisations, communities and individuals, as well as professionals in several sectors. In the current systems for protecting children, often stakeholders are attempting to 'tame' the wicked problem of protecting children by breaking it up into sub-problems that can be solved within their domain of control. For example, schools are attending to a child's behavioural issues but not delving further into what is happening at home. Under a collaborative model, stakeholders across multiple sectors would seek to implement a holistic approach driven by a shared understanding of the problem.

In the past, governments across the country have largely implemented authoritative approaches to child protection, driven from the statutory system. As noted above, authoritative approaches are most effective for emergency situations. However in consultations conducted for this project, stakeholders consistently noted that child protection can no longer be treated as an emergency in response to a critical incident. Child protection is a chronic and ongoing issue that requires a systematic and long-term response. Given this context and that a shift towards prevention requires commitment from many interconnected system players, collaborative strategies are required to improve the effectiveness of Australian systems for protecting children.

Collaborative strategies are more than just organisations working together more effectively. They recognise that systems for protecting children are like all systems — 'a collection of parts that, through their interactions, function as whole' (Foster-Fishman et al. 2007) and should therefore be considered as a whole. This impacts on all aspects of systems operations not just between but also within organisations. Reflecting this, Scott (2005) presents a conceptual framework for analysing interagency collaboration that covers five levels of analysis: inter-organisational, intra-organisational, inter-professional, inter-personal and intra-personal. In this framework, conflict at any one of these levels can impact on inter-organisational collaboration.

But collaborative strategies alone do not solve wicked problems. Collaborative strategies provide a way to overcome 'high diversity' in wicked problems but do not address 'high complexity' issues (see Table 2.1 above). Head and Alford (2008) propose that problems with high complexity also require a problem solving approach that analyses the casual relationships within the problem. However, they note the clear benefits of collaborative strategies in facilitating problem solving. The benefits of collaboration for problems with high diversity *and* high complexity are:

- cooperative networks allow the problem and its underlying causes to be better understood as a wide range of stakeholders bring insights to make sense of the complexity
- provisional solutions are more likely to be found and agreed upon

- implementation of solutions is easier as there is agreement and adjustments can be made along the way.

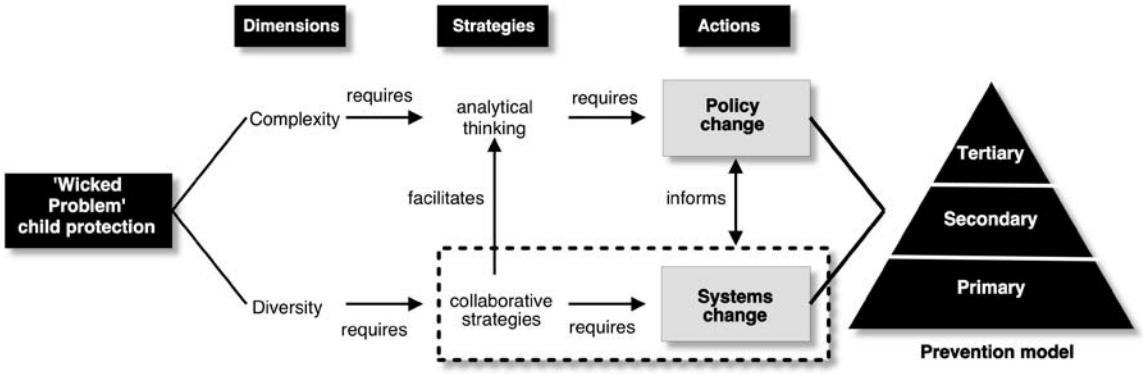
This was also a key finding from the consultations. For example, Professor Scott reported that collaboration, although one part of the solution, was not the panacea to 'solve' the child protection problem. She, and others, considered that major policy reform is also required to embed a preventive approach. Recognising this, the remainder of this chapter is focused on the *systems change* required to shift to prevention in line with collaborative strategies.

2.8 The framework

A diagram of the conceptual framework for addressing child protection as a 'wicked problem' is illustrated in Figure 2.1. The framework begins with the wicked problem and ends with a prevention model — in between are dimensions, strategies and actions that need to be systematically addressed in order to achieve the goal. The collaborative strategies and systems change (denoted within the dashed box) represent the scope of the current project as outlined in the original ARACY brief. The analytical thinking and the policy change lie outside the scope of this project but remain intrinsic to shifting systems to a more preventive model.

Figure 2.1

CONCEPTUAL FRAMEWORK



Source: Allen Consulting Group.

2.9 A collaborative approach

Current systems are complex – aka 'collaboration <u>is</u> rocket science'

The current child protection systems in Australia are complex — covering primary, secondary and tertiary services — with Australian Government, state and territory governments, local government and non-government organisations all involved in planning, funding and delivering services (Holzer 2007). The current systems are also heavily focused on the role of tertiary child protection services, which, although necessary, simply do not address the problems early enough to protect children from abuse and neglect.

Some critical changes are required to enhance systems for protecting children in Australia. These changes need to centre on shifting the focus to prevention and early intervention in child protection systems. This will require increased coordination and collaboration across the range of primary, secondary and tertiary services that aim to prevent the occurrence or re-occurrence of child abuse and neglect (Allen Consulting Group 2003).

From a national perspective, there are three overlapping levels of division in child protection systems where collaboration and coordination are needed. These divisions are:

- Between *organisations* — child protection systems require 'transformation from a single child welfare agency to a system of shared responsibility and mutual support' (Daro et al. 2005)
  - this means improving cross-agency collaboration within government between core child protection agencies and those agencies providing services for families and children more broadly, including primary and secondary services
  - it also involves improving collaboration between those non-government providers that deliver the wide range of community-based supports to families and children.
- Between *jurisdictions* — the Australian Government, the states and territories (the states) and local governments are all engaged in systems that work with families and children. Child protection has traditionally been a state responsibility, however the Australian Government funds and delivers a range of primary and secondary services that aim to assist in preventing child abuse and has primary responsibility for welfare payment systems. To varying degrees in different jurisdictions, local governments also provide services to support children and families.
- Between *sectors* — between the government and non-government sectors. The non-government sector is a large provider of child protection services, including in some jurisdictions, as a provider of tertiary services.

In addition, in each of the levels described above there is a need for different *human services systems* to interact more effectively. These human services systems include primary systems such as primary health care and the education system, secondary systems such as the family support, and tertiary systems including intensive child protection services.

Strategies for preventing child abuse and neglect need to be multi-faceted and span a variety of systems across organisational, jurisdictional and government and non-government lines. Currently, the systems for caring for and protecting children are not well coordinated, are poorly integrated and lack ongoing financial support. There is increasing acknowledgement that these fundamental issues can be successfully addressed only through approaches based on a '*sound knowledge base and effective collaborative processes'* (Head and Stanley 2007). Sustainable change can be achieved only if there is long-term collaboration and coordinated delivery of services across all organisations and systems that affect children and youth.

Moving from child protection systems to a system for protecting children

If Australia is to move to a more preventive focus for protecting children we need to move away from the context of 'child protection' which is seen as the domain of statutory authorities to a focus on 'protecting children' which is understood as being everyone's responsibility. While the nomenclature is a small point, the implications are huge. Moving to prevention requires *all* systems that provide services to children and families to be part of the *collaborative system* for protecting children.

Achieving success in moving toward prevention is critically dependent on a strong partnership among a range of relevant government and non-government agencies. This requires an acknowledgement of mutual interest and responsibility to help solve the problems and address the issues. The requirement to involve a broad array of agencies in addressing the problems poses challenges in all jurisdictions. This is illustrated by the range of factors regularly cited as problems in child death inquiries. According to the Victorian Child Death Review Committee (2002) these include divided responsibilities, poor mechanisms for interagency consultation and support, and lack of shared responsibility for service provision, among the various agencies involved with child protection clients (for example, mental health professionals, schools, drug and alcohol treatment services).

The UK Children's Green Paper identified the key causes of fragmentation as separate targets, planning requirements, funding streams, and review and accountability arrangements. The experience in the UK historically was that local areas attempted to join up services — for instance, across the local education authority and children's social services — but the central government still expected them to account for money separately, and had separate inspectorates assess them, even if operationally the services were integrated and outcomes were mutually reinforcing (UK Children's Green Paper 2003).

In Australia, the challenges of collaboration are complicated by the fact that essential services such as education, housing and health are provided by separate government agencies. These organisations and agencies have their own government and management structures, priorities and accountability arrangements. Such structures and processes partly exist in order *to maintain* the clear distribution of responsibilities and specialisation of tasks among sectors and across agencies. These arrangements present difficulties in building an effective partnership for protecting children.

The way forward is to merge separate service organisations — both government and non-government — into an integrated system that is managed as a 'system' and held accountable for effective service provision in the context of local needs and conditions (Vinson 2001). What has been called integrated governance is aimed at doing this:

> Integrated governance describes the structure of formal and informal relations to manage affairs through collaborative (joined-up) approaches, which may be between government agencies, or across levels of government (local, state and Commonwealth) and/or the non-government sector.
>
> IPAA 2002

Integrated governance is not an end in itself but is about addressing those issues and problems that can only be solved in partnership. Hence, the concept of integrated governance incorporates an element of 'mutuality', as opposed to individual action. This is mutuality in terms not just of consultation but also in terms of shared responsibility for policy and program development, planning, implementation and evaluation. It begins with the articulation of a shared vision and purpose, agreement on the key tasks to achieve them, and identification of the indicators to judge effectiveness. It must necessarily also involve individual organisations and agencies relinquishing some control.

Integrated governance arrangements permit, support and facilitate cooperation and collaboration among different agencies. The structures and relationships that are appropriate in a particular case should be determined by what is necessary to achieve the agreed objectives and outcomes, taking into account the specific local conditions.

It is not enough to just integrate relationships at the local level. Each level of integration is hindered if there is a lack of integration above it. Hence, as would be expected, leadership and commitment at the top of the organisations are critical to successful integration, with formal structures for ongoing dialogue to clear the barriers (IPAA 2002).

Legislative support may be required to give effect to collaborative relationships among the relevant government and non-government agencies. The aim would be to provide a unifying framework for the protection and welfare of children.

Chapter 3

Project methodology

3.1 Introduction

This chapter provides an overview of the methodology used to produce this report and defines the system boundaries for the analysis in the report. In short, the methodology involved five phases:

- Phase 1: Developing a conceptual framework for analysis
- Phase 2: Literature review
- Phase 3: Stocktake of child protection systems in Australia
- Phase 4: Stakeholder consultations
- Phase 5: Systems analysis

These phases are briefly described in this chapter and are detailed as appropriate throughout the report.

3.2 Project phases

Phase 1: Developing a conceptual framework

The first phase involved developing an overarching conceptual framework to guide the project. This phase included an affirmation of the public health prevention model as the 'change goal' and the development of a conceptual model to move the system from tertiary dominated interventions to a more preventive focused model. The conceptual framework is described in detail in Chapter 2.

Phase 2: Literature review

The literature review for this project involved querying the literature to better understand:

- ways in which systems for protecting children are arranged in selected other countries in systems and organisational terms and the ways in which they collaborate in order to reduce the incidence and prevalence of child abuse and neglect
- ways that shifts towards prevention strategies have been, or can be, managed within systems, in order to reduce the need for tertiary service interventions and associated ever-expanding costs.

Three case studies were selected for detailed analysis in this phase of the project. Each of the chosen case studies used collaborative strategies and demonstrated a movement towards a preventive model for protecting children. The case studies include one from Australia (every child every chance and Child FIRST in Victoria), the UK (Every Child Matters), and the US (Community Partnerships for Protecting Children).

Before reviewing the case studies an evaluation matrix was developed. The matrix assisted in examining the key systems and organisational features of each case study, identifying innovative and effective elements, and identifying the change that has occurred over time. Part III includes the evaluation matrix and the detailed analysis of the three case studies using the matrix.

In addition, key sources from the academic literature were reviewed, which informed the analysis throughout the report.

Phase 3: Stocktakes of child protection systems

In this phase we developed stocktakes of the service systems for protecting children in Australia based primarily on publicly available information. The stocktakes are organised around a public health model of primary, secondary and tertiary prevention. Systems were characterised by sectors, namely:

- health
- family support
- education and care
- child safety
- specialist services for parental risk factors
  - substance abuse
  - mental health
  - family violence.

The stocktakes were initially expected to include detailed information on the costs of the service systems for protecting children. However, due to difficulties described in Appendix A, this information was not included in the report.

Phase 4: Stakeholder consultations

During July and August 2008 the Allen Consulting Group conducted a number of face to face and telephone consultations to inform the review using a targeted consultation strategy. The primary arm of this strategy involved meeting with *key strategic thinkers* in the child protection and child wellbeing field and informants, and included:

- key government and non-government stakeholders with significant experience and expertise in child wellbeing and/or child protection
- academics working in child protection and/or child wellbeing
- the children's commissioners in most states and territories namely the Australian Capital Territory, Victoria, Tasmania, Queensland, Western Australia, and the Northern Territory.

These strategic thinkers provided insights and observations into the functioning of the systems for protecting children *as a whole*, including the interactions between the various systems.

In addition, the Allen Consulting Group conducted a limited number of consultations with key providers of services to children and families. These consultations particularly focused on government and non-government providers of children's and family support services, namely:

- child and family health services
- education services
- family support services
- statutory child protection services.

Consultations with providers were in no way intended to comprehensively cover all of the services involved in preventing child abuse and neglect, but were designed to elicit broad insights at the operational level on systems enablers and barriers to a preventive model for protecting children. Additionally, as this report focuses on organisational 'systems' for protecting children, families were not included in the consultation process.

Consultations with providers offered rich information into the culture and perceived roles of these groups and these have been included in the analysis. It should be noted, however, that many other provider groups were not consulted. This is a limitation of this project and further consultation with the many provider groups would be valuable to progress systems change.

The consultation discussions centred around *how* to shift from a statutory dominated model for protecting children to a model that emphasises primary and secondary prevention. A consultation guide was developed and sent to each participant prior to the consultation session. This guide gave an overview of the project and outlined questions to be discussed. The full consultation guide is included in this report as Appendix A.

Detailed findings from the consultations are incorporated into Part II — systems analysis.

Phase 5: Systems analysis

The systems analysis phase of this project incorporated findings from the:

- consultations
- case studies
- literature review.

A framework for systems analysis was adopted from the work of Foster-Fishman et al. (2007) on organisational and systems change in the human services. This framework assisted in structuring the analysis and providing a firm foundation from which to identify levers for change. This framework is described in detail in Chapter 4.

3.3 System boundaries

This project is essentially a systems analysis. Systems can be defined as 'a collection of parts that, through their interactions, function as a whole' (Foster-Fishman et al. 2007, p. 198). This definition can apply to relatively small units, such as a family, and to a relatively large network, such as a human service delivery network. In the context of systems change, the systems are 'the set of actors, activities, and settings that are directly or indirectly perceived to have influence in or be affected by a given problem situation' (Foster-Fishman et al. 2007, p. 198). This definition can also allow for systems of varying scope and size, and this project sought to establish the boundaries of the systems for the analysis that follows — essentially, who and what is contained in the systems for protecting children.

First, this report focuses on the *service systems* that provide primary, secondary and tertiary interventions to children and families to prevent child abuse and neglect from occurring and re-occurring. Focusing on *service systems* in this report does not imply that broader family, community and societal influences (and strategies) do not have a significant role to play in shifting to a preventive model for protecting children. Rather, it is a limitation in the scope of the project and should be carefully considered and researched as a 'next step'.

Second, this report defines five subsystems (or sectors) within the broader system for protecting children. These are:

- children's services — including health, education, care, disability
- family support
- statutory child protection including out-of-home care
- specialist services for parental risk factors including drug and alcohol, mental health and family violence
- police and justice.

System boundaries are inherently an arbitrary construction but must be drawn to facilitate a manageable analysis (Midgley 2000 in Foster-Fishman et al. 2007). There are many other service sectors that influence child abuse and neglect. For example, homelessness and parental intellectual disability are both risk factors for child abuse and neglect but have not been included in this analysis. Many of the findings of this report will apply to these sectors, although they can not necessarily be generalised.

Finally, although the system boundaries include specialist services for parental risk factors including drug and alcohol, mental health and family violence, and police and justice, most stakeholders consulted for this review presented views and perspectives from, and about, the first three subsystems listed above. This bias is reflected in the analysis contained in the report and the findings should be tested with stakeholders across the subsystems in future work.

Indigenous issues

The basic elements of systems change to move from a tertiary dominated child protection system to a preventive public health model for protecting children would in principle seem highly relevant and appropriate for Indigenous children, young people and their families. The elements of this change emphasise collaborative working relationships between and among the *service systems* that provide primary, secondary and tertiary interventions to children and families to prevent child abuse and neglect from occurring and re-occurring. This collaboration necessarily includes:

- articulation of a shared vision
- building a supportive culture
- integrated governance arrangements
- legislative support.

Although it is hoped that a move to a prevention focus with collaborative working relationships at its centre is appropriate for Indigenous children and families, this should not be assumed.

As was highlighted in Section 1.1, there are notable differences in Indigenous children's experiences of the child protection system compared with non-Indigenous children. Indigenous children are significantly over-represented in the number of substantiations and placements in out-of-home care. These differences indicate that there are serious and entrenched child protection concerns within Indigenous communities that need to be further explored. These issues are so important and challenging that it is not possible to adequately address them in this report. They require further exploration, led by consultation with Indigenous communities, organisations and stakeholders.

Part II

Systems analysis

Chapter 4

Introduction to systems analysis

4.1 Introduction

Part II of this report provides an analysis of the current systems for protecting children in Australia in the context of our change goal — developing a system for protecting children that prevents child abuse and neglect based on the public health model. The conceptual framework for this project, described in Chapter 2, argues that an effective prevention model requires a collaborative approach that brings various subsystems and system members together to prevent child abuse and neglect.

The analysis in this part seeks to answer the question at the heart of this project — *how* can we shift the current systems for protecting children to a prevention model?

Part II is structured as follows:

- the remainder of this chapter introduces the framework for system analysis used in this part, and the methodology for systems analysis
- Chapter 5 analyses system norms — attitudes, beliefs and values — that underpin the system
- Chapter 6 analyses system resources — human, social and economic — that reflect the capacity of the system to perform its functions
- Chapter 7 analyses system regulations — rules and practices — that govern the system
- Chapter 9 analyses system power and decision-making that influence system functioning.

4.2 A framework for systems analysis

The framework for systems change used in this report draws on the work by Foster-Fishman et al. (2007) on organisational and systems change in the human services.

Systems change is required when a system is failing to meet its goals. It is clear that child protection systems in Australia are failing to protect children in the short-term and the long-term. The high rate of re-notifications of alleged child abuse and neglect and re-substantiations (AIHW 2008) suggests that children are not being protected from short-term harm. Moreover, research demonstrates the very poor long-term outcomes for children who have been engaged in the child protection system, particularly those in care (Doyle 2007).

The process of systems change outlined by Foster-Fishman et al. (2007) requires:

- Step 1: establishing system boundaries by determining who and what is contained in the system given the targeted problem. System boundaries for this project were established in Section 3.3.

- Step 2: locating root causes to systemic problems by identifying system parts that explain the status quo.
- Step 3: using this information to identify leverage points for change.

Identifying fundamental system parts to leverage for change

To identify fundamental system parts to leverage change, we must identify both the 'deep' and 'apparent' structures of the system. Deep structures are the underlying beliefs and values of a system that uphold the status quo. Under cultural change theory deep structures are often the primary drivers of system problems and any systems change effort must drive modification in these structures for the desired change to be sustained.

Apparent structures are the visible elements of a system including regulatory processes, available resources, and power and decision-making processes. As Foster-Fishman et al. note:

> the deep and apparent structures are highly interdependent with each other … together they explain the system's purpose, define the roles for system members, and build structures for systems operations.
>
> Foster-Fisherman et al. 2007, p. 205

Incorporating these two dimensions, Table 4.1 provides guiding questions for analysing and understanding critical system parts.

Table 4.1

ANALYSING CRITICAL SYSTEM PARTS

System characteristic	Guiding questions
System norms: attitudes, beliefs and values	What are the values guiding the current programs, policies and practices within the system? What are the values guiding the proposed change? To what extent are the two compatible? Is there a shared understanding of the problem and the change goal? How do system members see their role in 'solving the problem'? Will these perspectives help or hinder the change?
System resources: human, social and economic	*Human resources* How will system members be expected to behave if the systems change effort is successful? Do they have the skills and capacity for this role? *Social resources* To what extent are relationships among stakeholders a contributing factor in system failure? What aspects of the system might support or hinder relationships? How will relationships need to shift in order for the change goal to be realised — who will need to interact with whom and what will be the nature of that interaction? *Economic resources* What new resources are needed to support the desired change? How does the system need to use its resources differently to support the change goal? Who might perceive this reallocation as a loss?
System regulations: rules and practices	What system rules might help or hinder change? What current processes and practices exacerbate the problem or have made it difficult to resolve issues in the past? What current processes and practices are incompatible with the change goal? What system regulations are not in place but are needed to fully support the change goal?
System power and decision-making	What types of decisions are most critical to the functioning of the system and where does authority for these decisions rest? Where should it rest to achieve the change goal? How are other system members engaged in the decision-making processes? What engagement will be required for systems change? How does the systems change effort challenge the existing power and decision-making structures? What new structures will need to be developed?

Source: Adapted from Foster-Fishman et al. 2007.

Identifying leverage points and levers for change

Using these system parts, we can identify critical leverage points and levers for change. Levers for change can be:

- shifting parts that are incompatible with the change goal
- strengthening the systemic influence of those parts that are aligned with the change goal.

In either case, systems change will depend on the ability of a shift in that system part to effect change in other system parts. Foster-Fishman et al. (2007) identify four questions to assist in identifying strategic parts to leverage for change. These are:

- Which system parts are currently inconsistent with the systems change goal?
- Which parts support the systems change goal?

- Which parts are most likely to trigger system wide change?
- Which of the above levers for change can actually be altered given current resources and understandings?

4.3 Methodology and limitations

Part II is an analysis of the current systems for protecting children *across Australia*, rather than a state-by-state analysis. This approach reflects the key finding of the recent project report of *A National Approach to Child Protection* — that child protection systems across Australia are largely similar. It also reflects the generally consistent messages from consultations across Australia about the problems in the current systems for protecting children.

It should be noted that recent reforms to the Victorian system for protecting children reflect a different model and the consultation messages from, and about, the Victorian system were not consistent with the issues raised about systems in other jurisdictions. As such, this report uses the Victorian reforms as a case study of systems change, and the general analysis of the current systems in Australia do not largely reflect the Victorian experience.

As Part II is a systems analysis it draws heavily on the views of system members gained during stakeholder consultations. Consultation data is necessarily the primary source of information in this part, as the views of system members provide the greatest insight into system functions, and malfunctions. Consultation data is complemented by findings from key academic sources, from the public sector management literature on wicked problems and joined-up working, and from the case studies of systems change (Part III). The limitations of the system analysis therefore reflect the limitations of the consultation data described in Chapter 3.

Chapter 5

System norms: attitudes, beliefs and values

5.1 Introduction

System norms and culture are a critical part of the functioning of a system. The values, beliefs and attitudes that system members hold determine how they see systemic problems, how they define solutions, and how the see their roles. When other system members share these values, they can become a 'dominant normative context' or culture that determines how a system or a subsystem operates (Foster-Fishman et al. 2007, p. 205).

To bring about systems change, existing culture is very important. Where the values underpinning the change goal align with the existing values, this facilitates systems change. On the other hand, where system values conflict with the values underpinning the change goal, many authors in change management argue there is likely to be resistance to change which can delay or derail the change effort. That said, system norms that are supportive of the change goal will not alone assure the change is successful (Foster-Fishman et al. 2007).

This chapter analyses the attitudes, beliefs and values that underpin the current systems for protecting children in Australia — universal, targeted (family support) and statutory child protection by considering three sets of questions:

- What are the values guiding the current programs, policies and practices within the system? What are the values guiding the proposed change? To what extent are the two compatible?
- Is there a shared understanding of the problem and the change goal?
- How do system members see their role in 'solving the problem'? Will these perspectives help or hinder the change?

5.2 Different approaches to protecting children

Before analysing the system norms underpinning the Australian system for protecting children, it is worthwhile to briefly describe the different approaches adopted by governments to protecting children. These approaches provide the context for analysing system norms, as they reflect the broad philosophy that underpins the way child protection is conceptualised in a society.

The following section is an extract from previous work by Allen Consulting Group (2003, pp. 12–14) for the Victorian Department of Human Services, which compared international approaches to protecting children.

All governments would agree that children should not be abused or neglected and would wish for their safety, wellbeing and positive development into adulthood. However, governments differ significantly in the policies and programs they implement to ensure this.

Within western OECD countries, two *broad approaches* by government to the problems of child abuse and neglect have been identified: the child protection orientation (for example, Australia, UK, USA and Canada) and the family service orientation (for example, Sweden, Germany, Belgium and the Netherlands).

The different approaches are based on different views about what can and should be done by government to protect children from abuse and neglect and ensure their wellbeing. They have developed in different socioeconomic and cultural contexts and are founded on different orientations to children and families:

- The *child protection orientation* emphasises the individual rights of parents and children. Government recognises the rights and responsibilities of parents to care for their children and their right to privacy. But if there is evidence of suspected abuse or neglect the government recognises the rights of children to protection. In the context of suspected abuse, the primary focus of interventions is the child's welfare, which may require the early involvement of government in protection interventions. The *potential* for coercive intervention is therefore indicated at an early stage in any work with families.
- The starting point for intervention in the *family service orientation* is the recognition that children are best cared for within the family. The emphasis is placed on family unity and working with families as a whole to support and strengthen the parent-child relationship and family wellbeing. Under this orientation, there is much broader government and community support for all families in their care of children. The normalisation of community intervention is associated with a greater degree of voluntary accessing of services by families. Within this approach, the invocation of statutory powers is an intervention of last resort.

The two approaches have very different service responses and consequences for children and families. The different orientations impact on how families access services, the type of services offered, the role of the legal system, and attitudes to out-of-home care. The key characteristics of the two approaches are set out in Table 5.1.

Table 5.1

CHARACTERISTICS OF TWO BROAD GOVERNMENT APPROACHES TO CHILD ABUSE AND NEGLECT

Characteristic	Child protection orientation	Family service orientation
Framing the problem of child abuse and neglect	The need to protect children from harm.	Abuse and neglect is most often a result of family conflict or dysfunction stemming from social, economic and psychological difficulties.[1]
Entry to services	Single entry point; report or notification by third party.	Range of entry points and services.
Basis of government intervention and services provided	Legal, investigative in order to formulate child safety plans.	Supportive or therapeutic responses to meeting the needs of children and families or resolving problems.
Place of services	Separated from family support services.	Embedded within and normalised by broad child welfare or public health services.
Coverage	Resources are concentrated on families where risks of (re-) abuse are high and immediate.	Resources are available to more families at an earlier stage.
Service approach	Standardised procedures; rigid timelines.	Flexible to meet clients' needs.
State–parent relationship	Adversarial.	Partnership.
Role of the legal system	Adversarial; formal; evidence-based.	Last resort; informal; inquisitorial.
Out-of-home care.	Mainly involuntary.	Mainly voluntary.

Source: Allen Consulting Group (2003), based on Gilbert, N (ed), *Combating Child Abuse: International Perspectives and Trends*, Oxford University Press, New York, 1997; Scottish Executive, *'It's Everyone's Job to Make Sure I'm Alright': Report of the Child Protection Audit and Review*, 2002; and Hetherington, R, Cooper, A, Smith, P and Wilford, G 1997, *Protecting Children: Messages From Europe*, Russell House Publishing, Lyme Regis.

5.3 Guiding values

The change goal — preventing child abuse and neglect — is guided by a moral obligation to children to protect them from direct harm from abuse and neglect within their families and from the indirect harm associated with involvement with the child protection system (O'Donnell et al. 2008). It also reflects values of supporting families *before* they are in crisis and the belief that abuse and neglect *can be prevented* in most families if adequate support is provided early enough. At its core, preventing child abuse reflects a belief that for the vast majority of children, the best place for them is with their families.

The values underpinning the current system can be analysed at two levels:

- at a whole-of-system level — the values reflected in the way the whole system for protecting children functions
- at a subsystem level — the values reflected in each subsystem (including children's services, family support and statutory subsystems).

[1] Family service orientation systems also acknowledge 'dangerous families' and/or 'the psychopathic carer' from whom children need to be protected.

Values guiding the whole system

Stakeholders reported that the relative imbalance between support and statutory response in the system reflects a culture of systemic risk aversion. Stakeholders and commentators argue that this risk aversion stems from reactive media and political responses to critical incidents in child protection (at the most extreme, a child death). These responses have largely focused on what the relevant child protection department did wrongly, rather than assessing the overall systems for protecting children (Bromfield and Holzer 2008).

A culture of systemic risk aversion has two key impacts on the system as a whole:

- net widening for statutory child protection
- narrowing of service delivery in universal and secondary services.

Governments have, in response to intense media and political pressure, continually refocused child protection efforts to identifying children at risk and statutory responses — employing surveillance and control mechanisms (Harris and Wood 2008). The fear of 'false negatives' in child protection agencies has led to net widening — more cases being screened into child protection and forensic investigation of many families that seek help, rather than a more appropriate offer of support (Thorpe 2007). As a result of net widening, a large number of families are engaged in the statutory system that do not meet the threshold for statutory intervention — around 80 per cent of notifications to child protection agencies are not substantiated (O'Donnell et al. 2008; Thorpe 2007; Bromfield and Holzer 2008).

Associated with net widening is a concern from many that the emphasis on statutory intervention 'is undermining, or swamping, other important (regulatory) strategies such as the provision of support' (Harris and Wood 2008). The experience of involvement with the statutory child protection system is highly traumatic for families. Parents' negative experiences of the statutory child protection process is well documented in the literature (see example in Thorpe 2007) and was supported by several stakeholders consulted for this project. Parents feel strongly aggrieved by the process, that they are 'demonised' by departmental staff, treated with little respect and cast as 'bad parents'. Moreover, several studies have found that parents experienced a betrayal of trust when they voluntarily sought assistance and instead were investigated.

As a result, Thorpe (2007) reports that evidence is building that families are avoiding contact with other government services through fear they will come to the attention of the child protection department. This response by families clearly undermines the goal of prevention. As a result of the culture of risk underpinning the statutory child protection system, engaging with families using the statutory system is not effective for providing support to those many families who are in need (rather than in crisis) when they come into contact with the statutory system (Bromfield and Holzer 2008). Another entry point for support services for who are families in need is required.

Many stakeholders also reported a systemic culture of risk aversion in organisations that deal with vulnerable children and families in universal and targeted subsystems. As one stakeholder noted in consultations: 'we have moved from risk management to risk avoidance ... service delivery is poorer for it because we are so frozen by risk'. As a result, several stakeholders reported chronic 'dumping' of complex (or high risk) cases between services and subsystems, and stringent 'gatekeeping' in services to exclude families that present a high risk.

Some child protection agencies reported that universal and secondary services (including adult services such as drug and alcohol services etc.) were not adequately responding to complex families and so by default these families come into contact with the statutory system. These stakeholders perceived that universal services in particular were happy to work with 'good families' but were transferring the risk associated with more complex cases to child protection rather than taking any responsibility for these clients. It was perceived by some stakeholders that once universal (and some secondary) providers had made a report of alleged abuse or neglect to child protection agencies that they then withdrew service provision from the complex family. This risk aversion in universal and secondary services further contributes to the overburdening of the tertiary system.

An opposing view from some universal providers was that child protection agencies were relying on universal services to provide 'surveillance' of clients that did not meet their risk threshold rather than providing appropriate secondary support.

Values guiding subsystems

There are clear differences in the key values underpinning the current children's services and family support subsystems when compared with the statutory child protection subsystem. These values shape the programs, policies and practice of these subsystems.

Children's services and family support

The children's services and family support systems are characterised by an approach that works in partnership *with* families. This centres on a core value that children's *wellbeing now and for their lives* is paramount and can be improved by assisting parents to build their confidence, capacity and skills — essentially to empower them to be 'good parents'. These service systems assess the *needs* and *strengths* of families to determine appropriate responses in their role of supporting families, and recognise the effects of social disadvantage on vulnerability. Families engage *voluntarily* with these systems. The subsystem reflects the values that underpin a family service orientation to protecting children.

These values are largely consistent with the change goal, however a number of stakeholders reported that universal services in particular do not effectively engage with complex families. This could suggest that when families challenge the values of this subsystem (for example, they do not engage with the partnership approach offered), universal services are unwilling to continue to provide support. In addition, stakeholders reported that there is a certain amount of rhetoric in relation to family support services that does not always reflect practice.

Statutory child protection

In comparison, the statutory child protection system is characterised by an approach that centres on *immediate risk* to a child of child abuse and neglect. Processes for assessing risk involve surveillance and investigation *of* families in a legal approach rather than working *with* families in partnerships. Parents report 'judgemental rather than supportive attention given to social disadvantage' in child protection agencies, and a focus on individual responsibility (Thorpe 2007, p. 5).

Entry to the statutory system for a family is primarily through a report and participation is *involuntary*. The system has a range of strong coercive tools to protect children from further harm, with the most powerful being removal. A core value underpinning this system is that a child's *safety* is paramount and that the family is not always the best place for a child. This subsystem reflects the values that underpin a child protection orientation to protecting children.

These values are not consistent with the change goal but they reflect the current function of the statutory system — to investigate and intervene in (including through removal of children) families in a crisis situation. That these values do not reflect the values of the change goal is not itself a problem, as these activities will always be a part of the child protection system. However they may be reformed for a *small number* of families where primary and secondary prevention efforts have chronically failed (O'Donnell et al. 2008). Values of mistrust of parents that underlie investigatory processes in the statutory system may be necessary to identify those families that would escape detection in family partnership approaches, similar to the values that underpin police processes to detect criminal offenders.

However, as noted above, many families who come into contact with the statutory system need support, rather than forensic investigation. For these families, the values underpinning the statutory system are counterproductive to prevention and 'incident-based risk frameworks which have dominated child protection systems for decades are problematic as a basis for early intervention and achieving collaborative models of care' (Winkworth and McArthur 2007, p. 46).

Collaboration

Different values between subsystems (and between professional groups) also impact on the ability for services to collaborate to deliver services around a child or family's needs. Some stakeholders directly reported a culture of distrust between professional groups and subsystems whereas others made observations that suggest a culture of distrust, for example:

- universal children's services providers reported a reluctance to refer their clients to statutory child protection agencies for support due to perceptions of different values underpinning their practice
- some child and family health providers perceive that general practitioners (GPs) are unwilling to engage with psycho-social health issues
- child protection agencies perceive an unwillingness in universal services to identify when a child is at risk of harm
- several stakeholders reported that they were frustrated with inadequate responses from other agencies that did not see their case as a priority.

In these examples, different values are a barrier to developing an integrated system for protecting children and collaboration between different professional groups remains a key challenge. Professional groups develop and maintain specialised knowledge — this is what makes them professionals. It has been argued that:

> professionalism is characterised by domination, authority and control rather than collegiality whereas the development of collaborative practice depends on recognition by people with differing expertise of their interdependence, including accepting that there are 'grey zones' where this expertise may overlap
>
> Winkworth and McArthur 2007, p. 48

However, stakeholders also reported many positive experiences in working collaboratively across subsystems where respect and trust had been built between professional groups and individuals in agencies. Some examples of mechanisms to build this trust are:

- liaison officers who are embedded in another agency and can reflect the values, practices, concerns and ideas of their home agency
- joint training between professionals
- training from child protection agencies to other professional groups that work with children and families to showcase their role and practices. This was seen to reduce the mistrust of child protection workers
- co-location and integrated services such as wraparound child and family centres which bring together a number of key services (including child protection officers in some cases).

5.4 Shared understanding of and responsibility for the problem

The importance of building shared understanding of, and responsibility for, the problem cannot be understated in tackling wicked problems:

> the Holy Grail of effective collaboration is in creating shared understanding about the problem, and shared commitment to the possible solutions. Shared understanding does not mean we necessarily agree on the problem ... Shared understanding means that stakeholders understand each other's positions well enough to have intelligent dialogue about the different interpretations of the problem, and to exercise collective intelligence about how to solve it.
>
> J. Conklin cited in APSC 2007, pp. 27–28

There was a high level of agreement amongst stakeholders from all states and territories and across service systems about the problem at a broad level. This is that current systems were failing to adequately protect children and that this failure had wide ranging impacts on children's lives. Stakeholders also consistently reported that the demand on the statutory child protection system was unsustainable and was counterproductive to the goal of protecting children. Further, many stakeholders considered that the high numbers of children in out-of-home care was also counterproductive to protecting children from poor outcomes in the long-term.

There was also clear agreement from stakeholders that the best way to protect children is to prevent child abuse and neglect from occurring in the first place. All stakeholders recognised the value of the public health model in providing families with tiered interventions along the continuum of need. Further, there was wide agreement that more secondary prevention interventions for families are required.

Despite agreement on the broad problem and the goal, stakeholders did not all agree on *how* and *why* systems for protecting children are failing children. Stakeholders across and within service systems also presented a range of views about how they perceive their role in 'solving the problem'.

Children's services

Universal child and family health and education stakeholders presented mixed views when asked about their role in preventing child abuse and neglect. Many stakeholders' initial responses were that they report suspected cases of child abuse and neglect according to mandatory reporting obligations. Most stakeholders in universal services also saw their role as identifying families that require additional support and referring them to targeted services. They considered that they already fulfilled this role and saw an increased role for secondary family support services in bringing about change.

Some stakeholders from the education sector did not see family support as their core business and reported a resistance among their professional group to expectations that universal service providers should undertake this function. In addition, some universal providers also reported that they were 'uncomfortable' with protecting children being an explicit part of their professional role. Some stakeholders also did not consider that their workforce was equipped to respond effectively to complex cases and reported frustration that there were inadequate secondary services for them to refer such clients to.

However, stakeholders from community child and family health services and education considered that they are well placed to take on an expanded role in protecting children. Some of these universal service providers saw a role in providing secondary interventions to address risk factors for child abuse and neglect, such as providing support for parents dealing with behavioural issues. In other cases, providers are already taking on an expanded role as part of multidisciplinary teams with explicit child protection objectives. They consider that their workforce is highly skilled in working with families and has regular contact with families. In addition, universal services are well accepted by families as they are non-stigmatising and non-threatening, and they provide an opportunity to work with families that may not seek help from a statutory child protection agency.

Universal service providers such as GPs and early childhood education and care workers were not consulted for this project. However, other stakeholders did comment on the role of these providers in line with the change goal. For GPs, stakeholders noted that professional boundaries and funding arrangements (that is, GPs are private businesses) were potential barriers to an enhanced role in protecting children. For early childhood education and care workers, some stakeholders considered that lack of a skilled workforce would restrict this group from taking on an enhanced role in working with families to protect children.

Targeted

Stakeholders from the targeted family support system (including government and non-government) clearly reported that an expanded role in their sector was critical to preventing child abuse and neglect. Stakeholders from the community sector considered that their services were best placed to deliver family support services because:

- they have strong connections with the community
- they are perceived as less threatening than government services by clients who 'fear' the surveillance of child protection agencies.

They suggested that government agencies — particularly those that also provide statutory child protection services — need to relinquish some control of family support services.

Stakeholders from adult services that address parental risk factors, such as mental health and drug and alcohol services, were not consulted for this project. However, a number of commentators consulted for this review, including Professor Dorothy Scott, reported the critical importance of the role of the services in driving systems change. It was argued that these adult services do not 'see the child' when dealing with their client — the parent. These services need to reconceptualise (or conceptualise in the first place) their role in protecting children by seeing the adult client in the context of their family (Cashmore, Scott and Calvert 2008).

Statutory child protection

Stakeholders in the statutory child protection system articulated a number of views about their role in preventing child abuse and neglect:

- There is an ongoing need for statutory child protection services in tertiary prevention — to prevent the re-occurrence or continuation of child abuse and neglect where it has occurred. This includes intake, investigation, court and out-of-home care processes.
- All jurisdictions recognise that they need to do more in sorting those 'at-risk' from those 'in need' and providing adequate responses for those that do not require statutory interventions. As such, all jurisdictions have either already implemented, or are developing, processes for differential responses for children in need versus those at risk.

Stakeholders generally considered that their workforce was highly qualified and best placed to identify those families in need, and provide secondary prevention services. As such, most agencies with responsibility for statutory child protection also provide primary and/or secondary prevention services. Most of these are also in the process of building or developing the capacity of their early intervention services that, in most cases, receive direct referrals from the statutory child protection process (Bromfield and Holzer 2008).

The Australian Government

The Australian Government has committed to developing a *National Framework for Protecting Children*. Bromfield and Holzer (2008) also report that there are many areas of Australian Government activity that contribute to the systems for protecting children. That said, stakeholders consulted for this project rarely raised the role of the Australian Government in systems change without prompting. When prompted, stakeholders reported two consistent suggestions for any additional Australian Government investment:

- Australian Government service activity should remain in primary and secondary prevention (that is, the Government should not take on a new role in tertiary prevention)
- the Australian Government controls many of the levers to address broader societal conditions for child abuse and neglect — for example, income support and regulation of working conditions including parental leave — and these could be used more effectively for protecting children.

In addition, stakeholders noted that any new investment from the Australian Government in protecting children should be implemented in collaboration with the state and territory governments, rather than as stand alone Australian Government programs. Several stakeholders noted that the *Communities for Children* program was an example where a stand-alone national program was not implemented collaboratively with the following impacts:

- state and territory stakeholders felt they had been sidelined
- the program implementation did not benefit from local knowledge
- the program undermined or duplicated existing state and territory programs.

Shared responsibility?

How system members see their role in 'solving the problem' reflects in part the degree of shared responsibility for solving the problem in the system as a whole. From consultations conducted for this review there is a broad *sentiment* of shared responsibility and a willingness to be part of the solution. This is consistent with the findings of *A national approach to child protection: project report*. On the basis of their comprehensive review of mechanisms to facilitate 'joined-up working' in child welfare, Bromfield and Holzer (2008) report:

> it appears that there exists a shared view across governments that 'child protection is everyone's responsibility'. There was the belief in the notion that child welfare is a whole-of-government, whole-of-community, interagency responsibility; and that children's safety and wellbeing is enhanced when services are available to strengthen families an communities. A wide range of mechanisms had been established to facilitative joined up responses within government as well as between governments and non-government organisations
>
> Bromfield and Holzer 2008, p. 52

However, the broad sentiment of shared responsibility (which is also formalised in a range of whole-of-government mechanisms) does not appear to be fully reflected in the way system members saw their roles. Overall findings are:

- Universal providers consider that their role is to promote the wellbeing of all children rather than safety or child protection. Views were mixed among universal providers consulted for this project about their role in protecting children.
- Family support service providers (outside of child protection agencies) expressed a strong willingness for an expanded role in secondary prevention.
- Statutory child protection agencies clearly acknowledged the need for differential responses to reports of alleged child abuse and neglect, and a role for their agency to further develop and/or provide secondary prevention strategies.

The sentiment of shared responsibility needs to be translated into action through a cultural shift. This requires consideration of which systems players are best placed to deliver prevention strategies — some systems players will need to 'step up' whilst others may need to 'let go' and transfer responsibility.

Stakeholders involved in implementing the Child FIRST reforms in Victoria reported that risk and responsibility were key issues that needed to be addressed with the NGO sector in Victoria. They reported there was a concern from NGOs that the government was transferring risk by introducing community-based intake. To overcome this, Victoria underwent a very rigorous process of clarifying responsibilities and accountabilities with the sector.

Further discussion about roles of systems players to meet the change goal is provided in Chapter 6.

Chapter 6

System resources: human, social and economic

6.1 Introduction

The resources available to a system reflect the capacity of a system to perform its functions currently, and in-line with the change goal. System resources represent 'inputs' into the system and can be categorised as:

- *Human resources* — the knowledge, skills and capabilities available to the system. Inadequate or inappropriate human resources can limit the ability for systems change. Even if the values, attitudes and beliefs of system members are aligned with the change goal, they may not have the right skills and expertise to implement the desired change.
- *Social resources* — social resources are the social relationships between critical systems players. Relationships can play a facilitating or constraining role in systems.
- *Economic resources* — assessing what economic resources are available within a system and how it is allocated can help understand who and what is valued in the system and determine whether resourcing reflects the change goal (Foster-Fishman et al. 2007).

This chapter analyses the resources available in the current systems for protecting children in Australia by considering three sets of questions:

- Human resources:
  - how will system members be expected to behave if the systems change effort is successful? Do they have the skills and capacity for this role?
- Social resources:
  - to what extent are relationships amongst stakeholders a contributing factor in system failure? What aspects of the system might support or hinder relationships?
  - how will relationships need to shift in order for the change goal to be realised — who will need to interact with whom and what will be nature of that interaction?
- Economic resources:
  - what new resources are needed to support the desired change? How does the system need to use its resources differently to support the change goal? Who might perceive this reallocation as a loss?

6.2 Human resources

Implementing a public health model for preventing child abuse and neglect requires a fundamental change in roles for many systems players. If we recall the visual depiction of the current system in most states it reflects two scenarios:

- where a state or territory's system reflects an inverted pyramid (scenario one) — an increase in primary prevention and secondary prevention strategies for protecting children is required
- where a state or territory's system reflects an hourglass (scenario two) — an increase in secondary prevention strategies is required.

Both scenarios would see a decreased role for tertiary prevention strategies. The implications for system human resources of these changes is analysed below.

Human resources for primary prevention

Increasing primary prevention of child abuse and neglect will involve increased demand for skilled professionals in universal services. Given workforce constraints in many of the professional groups that make up universal services (nurses, general practitioners, teachers etc) it is critical that the skills of the existing workforce are maximised.

The skills and capacity of the workforce vary between professional groups. Stakeholders noted that early childhood education and care in particular is an opportunity that is not currently being maximised due to the underdevelopment of the workforce. In addition, several stakeholders noted that GPs were also potentially under-utilised in child abuse and neglect prevention, although it was noted that family partnership may be challenging to GPs who work in a medical patient-doctor model.

The skills and capacity of other professional groups (nurses and teachers in particular) in providing quality primary prevention was recognised by many stakeholders.

Human resources for secondary prevention

An increase in secondary prevention strategies would involve an enhanced role for professionals and organisations that work effectively with vulnerable families. This could include:

- an expanded role for children's services providers to provide enhanced secondary interventions
- an expansion of specialist, targeted family support services for secondary prevention
- an expansion of the role of adult services for parental risk factors.

As noted in Chapter 5, universal children's services providers consulted for this review expressed a range of views about taking on an expanded role to provide more targeted interventions. However, in many jurisdictions universal providers are already providing targeted services. Interventions provided off universal platforms have also been shown to work. For example, targeted nurse home visiting is provided in several jurisdictions and has been found to have positive outcomes for reducing the incidence of child abuse and neglect (Karoly et al. 2005).

Several stakeholders noted that nurses in particular are well-trusted in the community by families and this should be leveraged for more intensive interventions. On the other hand, others suggested that the role of the community child and family nurse was already over stretched and, at the risk of losing the services that nurses currently provide as core business, it may be more strategic to use other professional groups to provide secondary supports.

O'Donnell et al. (2008) argue that providing secondary strategies off a universal platform reduces the stigma associated with a dedicated 'targeted' service. Professor Scott and others in consultations argued for increased training, professional development and supervision for universal providers such as nurses to deliver an expanded role.

In addition, most stakeholders reported that there was a critical shortage of secondary family support services (particularly providing intensive support) in the system and this was the key area for expansion. Further, most child protection agencies considered that there was a lack of NGO capacity for expansion in their jurisdiction. Most states suggested that the expansion of the family support sector in Victoria was a reflection of the stronger capacity in the NGO sector in Victoria.

In contrast, NGOs reported that their capacity was restricted primarily by funding, and that they had the skills and expertise to deliver secondary prevention. They reported that current funding levels for NGOs made it difficult for them to attract and retain qualified staff as government agencies were able to pay higher rates.

Finally, several stakeholders reported that improving the capacity for workers in adult services to respond to children and families provides a significant opportunity for preventing child abuse and neglect given the strong correlation with drug and alcohol use, mental health and family violence (O'Donnell et al. 2008). This would require a philosophical shift for the human resources in this subsystem and would require training and professional development.

Human resources for tertiary prevention

In a public health model — if primary and secondary prevention efforts were effective — there would be less need for tertiary prevention services as the needs of many families would be addressed by lower level strategies. Tertiary prevention services will always be required for those families where all other efforts have failed.

Several stakeholders outlined a vision for system under a public health model where the statutory child protection subsystem comprised a highly expert workforce — the most experienced, specialist social workers, rather than a high reliance on recent graduates and relatively unexperienced workers as characterises the system now. This workforce would then have the skills as well as the capacity (as a result of reduced demand) to effectively service the intensive needs of those children who have been subject to abuse and neglect.

In the current system, child protection agencies experience chronic workforce shortages, high turnover and difficulties recruiting staff. One jurisdiction reported that they now recruit social workers twice a year from the UK to fill positions. This presents difficulties for child protection workers to adequately meet demand, but also has particular implications for effective collaborative working. Stakeholders from other subsystems expressed frustration at the high turnover for collaborative working. Reducing demand for statutory services would ease this human resources capacity issue and may also allow human resources within the system to be reallocated to secondary prevention activities (either within government or in the NGO sector).

Human resources for collaboration

Implementing an integrated system for protecting children also requires system members to have the skills and capacity to work collaboratively. Several stakeholders noted that collaboration is not always easy and takes time and specialist skills. Stakeholders reflected two key approaches to ensuring that collaboration did not fail due to human resourcing issues, although the two approaches are not mutually exclusive. These are:

- Dedicated resourcing and a specialist role for facilitating collaboration. Several stakeholders reported that when collaboration was required of staff in addition to their usual duties it has failed because staff do not have the skills or the capacity to collaborate. It is argued that collaboration needs to be appropriately resourced, and managed by a skilled facilitator. One example of this approach is in the Victoria Best Start program. Best Start includes funding for dedicated 'facilitators' to build partnerships between service providers for children and families.
- Making collaboration 'core business' and developing collaborative skills in the workforce. Some stakeholders reported that collaboration does require specialist skills, but is such a central part of an effective model for protecting children that all staff should be skilled in this area. The UK Every Child Matters reforms reflect this approach. In the UK reforms, developing skills for collaboration is a cornerstone of the training and professional development program, which is delivered across agencies, professional groups and sectors. The goal is to build an ethos across the entire children's workforce that values working collaboratively.

These approaches need not be mutually exclusive. For example, although UK reforms hinge on building a culture of collaboration based on appropriate skills and expertise, they also include dedicated resources for coordination and collaboration efforts.

The Management Advisory Committee report *Connecting Government* recognises the importance of building culture and capability for whole-of-government working and highlights the role of leadership in building this capacity. Leaders in the Australian Public Service are required to 'promote cooperation', 'give explicit and consistent support for collegiate and horizontal approaches', and 'participate in cross-portfolio training activities' (MAC 2004, p. 5). The MAC report also notes that working across boundaries is core business for agencies who should provide practical support to build the capability for joined-up working within their agencies. The MAC guidance on what support should be provided is in Box 6.1.

Box 6.1

BUILDING CAPABILITY FOR WHOLE-OF-GOVERNMENT ACTIVITIES

The MAC report on *Connecting Government* suggests that departments and agencies should support whole-of-government activities by:

- developing systems and procedures to support authorisation for appropriate local decision-making; capability development focusing on constructive working relationships with other APS agencies and external organisations; and accountability arrangements
- taking steps to become more responsive to whole-of-government demands, including through
  - more intensive training for those directly involved in whole-of-government projects
  - learning opportunities for middle and senior managers in skills relevant to whole-of-government activities, including project management, communications and relationship management
  - networking to broaden the exposure of APS employees to different organisational cultures and ways of working
  - access to better practice guidance and to assistance with team building and conflict resolution
  - the adoption of reward and recognition arrangements for whole-of-government achievements.
- reflecting whole-of-government perspectives in induction and learning and leadership development programs.

Source: MAC 2004, pp. 5–6.

6.3 Social resources

As noted in the introduction to this chapter, social resources refer to the relationships between system members. A collaborative model for protecting children in its essence is built on the relationships between:

- government agencies and services
- government and non-government agencies
- professional groups in both government and private sector services (for example, GPs).

Relationships between government agencies and services

Most stakeholders consulted for this project stressed the importance of relationships between agencies to prevent child abuse and neglect. Stakeholders reported clear views on how these relationships should 'look' in a system that protects children. At the planning level, relationships should be established between all agencies that provide services to vulnerable children and families, including adult services that respond to parental risk factors for child abuse and neglect. In addition, interagency planning level relationships should include children's advocates such as Children's Commissioners. Finally, for planning level relationships to be successful, several stakeholders argued that processes need to be led by, or at least include, central agencies such as treasury and premiers' departments.

At the service delivery level, relationships should be established between all services that support the same client group, or the same client (for individual case management).

Key findings from stakeholders are that relationships should enable:

- At the planning level
  - cross-agency agreement on goals and objectives
  - joint planning of services to avoid duplication and gaps
  - sharing of local population level data to allow joint planning of services according to local needs
  - sharing of knowledge and evidence about what works
  - sharing of resources (funding and/or staff) to meet service needs.
- At the service delivery level
  - integrated case management and/or case coordination to provide more comprehensive services for the most vulnerable families
  - development of formal or informal processes and protocols between services (including for referrals)
  - sharing of knowledge, experiences and issues to build trust and professional respect.

Stakeholders also reported a commitment in their jurisdiction to interagency relationships with a range of mechanisms in place to support interagency working at the planning level (strategic) as well as at the service delivery (operational) level.

The project report, *A National Approach to Child Protection* (Bromfield and Holzer 2008), provides a comprehensive overview of the strategic and operational mechanisms currently in place within jurisdictions. Their key findings were:

- all jurisdictions had a number of mechanism in place for joined-up working, with a strong focus on interagency collaboration
- the most popular strategic mechanisms were state-wide strategic plans and interdepartmental committees and senior officers groups, with political and departmental structure also commonly utilised (such as a Minister for Child Safety, or dedicated child safety directors within departments)
- the most common operational mechanism were interagency guidelines and groups and response teams; legislative mechanisms and local strategies were also important.

However, despite these mechanisms and broad consensus on how effective relationships would look, several stakeholders reported that interagency relationships have been a clear area of failure in protecting children, and that collaborating effectively remains a challenge. These stakeholders report the following key challenges in interagency relationships:

- *Information sharing* — stakeholders reported a range of barriers to sharing client information
  - Legislative barriers such as privacy legislation. However, some stakeholders considered that this was perceived as a bigger barrier than it actually is: 'if consumers were asked for consent, many would give it if it meant they could get better services' (stakeholder consultation).

  - Professional culture leads to concerns about confidentiality and breaking client trust. For example, adult-focused services are reluctant to share information with child protection agencies as it compromises their client confidentiality (Scott 2005).
  - Lack of understanding, time or not having established relationships with other providers is an issue. Beyond mandatory reporting of risk, some stakeholders were unclear about who they would share information with and for what purpose.

- *Data collection and sharing* — agencies do not have integrated systems for collecting, storing and sharing data to allow service planning. As one stakeholder noted: 'communities can't act in response to children that they don't know'.
- *Capacity* — high turnover and vacancy rates make it hard to maintain momentum where effective relationships are established. This reflects the experience of several stakeholders that effective relationships are often based on particular personalities and they 'die off' when those personalities move on. One stakeholder described this as 'heroic examples' of collaboration, strongly associated with passionate leadership.

In addition, several stakeholders reported that siloed funding is also a critical barrier to effective collaboration between services — this is discussed further in Section 6.4.

Several stakeholders also reported very positively about interagency relationships in their jurisdiction. Mechanisms that were identified as very effective in building interagency relationships were:

- developing shared outcomes — allows common objectives and shared responsibility
- clarifying roles, responsibilities and accountabilities — provides system members with a solid basis for their relationships with other members
- protocols for information sharing — clear protocols establish policy and procedure to facilitate information sharing
- liaison officers and joint training — build shared understanding and respect
- legislation — can provide a compulsion to collaborate
- specialist case management processes/programs — provide a framework to bring respective providers together
- co-location — physical proximity can encourage informal communication and build respect between professionals.

The recent Wood Inquiry recommended that a unit be established in key agencies that work with children and families (for example, area health services, the Department of Educations and Training, the NSW Police Force etc). This unit would have two functions:

- to receive reports of risk of significant harm from staff within their agency and take appropriate action
- to provide a mechanism for interagency communication and collaboration.

Workers in these units would be child protection trained and meet regularly with their counterparts in other agencies to share information and identify any problems or emerging trends in interagency collaboration (Wood 2008). This model is an extension of a liaison officer model, which many stakeholders reported had been useful in their jurisdictions.

Notably, stakeholders' views were contained to the relationships between state government agencies, rather than between state and national agencies. This reflects that although the Australian Government currently delivers services within the system for protecting children, mechanisms for collaboration do not generally extend beyond a state or territory boundary.

Relationships between government and non-government agencies

A system for protection that is prevention-based will require an expanded or sustained role for the NGO sector, particularly in delivering secondary prevention strategies. This means that relationships between government and NGOs will be critical to implementing the systems change goal.

NGO stakeholders consulted for this project were drawn primarily from the family support and tertiary child protection sector. As such the comments in this section largely relate to the relationship between NGOs and agencies responsible for commissioning such services (predominately child protection agencies) in some states.

Stakeholders reported that current relationships between government and NGOs in the system are problematic and do not support the change goal. The issues NGOs raised that impact on relationships with government agencies can be sorted into three themes:

- *Consultation* — services are planned by government without consultation with NGOs. NGOs have the 'operational know-how' and are well connected to the community and consider they have much to offer in terms of input. NGOs also consider they should be consulted on processes that will affect their operations such as intake processes. The NSW Council of Social Services submission to the Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry) also reflected these concerns 'NGOs feel their input is not sought by Government and when it is, is ignored or not considered relevant' (NCOSS 2008).
- *Culture* — positive relationships require trust and respect. NGOs in some states consider that there is not a culture of collaboration between NGOs and government in the child protection system:

  > Collaboration and coordination works best when there is a clear understanding of each others' roles and responsibilities and a level of trust that people will do their job properly and well. It requires sharing of information and a willingness to work constructively to overcome problems. There is, however, amongst NGOs a perception that DOCS does not take criticism well and is often more defensive rather than open to suggestions constructively made.
  >
  > NCOSS 2008, p. 7

- *Resourcing* — working in partnership with families with complex needs requires time and resources. Current funding levels do not recognise the complexity of the task.

Government stakeholders did not generally report relationships with NGOs as an issue; rather the capacity of the NGO sector was raised in a number of jurisdictions.

Relationships between professional groups

An integrated system for preventing child abuse and neglect would require enhanced relationships between a range of professional groups:

- medical professionals — for example, nurses, GPs, psychologists
- education professionals — for example, teachers, early childhood workers, school nurses, school counsellors, student welfare coordinators
- social workers — including in adult community-based services (such as drug and alcohol, mental health), family support services and statutory child protection services
- criminal — legal groups including police and courts.

These professional groups operate with quite distinct professional values and practice philosophies embedded in their training. GPs in particular also work with a high level of autonomy from government and are relatively isolated from other groups outside the medical profession. For these reasons, building relationships between previously unconnected (or poorly connected) professional groups presents a challenge to the change goal.

The issues associated with interagency relationships also apply to inter-professional relationships. Stakeholders suggested a multidisciplinary approach was required for training of all professionals that work with vulnerable families. This training should be embedded in university training and include establishing a shared understanding about appropriate pathways for vulnerable families at risk of child abuse and neglect.

6.4 Economic resources

Fundamental systems change to implement a preventive model for protecting children has implications for economic resources and funding. There was a consensus among stakeholders that a preventive model for protecting children required more resources for primary and secondary prevention.

Most jurisdictions considered that additional funding for secondary prevention was required to increase the coverage of secondary prevention programs. Jurisdictions consistently reported that:

- there are inadequate places available in family support services which has resulted in waiting lists, strict eligibility criteria or limited referral pathways. For example, several stakeholders reported that the only way to access family support services was by referral through child protection agencies
- family support services are restricted in the intensity of service they can provide due to resource constraints
- universal services do not have the resources to provide more intensive support to vulnerable families.

This is consistent with the experience in Victoria, where change involved a significant new investment in the family support sector (from around $20 million to $600 million). Several Victorian stakeholders reported that the change simply would not have been possible without this investment.

In addition, the coverage and capacity of universal services varies across jurisdictions and, in some states, stakeholders reported that universal services need to be bolstered to ensure that access was in fact universal. This includes investment in assertive outreach for the 'hard to reach', and quality and high intensity services for the most disadvantaged children to 'narrow the gap' with other children. It was also noted that increased access to universal services will mean that more problems are identified in families. This creates an expectation in the community that these problems will be addressed, which also increases demand on targeted services. One stakeholder noted that adult drug and alcohol, and mental health services are particularly overstretched in relation to community need.

There was a view among some stakeholders that in the medium to long-term, resources could be reallocated from statutory child protection to primary and secondary prevention as prevention efforts should reduce demand for tertiary services. This would however, follow a period of 'double-budgeting' whereby increased resources are allocated to primary and secondary prevention but the impacts of this investment do not immediately translate into reduced demand for tertiary services. Until demand does ease, a need remains for full funding of tertiary services *in addition to* the new investment.

There was also caution from some stakeholders on this issue. It was noted that behavioural change in parenting behaviour can be generational. Moreover, the broader societal issues associated with child abuse and neglect such as poverty and substance abuse are deeply entrenched and tertiary services will need resourcing for an undefined amount of time.

A number of stakeholders also saw reduced demand on tertiary services as an opportunity to enhance service provision to those children who have been subject to abuse and neglect. It was reported that these children have high and complex needs that are not currently being met because tertiary services are overburdened with assessment and screening. This approach would limit the economic resources available for reallocation to primary and secondary prevention.

The impact of prevention efforts on demand for tertiary services will reflect the effectiveness of strategies in reducing the incidence of child abuse and neglect. Policy reform is outside the scope of this project, however several stakeholders reported an urgent need for better evidence about what works in preventing child abuse and neglect to assist policy-makers in designing programs and policies that will have the intended effect. Better evidence would also allow governments to reallocate finite resources from things that do not work to things that do, even within the prevention space.

Shrinking the size of the tertiary prevention activities relative to primary and secondary prevention could be perceived by some players in the statutory child protection system as a loss. However, this does not reflect the views of stakeholders consulted for this project who were wholly supportive of this goal. That said, child protection agencies generally see a role for their agency in providing secondary prevention services. This role shift would not necessarily result in a net loss for the organisation. This is opposed to the view of some family support NGO stakeholders and commentators that child protection agencies are not an appropriate organisation for providing support to vulnerable families.

Chapter 7

System regulations

7.1 Introduction

System members' behaviour is regulated through a range of mechanisms to ensure that it aligns with the overall system goal or purpose (Foster-Fishman et al. 2007). These are:

- system rules — formal government or organisational policies, including legislation and accountability arrangements
- system practices — routines, processes and procedures that emerge from formal and informal protocols.

In the context of systems change, existing system regulations can help or hinder change according to how compatible they are with the change goal. Moreover, system regulations may need to change, or new system regulations be introduced, to reflect the change goal.

This chapter analyses the system regulations in the current system for protecting children according to three groups of questions:

- What system rules might hinder or help change?
- What current processes and practices exacerbate the problem or have made it difficult to resolve issues in the past? What current processes and practices are incompatible with the change goal?
- What system regulations are not in place but are needed to fully support the change goal?

All the distinct subsystems for protecting children are governed by a myriad of government and organisational policies, and numerous legislative arrangements. There are also a multitude of processes and practices within subsystems that contribute to the goal of protecting children. There is not scope within this report to analyse these policies, legislation and processes and how they conflate, although we recognise this work would be highly valuable. Instead, this project focuses on an analysis of the rules and practices that regulate the behaviour of system members where subsystems currently or potentially *intersect*, taking a holistic view of the system.

7.2 System rules: legislation and accountability arrangements

System rules determined by policies, legislation and accountability arrangements are important as they 'clarify what is normative and expected, sanctioned and rewarded' (Foster-Fishman et al. 2007, p. 208).

Policy and legislation

Policy frameworks and legislation provide the regulations for system operation. Child protection legislation in each jurisdiction generally prescribes the activities for protecting children and together with policy frameworks reflects the goals of services in protecting children (Bromfield and Holzer 2008).

Bromfield and Holzer (2008) systematically reviewed the legislative and policy frameworks underpinning practice for protecting children in each jurisdiction. They found a high level of consistency across jurisdictions in the principles embedded in legislation and policy (see Box 7.1 below).

Box 7.1

CONSISTENT PRINCIPLES IN CHILD PROTECTION LEGISLATION AND POLICY

- The 'best interests' principle whereby the best interests of the child should be central to all decision-making
- Whole-of-government and community responsibility for child protection
- Early intervention
- The participation of children and young people in decision-making
- Culturally specific responses to Aboriginal or Torres Strait Islander peoples
- Diversion from the court system
- Permanency planning and stability of care
- After care

Source: Bromfield and Holzer 2008, pp. 18–24.

These legislative provisions would not hinder systems change and were not noted by any stakeholders as barriers to prevention efforts. In fact, several principles, particularly 'whole-of-government responsibility for child protection' and 'early intervention' explicitly support the change goal.

Victorian stakeholders reported that legislation was key to implementing their Child FIRST reforms. The *Children, Youth and Families Act 2005* incorporates child protection and community services for children into one Act and the role of secondary family support services are embedded in legislation. Victoria stakeholders reported that this provided assurances to the NGO sector of their role in protecting children. It also delivered a unifying legislative framework for protecting children that went beyond the tertiary system.

Mandatory reporting

One legislative issue that some stakeholders did consider hindered the change goal was mandatory reporting legislation. Mandatory reporting legislation requires that certain specified groups must report suspected cases of child abuse and neglect. The groups that are required to report vary between jurisdictions but all states and territories have some form of mandatory reporting legislation (Higgins et al. 2006).

Some stakeholders considered that mandatory reporting exacerbates the problems in the current system of net widening. It was argued that:

- it significantly contributes to the demand on the tertiary system
- it overwhelms the statutory system, which is unable to respond appropriately to the notifications
- it has resulted in responses being targeted to very high risk cases only, with other cases being unattended.

The indirect implications of mandatory reporting reported by stakeholders were:

- a view that legal obligations (and legal sanctions) to report alleged child abuse and neglect contributed to the risk averse culture in the system
- a perception by some stakeholders that universal providers feel they have 'done their bit' once they have made a mandatory report
- frustration from some providers that their reports of alleged child abuse and neglect are not being attended to, or feedback on their report is not timely or simply does not happen.

These views are consistent with several of the submissions to the Wood Inquiry (for example, DPC 2008).

Privacy legislation

Many stakeholders also reported that privacy legislation restricted their ability to share information about clients in order to provide integrated services. Several states including South Australia and Victoria have recently changed their privacy legislation which has reportedly improved information sharing. Information sharing provisions in legislation are being considered in detail by the Council of Australian Governments.

Other stakeholders reported that privacy legislation was less of a barrier than it was perceived to be and that professional boundaries were responsible for the poor information sharing between services. In addition, one stakeholder considered that providers were 'hiding behind' privacy legislation to manage their risk.

Accountability and funding arrangements

Accountability arrangements are central to systems change because as Foster-Fishman et al. note:

> system regulations that indicate what will be rewarded or punished are viewed as particularly powerful regulatory mechanisms and should be given careful consideration during a systems change endeavour.
>
> Foster-Fisherman et al. 2007, p. 209

Several stakeholders noted that government funding and accountability arrangements are barriers to developing an integrated system for preventing child abuse and neglect. The reported barriers are two-fold:

- current agency funding and accountabilities are siloed and restrict the incentives for agencies to collaborate on integrated services for vulnerable client groups with complex needs that run across several agencies
- competitive purchaser and provider arrangements for contracting service providers encourage siloed service delivery.

Government agencies

Traditional government accountabilities operate in a vertical approach, with a single, clear line of accountability to the Minister. This has resulted in siloed departments where funding is 'ring-fenced' by departmental responsibility. Performance-based budgeting that allocates funds according to outcomes and then according to outputs has been widely introduced by Australian Governments. These accountability arrangements reflect reforms to public sector management to deliver increased cost effectiveness. In fact, current accountability arrangements are designed with the *express intent* to maintain clear distinctions between responsibilities so that organisations and managers can be held accountable for outcomes.

Stakeholders reported that accountability arrangements are too rigid for effective prevention efforts. The APSC (2007) also questions the appropriateness of current government accountability frameworks in allowing the flexibility required to tackle 'wicked problems' noting the following issues:

- performance indicators may undermine the responsiveness of complex service delivery as the focus shifts to attaining the indicator (or target) rather than delivering the service
- program outcomes for dealing with wicked problems may not be evident for many years which makes measuring 'performance' and evaluations for traditional funding cycles difficult
- specification of outputs and outcomes may be difficult when the nature of the wicked problem is not always clear (for example, causal pathways to child abuse and neglect are by no means established).

Stakeholders also noted that siloed funding and accountability arrangements raise a number of challenges for collaborative prevention efforts:

- Each department has defined performance measures against which it is measured and to which incentives are tied. Departments are generally unwilling to contribute resources to activities that do not relate to these measures. Moreover, agencies may actually have performance measures or targets that are inconsistent with the goals of another potential collaborating agency.
- Agency accountability arrangements encourage services to deliver very narrowly within their mandate only, and contribute to the risk aversion discussed in Chapter 6. One stakeholder noted that child death reviews have highlighted the dramatic impacts of agencies only attending to their particular responsibility.
- Cross-agency funding bids are not easily accommodated within traditional budgeting structures, which makes them 'difficult'.
- Successful prevention efforts can mean significant costs falling on one budget while the benefits accrue to another. Reallocations of funding are fiercely contested as agencies perceive a risk to their own mandates.

In addition, stakeholders reported that accountability arrangements within organisations — both incentives and sanctions — need to be restructured to encourage collaboration. This could involve building a requirement to collaborate into agency chief executive officers' performance agreements, or prioritisation of cross-agency funding bids by decision-makers in budget processes (WA Commissioner for Children and Young People 2008). The Wood Inquiry also recommended that agency CEOs, and the Director-General, Deputy Director-Generals and each Regional Director of DoCS should have measurable provisions in their performance agreements relating to interagency collaboration on child protection (Wood 2008).

Service providers

Stakeholders also reported that current purchaser-provider funding and associated accountability arrangements for contracted services are counterproductive to a collaborative prevention model. They argued that they result in siloed service delivery as services are generally funded on a single-input basis. Service providers are funded to deliver a certain service to a certain client group within a certain domain (Scott 2005). The implication of this funding approach is that an adult service delivering to a parent (for example, mental health) will only deliver narrowly within their particular mandate, and has no accountability (or incentive) to address the needs of the child or family.

In addition, many stakeholders considered that competitive tendering between NGOs for funding was in its essence anti-collaborative. Competitive tendering provides a disincentive for services to:

- work together to develop programs and initiatives
- share knowledge and information
- work with more complex (and expensive) clients
- address a client's needs holistically.

Finally, stakeholders noted that organisations (both government and NGOs) seek to conserve their own resources for service delivery within their particular mandate, and this may result in 'gate-keeping' to resist referral of cases that are resource-intensive. Scott (2005, p. 136) notes that two key gate-keeping strategies used by organisations to manage scarce resources are:

- developing eligibility criteria that exclude certain categories of clients, or requires clients to meet criteria that is difficult in their circumstances
- requiring clients to make their own appointments for services when the client is likely to require an outreach model of delivery to assist them to access the service.

Several stakeholders reported that the collaborative contracting model used in Victoria increased collaboration by overcoming many of the issues reported above. It also strengthened the capacity of the sector as smaller NGOs that were not viable service providers in their own right were able to partner with larger NGOs to form consortiums. Several other jurisdictions reported that they were considering collaborative tendering models.

The Victorian model also involves performance-based contracting with service providers. In this model, the strategic framework for the reforms sets out the outcomes to be achieved, but particular processes are not prescribed and there are no guidelines for services. This model was developed in partnership with the community sector and reflects a devolved accountability model. It is supported by performance standards embedded in legislation for community services to assure quality.

7.3 System practices: routines, processes and procedures

Supporting system rules in regulating the behaviours of system members are system practices — routines, processes and procedures that have emerged as a result of formal and informal protocols. Three interconnected system practices that were consistently raised by stakeholders as inhibiting an effective and integrated preventive approach to protecting children were processes for intake, referral and assessment. These are each discussed below.

Intake and referral

A clear finding from the consultations was that referral processes do not reflect a continuum of care in the public health model that 'steps up' from primary to secondary to tertiary strategies (if required). Stakeholders reported that the most common pathway for vulnerable families was either:

- receiving only universal supports (e.g. the child may be attending school) and then being reported to the tertiary system
- receiving no supports (i.e. not accessing universal services) and then being reported to the tertiary system (this is commonly the case for the most vulnerable families).

The needs of many of these families could be met by a more appropriate response at a lower level of intervention, and as such many reports of alleged child abuse and neglect (around 80 per cent) are unsubstantiated. A large proportion of these are referred to secondary services (Bromfield and Holzer 2008). The impact of these pathways is that in some jurisdictions the primary way for families to access support services is through the tertiary system.

Stakeholders provided a range of explanations for the current referral pathways:

- There are no or few institutionalised referral processes from universal to secondary family support (particularly intensive family support) so referrals of this kind rely on relationships between services and professionals.
- Some universal providers and/or professional groups may not be aware of the range of targeted services available in the community. Providers also reported that there are inadequate services available so referral options are limited.
- Although services are available for self-referral, families may not be aware of the range of supports available — entry points are not 'visible' in the community. In addition, parents may be concerned about engaging with services due to concerns that they will come under surveillance for child protection, and services may also be seen as stigmatising.
- The eligibility criteria for some support services specifically stipulate that the families must be involved with child protection, or referred from child protection.

- Family support services are under resourced and places are limited. Priority is given to the most complex cases, which are generally referred from child protection.

Bromfield and Holzer (2008, p. 57) suggest that options for expanding referral pathways to support a prevention focus are needed. These are:

- promoting and enhancing referral pathways down from and between tertiary services
- promoting and enhancing referral pathways directly into local secondary services for community members and professionals
- creating a single visible entry-point where families are assessed and referred to the most appropriate service response (for example, primary/secondary family services or tertiary child protection services).

In addition to these options, some stakeholders suggested that a truly integrated system for prevention would involve 'no wrong door'. This means that a family would be provided with appropriate support for their particular needs regardless of where they 'entered' the system. This does not necessarily require full service integration or co-location for all services to be able to address all needs but rather that services would need to be adequately linked. For example, a drug and alcohol service does not need to be able to provide family support services but should be able to actively link their clients with family support beyond simply providing information about services available.

All jurisdictions have introduced some form of differential response in their tertiary intake services that provides a formal pathway for provisions of support rather than investigation where cases do not meet the threshold for a statutory intervention (Bromfield and Holzer 2008). These are also known as 'multiple track' and 'alternative responses'. Stakeholders reported that these approaches showed promise for providing more appropriate support. There is also strong support for differential responses in the international literature as a 'commonsense' approach for child welfare that has been evaluated in several places. For example, evaluations in the US have found that:

- children are at least as safe in differential response pathways as traditional investigation pathways, with some evidence of lower levels of re-notifications for similar cases on the 'assessment track' rather than 'investigation track'
- differential responses are largely supported by parents, child welfare staff and community agencies with parents are more likely to engage (Schene 2005).

Differential response approaches implemented in Australia and overseas generally rest *within* child protection intake processes, rather than diverting cases from the child protection system altogether (Schene 2005). This approach, although very positive, is somewhat limited. Involvement with the child protection system at any level can be stigmatising for families, even if the family is referred for support rather than investigated.

In addition, stakeholders suggested that many of these referrals do not translate into a family receiving services for a number of reasons. It was reported that:

- child protection workers do not have the capacity to follow-up on referrals
- sufficient family support services of adequate intensity are not readily available

- families are not willing to engage voluntarily with services provided by the child protection agency
- service networks are not working collaboratively.

In this context, problems may escalate only to result in another notification at some stage creating a 'revolving door' of families repeatedly 'bumping up against the system'.

An additional limitation on the effectiveness of differential response processes is that the reliability of risk assessment tools in child protection is poor so it is inherently difficult to identify those 'in need' opposed to those 'at risk' (Gillingham 2000). Risk assessment tools have been found to produce a significant number of false negatives (failing to appropriately classify those children who are actually at risk) and false positives (investigating those families where the child is not at risk of harm). In fact, Gillingham concludes that due to unreliable tools and the way they are used:

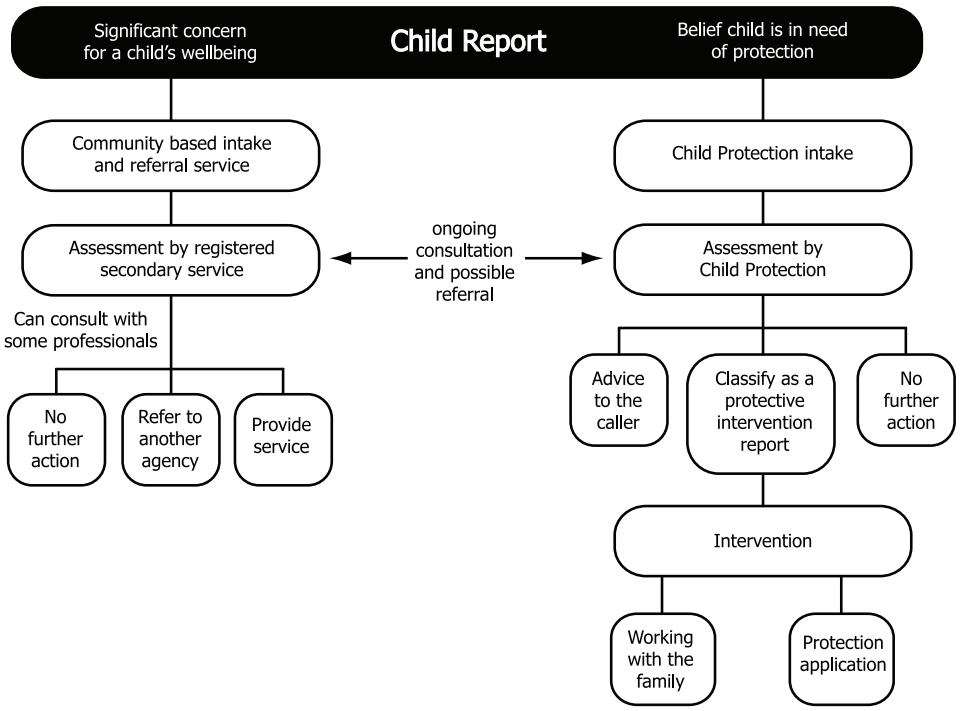
> the application of risk assessment ... is potentially a flawed process that may not live up to the promise that risk to the safety and wellbeing of children can be predicted and managed.
>
> Gillingham 2000, p. 95

Victorian reforms have combined differential response with community-based intake, and many stakeholders supported this as a promising intake and referral model. Victoria has established two separate — but interrelated — referral pathways into family services. First, the traditional pathway through child protection remains. Second, a new pathway through Child FIRST in local areas has been established. This reflects the concept that both the child protection agency and the community sector (through community-based intake) are partners in prevention and early intervention for children and families in Victoria.

Child FIRST receives referrals about families where a child's wellbeing is thought to be affected by severe family stress and where there are concerns about the families' resilience under such stresses. It can refer families to various services and supports, although family involvement is voluntary. Child FIRST workers have an obligation to refer children to child protection where there is concern for a child's safety. The twin pathways are shown in Figure 7.1.

Figure 7.1

VICTORIAN CHILD REPORT SYSTEM: INTAKE AND ASSESSMENT PATHWAYS



Source: Callister, G 2005, Presentation at the launch of *Protecting Children … the next steps* and the exposure draft of the Children's Bill, 3 August 2005.

The recent Wood Inquiry in NSW also proposes a new differential response that allows a unit within the major reporting organisations to determine if a report poses 'significant harm'. If they consider it does not, the unit can refer the family to a Regional Intake and Referral Service run by an NGO. This model reflects many of the system features of the Victorian model.

Stakeholders considered that a community-based intake model addresses many of the issues discussed above:

- it provides a non-stigmatising 'visible' entry point that the community and providers can refer families to without concerns about unnecessarily subjecting a family to a statutory intervention
- it allows families that are in need but not at risk of harming children to access supports to prevent issues from escalating by actively connecting them with services
- it relieves the tertiary system of much of the burden of initial assessment which allows it to focus on the high-risk cases
- it builds trust in families that need support, with the option of referral where professionals judge there is a risk
- it provides assurance that 'you've done all you can' with a family before they get to the tertiary system. One stakeholder considered this would support permanent placements for those children that are removed as the family's ability to change or recover has already been tested.

- Further, one stakeholder considered that community-based intake was so successful that there should be *one pathway* into tertiary services — through universal or secondary services. This would allow *professionals* to assess risk and need and provide referrals to tertiary services where necessary. It would remove the ability for the community to 'call in the SWAT team' by direct reporting to child protection.

Integrated assessment and case management

Services involved with families generally conduct assessments of a family's needs, or risk and protective factors. Tertiary child protection services also have risk assessment processes. A number of stakeholders reported that a common assessment framework across services for children and families would have a range of benefits for clients accessing multiple services.

The UK Every Child Matters framework has introduced a common assessment framework with the following intended benefits:

- to give all practitioners working with children and young people a holistic tool for identifying a child's needs before they reach crisis point and a shared language for discussing and addressing them
- to ensure important needs are not overlooked and reduce the scale of assessments that some children and young people undergo
- to provide a common structure to record information and facilitate information sharing between practitioners
- to provide evidence to facilitate requests to involve other agencies, reducing unnecessary referrals and enabling specialist services to focus their resources where they are most needed (CWDC 2007, p. 1).

A common assessment framework would not replace current risk assessment tools used in tertiary systems, or devolve risks assessment to universal services. The UK framework clearly indicates that the Local Safeguarding Children's Board (LSCB) procedures should be followed when a child is at risk of harm.[2] It would, however, provide information to the child protection agencies about the needs of the child and families broader than immediate safety concerns. It would also need to be supplemented by additional targeted assessment tools in universal and targeted services. For example, a specialist assessment of educational needs may be required for children with special needs.

No Australian jurisdiction has yet introduced a common assessment framework for use across multiple services and subsystems. However, the Wood Inquiry recommends the use of a common assessment framework to identify and respond to the needs of children and families (Wood 2008). Several states and territories have developed assessment tools for use in a particular setting that seek to assess the child and family in a holistic way, including health, development, family and environment factors.

[2] There are no mandatory reporting laws in the UK however LSCB procedures document clear reporting processes.

Several stakeholders also noted that effective prevention efforts also require integrated case management. Vulnerable children and families generally access multiple services, or have multiple needs that require multidisciplinary service responses. These children and families would benefit from integrated case management to *reduce duplication* and ensure that services are *coordinated* so that they are easily accessible and delivered in a way that meets the client's needs. Moreover, the Wood Inquiry proposed that an integrated case management response to the *most* vulnerable families — identified as those who are frequently reported to child protection authorities — would ensure that resources are targeted to those most in need (Wood 2008).

Stakeholders reported the importance of allocating a 'lead member' responsible for coordination, with other services contributing as team members. In models that jurisdictions reported as best practice, the client could choose the lead member. Jurisdictions reported that they had implemented programs that provide integrated case management, although these programs were generally limited to a select client group, for example, pregnant women with substance abuse issues. Stakeholders noted that integrated case management requires time and resources, as well as positive working relationships based on mutual professional respect.

Chapter 8

System power and decision-making

8.1 Introduction

The power and decision-making structures and processes within a system influence systems operation but also reflect the status quo. Foster-Fishman et al. (2007) note that in human services systems, it is common for systems change efforts to challenge existing power structures that are based on 'top-down' models of decision-making and service delivery.

Analysing power in a system involves understanding influences — 'specifically who and what influences how resources are distributed, how actions are carried out, and how decisions are made' (Foster-Fishman et al. 2007). This chapter analyses system power and decision-making by considering the following sets of questions:

- What types of decisions are most critical to the functioning of the system and where does authority for these decisions lie? Where should it rest to achieve the change goal?
- How are other system members engaged in the decision-making processes? What engagement will be required for systems change?
- How does the systems change effort challenge the existing power and decision-making structures? What new structures will need to be developed?

8.2 Critical decision-making

The two critical areas of decision-making for system functioning are:

- planning policy — setting objectives and strategies, and designing programs and interventions
- allocating resources — funding and human resources.

Policy and resourcing decisions in systems for protecting children are made at two levels — by elected governments and ministers and by government departments.

We have noted previously that wicked problems require innovative solutions that span agency and organisational boundaries. Stakeholders reported that a collaborative model for protecting children will require *integrated governance arrangements* that bring together system members for critical decision-making, planning and implementation based on *shared responsibility*.

To facilitate cross-agency governance, jurisdictions have implemented a range of structures:

- several jurisdictions have overarching relevant strategic plans for children, or for early childhood
- all jurisdictions have some form of cross-agency governance arrangements for child welfare including inter-departmental committees and senior officers groups

- around half of jurisdictions have some form of integrated governance arrangements at the ministerial level through inter-ministerial committees and ministerial advisory committees (Bromfield and Holzer 2008).

Despite these arrangements, decisions largely continue to be made by individual departments and ministers in accordance with their respective responsibilities under the linear accountability arrangements of a Westminster system (discussed in Chapter 7).[3] Stakeholders consistently reported that governance arrangements are fragmented and result in fragmented service delivery. As noted in the *Every Child Matters* green paper in the UK:

> Our existing system for supporting children and young people who are beginning to experience difficulties is often poorly coordinated and accountability is unclear … Some children are assessed many times by different agencies and despite this get no services. Children may experience a range of professionals in their lives but little continuity and consistency of support. Organisations may disagree over who should pay for meeting a child's needs because their problems cut across organisational boundaries. Fragmentation locally is often driven by conflicting messages and competing priorities from central government.
>
> DfES 2003, pp. 21–22

The challenges to joined-up government working are various. Collaboration requires skills and capacity (see Chapter 6). In addition, funding and accountability arrangements, discussed in Chapter 7, encourage siloed responses and provide no incentives for collaboration.

In child protection, as with many other complex social policy issues, causal pathways are interlinked with many agencies having influence over a family's capacity to care for their children. Addressing wicked problems raises issues of jurisdiction and domain — who owns the problem of child abuse and neglect, and whose responsibility is it to 'fix it'?

Graycar (2006) sets out a common situation with such problems:

- An intervention or activity in Agency A helps Agency B's core business, but it is not the main game of Agency A. Furthermore, while expenditure is in Agency A's budget, the benefit accrues (later) to Agency B. For both these reasons, the activity is not necessarily prioritised by Agency A.
- The implication is that priority setting and policy development in Agency A can limit Agency B's achievement of its core business.

This situation can easily be applied to child protection and highlights why integrated governance is so difficult, but essential.

But how can integrated governance be developed? The UK Cabinet Office sets out a vision for removing unintended barriers and disincentives for joined-up working. The vision outlines five key areas to improve the planning and management of 'cross-cutting' polices and services described in Box 8.1.

[3] High level policy and funding decisions are also made at the whole of government level — through, for example, cabinet or budget committees — however these are largely in response to submissions or bids from individual departments.

Box 8.1

ACTIONS TO IMPROVE JOINED-UP WORKING

Five key areas to improve the planning and management of cross-cutting policies and services in a Whitehall system are:

- *stronger leadership* from ministers and senior civil servants to create a culture which values cross-cutting policies and services, with systems of reward and recognition that reinforce desired outcomes
- *improving policy formulation and implementation* to take better account of cross-cutting problems and issues, by giving more emphasis to the views of those outside central government who use and deliver services
- equipping civil servants with the *skills and capacity* needed to address cross-cutting problems and issues
- *using budgets flexibly* to promote cross-cutting working, including using more cross-cutting budgets and pooling of resources
- *using the centre* to lead the drive to more effective cross-cutting approaches wherever they are needed. The centre has a role to play in creating a strategic framework in which cross-cutting work can thrive, supporting departments and promoting cross-cutting action whilst intervening directly only as a last resort.

Source: UK Cabinet Office 2000.

These actions are consistent with the views of stakeholders consulted for this project and most have been discussed elsewhere in this report:

- a culture for collaboration is discussed in Chapter 5
- skills and capacity including leadership is discussed in Chapter 6
- funding and accountability is discussed in Chapter 7.

The remainder of this section focuses on two remaining aspects of building integrated governance arrangements — establishing a strategic framework, and structures for cross-agency planning and implementation.

Establishing a strategic framework

Integrated governance arrangements require a shared vision of desired outcomes for children, and common goals and strategic objectives. This would enhance 'buy-in' from all agencies and organisations and facilitate joint planning of policies, programs and services. A number of stakeholders suggested that integrated governance arrangements could be supported by a strategic framework for children's welfare, including shared outcomes and objectives. They also suggested that the downstream benefits of preventing child abuse in terms of long-term justice, employment and health outcomes should be 'sold' to those government agencies with responsibility in those areas. This would blur the boundaries of jurisdiction within government for child protection and help gain cross-government support for change.

In all the case studies in Part III of this report, *common outcomes or a shared vision* was articulated to build shared responsibility for protecting children. All case studies also had a strong focus on *clarifying and defining the roles and responsibilities* of system players to improve accountability for protecting children.

Both Victoria and the UK implemented a common outcomes framework for all children built around wellbeing, as part of their reforms. In both frameworks, 'safety' is one aspect of wellbeing but all workers have a responsibility within their respective roles to work towards all outcomes.

In the UK reforms, the common outcomes framework was considered 'a driver for professional unification around this agenda for change' (DCSF 2008, p. 3). However, as one stakeholder from Victoria noted in consultations, 'developing a wellness framework is a starting point. It might not drive change but it is a necessary precursor'. In Victoria, an outcomes focus allows government to connect to wide-ranging community expectations and to report back to the public on the success of the community's efforts as a whole and on the specific contribution of government activity (DHS 2006).

The UK, as well as several states and territories in Australia, have developed a Children's Plan. The UK Children's Plan establishes the strategic directions and sets targets for the government to achieve outcomes for children. It sets targets for the outcomes and identifies specific policies to reach these targets. To support this plan, each local authority is required to develop a Children's and Young People's Plan with the aims of:

- driving better local integration of children's services
- strengthening local partnership arrangements
- describing what improvements will be achieved in the local area, and when these improvements will be delivered.

Structures for cross-agency planning and implementation

In addition to a shared strategic framework, integrated governance arrangements need to include structures for planning and implementation. An increased focus on integrated service models for children and families such as 'one-stop-shop' child and family centres, or extended schools require more sophisticated governance arrangements. Stakeholders noted how critical cross-agency planning and policy development was to the success of these projects. Where all affected agencies were not involved in planning from the start, there was poor commitment from partners to the project, which could threaten the ability of the project to sustain momentum.

In addition, stakeholders reported that where cross-agency initiatives do get up and running, they are hard to sustain. The WA Commissioner for Children and Young People notes that:

> If several departments do embark on a collaborative project, and manage to obtain joint funding, these departments take shared responsibility for the project. Although this can be very positive, it can also dilute the 'ownership' of the project and mean that the project does not get the benefit of one department strongly leading it, prioritising it, defending it, and advocating for its expansion … Requiring that departments provide combined reports/updates on collaborative projects to Ministers might be a way of strengthening cross-government ownership issues.
>
> WA Commissioner for Children and Young People 2008, pp. 2–3

The UK reforms also may provide some possible structural models for integrated governance both in planning and implementation. In the UK, integrated governance arrangements are established in legislation with a 'duty to cooperate for key strategic partners'. Children's Trust arrangements require an integrated governing board representing all key partners at a senior level. These arrangements 'require sophisticated leadership of a high order to secure a genuinely joint outcome-focused vision, full engagement of all stakeholders and clear lines of accountability' (DSCF 2008, p. 19). Despite this requirement, recent guidance notes that most Children's Trusts do not yet reflect this vision of integrated governance and that it is a 'very challenging goal' (DSCF 2008, p. 19).

UK integrated governance arrangements also involve joint planning and joint commissioning of services with pooled resources between partners. These arrangements are based on the principle that no single agency can deliver any one of the aims within the outcomes framework or Children's Plan working in isolation. An overview of the joint commissioning arrangements for Children's Trusts is in Box 8.2.

Box 8.2

JOINT COMMISSIONING ARRANGEMENTS IN THE UK REFORMS

Joint commissioning is much more than contracting and procurement. The commissioning cycle for all strategic partners encompasses:

- a strategic needs assessment — engaging with children and families, understanding their needs and taking a sophisticated approach to the use of data
- planning and service design — identifying what services need to be put in place to promote preventive solutions, and how to develop holistic services which can address the totality of each child's needs
- deciding on how to deliver and with whom — identifying which organisations are well placed to deliver services and contracting, or putting services level agreements in place so that all parties are clear about deliverables
- reviewing and challenging the fitness for purpose of services and providers, and monitoring their impact on outcomes.

Commissioning and joint commissioning can operate at a variety of levels:

- strategic — this includes regional and subregional collaboration for specialist services and whole service commissioning by the Children's Trust for a local area
- locality — multi-agency teams operating in a locality, commissioning by school clusters etc.
- individual — lead professional commissioning and individualised budgets and packets of support.

Source: DCSF 2008, p. 17.

In addition to concerns about fragmented governance, several stakeholders also noted that *local* planning and decision-making was required for effective prevention efforts, rather than centralised planning structures. These stakeholders argued that location-specific solutions based on the resources available to each community deliver the best results. One example provided was that NGOs are not present in all rural areas so they would not be the best mechanism to deliver secondary prevention strategies. Instead, the local school may be the community hub in that particular community and be an appropriate platform from which to deliver enhanced prevention efforts.

8.3 Engagement with system members

The literature about tackling wicked problems suggests that top-down decision-making embedded within traditional bureaucratic structures is not adaptive and flexible enough to address the complexity of these issues. Wicked problems require innovative and adaptive approaches and one way to address this is to:

> blur the traditional distinction between policy development and program implementation ... Policy development and evolution needs to be informed with on-the-ground intelligence about operational issues and the views of service users or recipients, and be modified in light of what works and what doesn't.
>
> APSC 2007, p. 14

This requires engagement with service providers (both government and non-government) when planning and making policy.

A lack of engagement of NGOs in decision-making was discussed in Chapter 6 as a barrier to effective relationships between NGOs and government. NGOs play a critical part in providing services in the current systems and it is likely that if the system was reformed to a public health model, the role for NGOs would also increase. Substantive engagement with NGOs will be required to bring about this change, including *real* consultation in policy development with NGOs, who hold much of the operational 'know-how' about what works from a policy and implementation perspective. Service providers also have detailed knowledge about the views of service users.

Victoria's stakeholders consulted for this project reported that establishing a partnership with NGOs and regional offices of the Department of Human Services was critical to the change. They reiterated the need for a *real* partnership rather than 'tick the box' consultation. This partnership was characterised by:

- a shared commitment to the vision developed between NGO and government
- real input from the NGO sector (and the regional offices) into policy development — NGOs were critical in designing the community-based intake model
- program arrangements that were negotiated with, rather than imposed on, NGOs — brokered by an external facilitator in some cases.

Stakeholders reported that this partnership approach built a shared responsibility for child protection between NGOs and government. Developing the partnership took time and resources but was critical from the government's perspective to overcome the initial reservations and suspicion from the NGO sector, particularly about perceptions that risk was being 'transferred' to NGOs.

Effectively engaging NGOs may require new structures to be developed to formalise relationships and processes for gaining NGO input. These structures need to be meaningful and validated by leadership within governments who have responsibility for decision-making. For example, the Wood Inquiry recommends an improved structure for engagement between key human services agencies and NGOs that is accountable to the Human Services and Justice CEOs cluster (Wood 2008).

This report provides a broad analysis of service systems and the community; families and children are not defined as 'system members'. That said, many stakeholders noted the importance of engagement with these groups in planning and decision-making and the participation of children in particular is critical. The responsive regulation framework could be an important mechanism for engaging families at the community level for collective responsibility in protecting children. For further information on the responsive regulation framework see Harris and Wood (2008).

The Community Partnerships for Protecting Children (CPPC) initiative in the US and the Every Child Matters reforms in the UK involve governance structures that engage community members. For example, each Network Neighbourhood site under CPPC site has a decision-making board which utilises evaluation information to inform decisions regarding strategies, funding and staffing (CSSP 2008). Decision-making boards are comprised of a mix of professionals and community residents, who work together to make the best choices for their community.

Part III

Case studies

Chapter 9

Introduction to case studies

9.1 Introduction

Three case studies were selected for detailed analysis. Each of the chosen case studies used collaborative strategies and demonstrated a movement towards a preventive model for protecting children. The case studies include one from Australia (every child every chance and Child FIRST in Victoria), the UK (Every Child Matters) and the US (Community Partnerships for Protecting Children). It must be noted that caution needs to be exercised when considering transferability of findings from the case studies to the Australian context because of the wide variation of underlying child protection structures, laws and definitions around the world.

Before reviewing the case studies an evaluation matrix was developed. The matrix assisted us to examine the key systems and organisational features of each case study, and to identify innovative and effective elements, and the change that has occurred over time.

Each case study includes a brief introduction which discusses the background of the program and any evaluations that have been conducted on its effectiveness, then offers a detailed review of system features based on the evaluation matrix described in Table 9.1. They conclude with an analysis of key findings based on an Australian context.

Table 9.1

A MATRIX FOR EVALUATING CASE STUDIES

System feature	Information sought
Governance and collaboration	Are there shared goals, joint objectives and joint planning activities in place?
	Is there an overarching outcomes framework in place around children generally and protecting children specifically?
	What governance mechanisms are in place at the planning level e.g. steering committees, joint teams, taskforces, management committees, etc.?
	To what extent do planning and decision-making processes involve all stakeholders e.g. NGOs?
	What formal and informal mechanisms are in place for collaboration?
	What type of organisational relationships exist (formal and informal) between agencies?
	Are there formal (or informal) relationships between agencies and the families they serve?
Policy and legislative arrangements	Are there legislative arrangements in place that enhance a preventive approach?
	Have whole-of-government policies been developed that enhance a preventive approach?
Accountability and performance management	What accountabilities and incentives are in place for a preventive approach?
	Have shared outcomes, objectives and performance measures been developed to encourage a preventive approach?
	How is data managed to facilitate effective performance management?
	Is there a formal process for evaluation and feedback of results to improve performance?
Information sharing, referral and intake processes	How are families 'at-risk' identified?
	How are referral processes structured to allow clients to move between systems or service streams easily? How can families access assistance themselves?
	What case management or assessment processes are in place e.g. common assessment tools, joint case management etc.?
	How are processes designed for intake into the child protection system?
	What processes are in place for sharing client and service data?
Culture and capacity	How is risk managed or shared between systems/services/providers?
	How has organisational cultural change been managed, for example, building shared responsibility through joint training?
	How are roles and responsibilities defined and articulated?
	How is workforce capacity developed, e.g. training, recruitment?
	Are there case practice frameworks – do they include relationships with families?
Consultation and engagement	How is operational 'know-how' fed from the bottom-up into top-down policies?
	How are clients and users engaged?
	How are stakeholders, including workers and the community engaged in the system?
Funding arrangements	What funding arrangements are in place to facilitate more effective service delivery (e.g. pooled funding, flexible funding for service delivery, collaborative tendering, joint funding submissions etc.)?

Source: Allen Consulting Group.

Chapter 10

Every child every chance (Australia, Victoria)

10.1 Introduction

The Victorian Government's overarching vision which governs child wellbeing and protection is embodied within the *every child every chance* framework. Every child every chance is a child-centred approach to driving government policy and services for children and their families in Victoria (DEECD 2006).

The Victorian Government developed a *common outcomes framework* that represents current knowledge of how children and young people grow, thrive and succeed in the world. The framework identifies 35 key outcomes related to the safety, health, development, learning and wellbeing for all children and youth, and sets the stage for a coordinated approach across departments and agencies (DEECD 2006). To achieve the goals inherent in the 35 outcomes, the Victorian Government committed to focusing on actions that generate the maximum impact on the wellbeing of Victoria's children.

An outcomes-based approach is believed to be especially valuable when dealing with a wide range of activities at a whole-of-government level or across a large population group. An outcomes focus allows government to connect to wide-ranging community expectations and to report back to the public on the success of the community's efforts as a whole and on the specific contribution of government activity (DEECD 2006).

The new Victorian Integrated Family Services (IFS) framework described below embraces both the common outcomes framework and the shift from a tertiary focus for protecting children to one that includes a strengthened role for secondary and primary prevention.

Integrated Family Services framework

The IFS framework replaces the previous Family Services and Family Support Innovation Project (FSIP) activities, and includes the Child and Family Information, Referral and Support Teams (Child FIRST) (DHS 2008a). The IFS was developed out of recommendations stemming from the *Protecting children – the next steps* (July 2005) white paper and is given legislative force through the *Child Wellbeing and Safety Act 2005* and the *Children, Youth and Families Act 2005*. The IFS, which was implemented on 1 July 2007, provides a contemporary approach to responding to vulnerable and at-risk children and their families in Victoria. It is governed by legislation that prioritises children's best interests in all decision-making and service delivery activities (DHS 2008b). The aim of the IFS framework is to promote the safety, stability and development, and build the capacity and resilience of vulnerable children and young people (from birth to 18 years) and their families (DHS 2007).

The IFS framework targets vulnerable families where concerns have been raised about the safety, stability, development or overall wellbeing of children and young people. The *Children, Youth and Families Act 2005* (section 22) outlines the basis for an integrated service response that addresses risk and supports the changing needs of children, young people and their families. The IFS framework addresses child protection at the primary, secondary and tertiary service levels. Indeed, a regulated capacity within registered community-based services exists to:

- provide a readily accessible entry point for families into an integrated local child and family services network, which allows for early intervention
- receive referrals about vulnerable children and families
- undertake assessments of needs and risks in relation to children and families
- promote and facilitate integrated local service networks working collaboratively to coordinate services and supports to children and families
- provide ongoing services to support vulnerable children and families (DHS 2007).

IFS brings together Child FIRST, Family Services and FSIP across the state into one service model. It is delivered at the local government authority level and provides a comprehensive range of services which adhere to the 'best interests' principles outlined in the *Children, Youth and Families Act 2005*.[4] Services include:

- identification of pathways and key transition points that focus on earlier intervention, prevention and diversion
- a strengths-based approach and comprehensive needs and risk assessment
- capacity to provide intensive, multidisciplinary responses
- authorisation to consult with or make reports to Child Protection when a child is believed to be in need of protection (DHS 2008a).

The IFS brings together public and private child and family service providers to provide a comprehensive framework to address issues of child neglect, wellbeing and protection. The IFS operating principles are consistent with legislative directions which aim to ensure better outcomes are secured for children, young people and their families. These principles underpin the way that services work with families to secure better outcomes. Box 10.1 outlines the family services principles.

[4] The 'best interests' principles state that the best interests of the child must always be paramount.

Box 10.1

FAMILY SERVICES PRINCIPLES

1. Children's safety, stability and development is everybody's responsibility.
2. The service system will intervene earlier to protect children and young people and improve family functioning.
3. All services will strengthen their focus on children's developmental needs.
4. Services will focus on building the capacity of parents, carers and families.
5. Children's and Family Services will be integrated and coordinated.
6. Flexible, timely and solution focused services will be provided with the intention of improving family functioning.
7. Culturally competent service responses will be available for Aboriginal children and families.
8. Culturally sensitive responses will be available for children and families from culturally and linguistically diverse groups.
9. Family services will be outcomes focused in their service delivery and practice approaches.

Source: DHS 2007, pp. 24–27.

Evaluation of previous innovations program — Family Support Innovations Project

To date, no evaluations of the newly implemented IFS project have been undertaken. However, evaluations of the original innovations program – Family Support and Innovation Projects (FSIP), have been conducted. In this context, it is important to note that because the outcomes of FSIP were to secure longer term sustainable changes in the child protection system and better outcomes for children, initial evaluations only provide evidence which supports conclusions of indicative, rather than definitive, change. The research undertaken demonstrated that the Family Support Innovation Projects have contributed to a 0.5 per cent drop in substantiated abuse in Victoria between 2000 and 2006 (DHS 2008b). The prevention policies and programs of the original innovations program were also very successful in enabling access to earlier intervention services for families and children (Thomas 2007).

10.2 Review of system features

Governance and collaboration

The IFS fosters a collaborative approach to service implementation. It is underpinned by a framework that brings together service networks, casework and planning approaches and services. Through these collaborative working practices and a focus on early intervention, the Victorian Government has committed to improving the wellbeing of children. Collaborative working practices are further enhanced under the IFS framework through the existence of Child and Family Services Alliances, which include Family Services, Child FIRST, child protection, Department of Human Services staff and, where capacity exists, Aboriginal-controlled family services (DHS 2007). Representatives of Child FIRST, Family Services, Child Protection and the Aboriginal Family Service (where capacity permits) participate in delivery coordination with other universal/primary (such as early years, schools and school support staff, and health), secondary (such as mental health, alcohol and drug treatment, disability and Australian Government-funded family relationship centres) and tertiary services (such as out-of-home care, police, family violence, youth justice and housing) invited to participate as appropriate (DHS 2007).

Governance of the child and family services sector can be characterised by activities undertaken at three levels:

- state-wide — coordinated and led by the Office for Children (DHS), in conjunction with key advisory groups, sector stakeholders and peak bodies
- regional — coordinated by the Department of Human Services and community services organisations, and responsible for monitoring performance of services
- subregional catchment — Child and Family Services Alliances responsible for catchment planning, operational management and service coordination (DHS 2007).

However, child and family services, in partnership with the Department of Human Services, are best placed to determine the operating model in each catchment.

The *every child every chance* overarching outcomes framework is the principal mechanism through which government policy and service ideas have been shaped around children generally and protecting them specifically. The outcomes framework provides a common basis for setting goals and objectives across the whole government and identifies a number of key aspects deemed integral to the health, wellbeing, learning, development and safety of children and young people. Box 10.2 details the Outcomes for Children.

Box 10.2

OUTCOMES FOR CHILDREN

Child health: implies not just the absence of disease, but protection from damage or danger as a result of disease, whether physical or psychological.

Child development: implies opportunities needed for growth, maturation and greater complexity in behaviour and interactions with others.

Child learning: implies opportunities for interactions with others and discovery of the world, the acquisition of skills and understanding.

Child safety: implies protection from unreasonable risk of injury, accident, harm or exploitation, and that the people involved in the care of children do not increase these risks.

Child wellbeing: implies resilience, social confidence, secure cultural identity and protection from prolonged isolation, emotional trauma or exclusion.

Source: DEECD 2006, p. 11.

Policy and legislative arrangements

The IFS specifically addresses the need for earlier intervention and prevention, better integration of services delivered to vulnerable children and their families, and more flexible and intensive responses to better meet complex and chronic family needs. The *Children, Youth and Families Act 2005* provides a contemporary legislative base for the delivery of the IFS and child protection. The Act sits within the overarching framework provided by the *Child Wellbeing and Safety Act 2005.*

Formal partnership arrangements — described in the *Family and Placement Services Sector Development Plan* and the *Partnership Agreement: Department of Human Services and the health, housing and community sector* — have also been established to ensure that service providers work together to secure the best possible outcomes for at-risk children. The Partnership Agreement recognises the mutual reliance and importance of the strength of the relationship between the Department of Human Services and the independent service delivery organisations it funds to ensure the development and implementation of effective public policy to combat child neglect. It is intended to provide an overarching statement, which encompasses planning processes, program agreements, service and funding agreements, and review processes.

Accountability and performance management

The Victorian Government's vision, as espoused through *every child every chance*, was that every child is entitled to the best possible start in life. The child and family services related policy and legislation which governs the framework places children's best interests at the heart of all decision-making and service delivery. The strategic framework, IFS, focuses more specifically on vulnerable children, young people and families in the greatest need.

The IFS is underpinned by a culture of quality and continuous improvement. Indeed, the *Children, Youth and Families Act 2005* stipulates that family service providers must provide services in line with the best interests of the child, ensure services are accessible and known to the public, prioritise based on the needs of vulnerable children, young people and families, and participate collaboratively with local service networks.

The Act also provides for the establishment of performance standards (outlined in Box 10.3) and the monitoring of compliance against these standards to ensure service providers remain accountable and effective. Annual self assessments and external reviews help to aid in the improvement of services, and the subsequent development of action plans every three years, to be agreed on by the community services organisation and the department. If services are found not to meet the agreed standards, action may be taken. The quality assurance framework for children and family services also allows for a state-wide evaluation of the effectiveness of services to be conducted by the Office for Children. As IFS was only implemented in 2007, a comprehensive review is yet to be conducted.

Box 10.3

IFS STANDARDS

Standard 1: Leadership and management provides clarity of direction, ensures accountability and supports quality and responsive services for children, youth and their families.

Standard 2: Promoting a culture that values and respects children, youth and their families, caregivers, staff and volunteers.

Standard 3: Staff and carers have the capacity to support positive outcomes for children, youth and their families.

Standard 4: Creating a welcoming and accessible environment that promotes inclusion of children, youth and families.

Standard 5: Promoting the safety, stability and development of children and youth.

Standard 6: Strengthening the capacity of parents, carers and families to provide effective care.

Standard 7: Providing responsive services to support the best interests of children and youth.

Standard 8: Creating an integrated service response that supports the safety, stability and development of children and youth.

Source: *Children, Youth and Families Act 2005*.

Data is managed through the Client Relationship Information System for Service Providers (CRISSP) system (DHS 2007). This system was developed by DHS for the non-government community services sector. It provides an extensive range of functions for recording client information, assisting case management and enabling electronic reporting of data required by the department. CRISSP helps to eliminate geographical boundaries by enabling authorised service providers to share information on common clients.

Information sharing, referral and intake processes

The *Children, Youth and Families Act 2005* requires service providers to prioritise service provision based on need. The primary targets for service providers are vulnerable children, youth and their families. At-risk groups are likely to be characterised by:

- multiple risk factors and long-term chronic needs
- long-term involvement, or risk of long-term involvement, in specialist secondary services (for example, alcohol, drugs, mental health, family violence or homelessness services and child protection)

- cycles of disadvantage and poverty resulting in chronic neglect and cumulative harm
- single/definable risk factors that need an individualised, specialised response to ameliorate their circumstances
- single/definable risk factors that may need specialised one-off, short-term, or episodic assistance to prevent or minimise the escalation of risk (DHS 2008c).

IFS plays an integral role in promoting good outcomes for children, young people and their families. These services strengthen parents' capability to provide basic care and assist them in nurturing and supporting the development needs of their children. They also support parents by connecting them with their community and available resources.

A significant challenge for vulnerable families is knowing where and how to access family and child-related services. Data shows that approximately one third of referrals are self-referrals, with another five per cent being from family and friends. This indicates that approximately 60 per cent of referrals come from other sources such as welfare organisations and local government services (DHS 2007). Child protection accounts for around 12 per cent of referrals (DHS 2007).

Within the IFS framework, Child FIRST acts as the main point of entry for families into an integrated local service network and allows for early intervention in support of children (DHS 2008). It operates at the local catchment area level and enables families to have access to a broader range of services that will better meet their needs. Child FIRST has the primary objective of ensuring that vulnerable children, young people and their families are effectively linked into relevant services.

Service duration and intensity varies according to the individual needs of children, young people and families. The IFS service model includes short- and long-term interventions and episodic assistance. Service duration and intensity, and the individual needs of children, young people and families are determined through ongoing assessment conducted by service providers. More specifically, service providers undertake assessment of the needs and risk in relation to children and families to assist in the provision of services to them and in determining if a child is in need of protection. They link families to relevant family and child services, which provides clients with timely and effective referral pathways between all services.

A state-wide agreement exists between Child FIRST and child protection providers that requires Child FIRST to make a report to child protection services if it suspects that children or young people are experiencing abuse, neglect or harm. Under this agreement, Child FIRST providers must report to child protection if, after consideration of all available information, providers are more inclined toward a view that the concerns have a serious impact on the child's immediate safety or development or are persistent and entrenched and are likely to have a serious effect on the child's development (DHS 2007). Assessment must also take into account the effects of 'cumulative harm'. This means that practitioners should view neglect and abuse in an historical context, taking into account the experiences of all children in a family, rather than as discrete, unconnected episodes (DHS 2007).

The *Children, Youth and Families Act 2005* also allows community-based child and family services to receive referrals and take action where concerns about child development exist. The advantage of this system is that it creates an alternative pathway from child protection for the intake of vulnerable children, young people and their families.

Intervention modes and approaches vary according to parents' capabilities, capacity and skills. They may also depend on the existing parent-child relationship, child development and social connectedness. Box 10.4 lists the various modes intervention.

Box 10.4

MODES OF INTERVENTION

- Advocacy, information and advice
- Active engagement
- Practical support and/ or material aid
- Outreach
- Short-term service responses
- In-home support
- Family decision-making, family group conferencing
- Crisis intervention
- Group work
- Counselling
- Skills enhancement
- Parent-child interaction
- A youth focus
- Community connection and social inclusion
- Brokerage
- Access to universal services
- Cross-sectoral interventions
- Secondary consultations
- Ongoing support

Source: DHS 2005, p. 58.

A common assessment and practice framework, which will be utilised by all family services within the Children and Family Services Alliance, is also currently being developed (DHS 2007). The aim of this framework is to improve transition between services, and support coordinated and integrated service delivery. There are also plans underway to put in place the practice of ongoing assessment to ensure that support provision and interventions remain appropriate and that outcomes are achieved.

Under the *Children, Youth and Families Act 2005*, registered community and child services have the capacity to share information. The IFS is underpinned by collaborative working styles, particularly the ability of service providers to share information. Information sharing is integral to building coherent and effective services for children, young people and families. It enables better early intervention and prevention to secure good outcomes, especially for those children, young people and families determined to be at risk (DHS 2007).

Culture and capacity

The organisational culture of child and family services and protection in Victoria has undergone an organisational shift toward more integrated work practices. This represents a significant cultural change as, traditionally, services were plagued by dissonance.

The IFS framework comprises three policy instruments — Family Services, Family Support Innovation Project (FSIP), and the Child and Family Information, Referral and Support Teams (Child FIRST). The Victorian Government's *every child every chance* overarching vision for child protection and wellbeing, in conjunction with the *Children, Youth and Families Act 2005*, outlines the specific roles and responsibilities for each of the policy instruments.

Consultation and engagement

Users of IFS may access these services independently or be referred by a third party — usually welfare organisations or local government services. Independent engagement in services, particularly the referral service Child FIRST, is facilitated by ensuring that services are clearly visible and accessible to vulnerable children, young people and families. However, participation in primary and secondary level services is generally voluntary.

Funding arrangements

Funding for the IFS is provided by the DHS through collaborative (non-competitive) contracting. The method of allocation of funds is determined in accordance with the department's *Policy on Funding Relationships*, which considers the need for best value, partnerships and financial responsibility. No IFS funds are distributed through formal tender processes (DHS 2008e). The area responsible for IFS has produced a Policy and Funding Plan for 2006–09 (DHS 2008e). The plan supports the department's objective of being transparent, accountable and more openly communicative with its funded agencies and the community.

10.3 Conclusions

There are a number of lessons that can be learned from the newly implemented Integrated Family Services (IFS) program, some of which could be applied on a national scale throughout Australia. The Victorian government's overarching vision to enhance the wellbeing and protection of children is embodied within *every child every chance* policy and the common outcomes framework. This vision underpins the operation of the IFS and drives the whole-of-government agenda for improving the life chances of, and securing better outcomes for, children.

IFS also aims to promote the safety, stability and development of vulnerable children, young people and their families, and to build the capacity and resilience for children, families and communities. The strength of the IFS approach comes from the whole-of-government support for its outcomes and the collaborative working style shared between service providers. This is further enhanced by the presence of effective referral pathways between services and the proliferation and presence of these services within local communities. By limiting fragmentation and creating easy access to services, the IFS is making progress in addressing issues faced by at-risk families.

The emphasis on the continued evaluation and monitoring of services is also a feature of the program design that has been advantageous. From these evaluations, IFS will be able to continually develop and improve on its strengths while simultaneously addressing problem areas. Ongoing assessment processes will also be utilised to monitor the progress, development and achievements of children, young people and families engaged in services. The purpose of these assessments is to ensure that the needs of service users continue to be met.

Evaluations of the previous Innovations program reveal that is was largely effective in achieving its goal of reducing the need for families to be connected to child protection services and securing better outcomes for children. However, evaluations to assess the effectiveness of the newly implemented IFS program are not yet available, as the program has only been in place for just over 12 months. This, in essence, limits the perceived presence of problems with the system. However, a small-scale assessment of family workers has revealed that, in the future, there may be supply issues relating to staff on account of a decrease in job satisfaction. Reasons for this decrease in job satisfaction have been attributed to the complexity of cases, unmotivated and unwilling clients, tensions between working creatively and time restrictions, and remuneration that is often incommensurate with qualifications and levels of responsibility. In order to ensure that a staff shortage does not ensue, it may be prudent to consider the development of an enhanced child and family services workforce strategy.

The IFS framework is primarily focused on strengthening secondary services. While whole-of-government collaborative working processes support the IFS, the system is inherently flawed as it does not yet adequately engage with primary-level service providers — such as, but not limited to, schools, childcare services, GPs and maternal and child health services, although this remains on the future agenda. Engaging with these service providers may further enhance identification and early intervention with at-risk children and families, thus enabling children access to the best possible start in life.

Chapter 11

Every Child Matters (UK)

11.1 Introduction

The *Every Child Matters*[5] framework grew out of the need to strengthen preventive services and establish enhanced measures to support the wellbeing of children and young people from birth to age 19 in the United Kingdom. The *Children Act 2004* is the legislation supporting the vision of *Every Child Matters* (DCSF 2008a).

The Children's Plan has also contributed to achieving the aims of the *Every Child Matters* framework. The Children's Plan sets out the government's plan for the next ten years under each of the Department of Children, Schools and Families' strategic objectives. The objectives which aim to address child protection include:

- happy and healthy – secure the wellbeing and health of children and young people
- safe and sound – safeguard the young and vulnerable (DCSF 2007).

The *Every Child Matters* framework encompasses five common outcomes identified as key to ensuring the wellbeing of children during their early years and later in life, they include being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic wellbeing (DCSF 2008a). This evaluation will focus on the 'staying safe' outcome as it is the primary outcome to address issues of child protection.

The five common outcomes are universal ambitions for all children in the UK. They ultimately aim to improve outcomes for all children and essentially underpin the development and work within the *Every Child Matters* framework and its associated policy instruments. The outcomes are also mutually reinforcing. For example, strong educational outcomes are less likely to be exhibited by children who are not safe at home. Improving outcomes also involves narrowing the gap between disadvantaged children and their peers.

To ensure that local children's services reflect the needs of children and young people, local authorities and partners need to ensure there is a good level of participation of children and young people in the design and delivery of services.

The realisation of the ambition for improved child protection services in the UK required radical change of the whole system of children's services. The *Children Act 2004* gave power to local authorities and their relevant partners to pool budgets and other resources. Pooling resources and developing integrated services across local agencies is at the heart of the public sector reform.

In addressing child protection, *Every Child Matters* identified three key areas which utilise primary, secondary and tertiary prevention:

- local and national collaboration through the development of Children's Trusts
- provision of universal services through existing Sure Start Children's Centres

[5] In 2003, the UK Government published a green paper called 'Every Child Matters'. This was published alongside the formal response to the report into the death of Victoria Climbié, the young girl who was horrifically abused and tortured, and eventually killed by her great aunt and the man with whom they lived.

- interagency governance to be achieved through the development of Local Safeguarding Children Boards (LSCBs) (DCSF 2008b).

Local and national collaboration — Children's Trusts

Children's Trusts oversee the strategic coordination and overarching strategy for improving child protection by bringing together all services, both public and private, for children and young people in an area (DCSF 2008c). The *Children Act 2004* devolves strategic responsibility to local authorities to secure cooperation among local partners. This is cemented by the 'duty to cooperate' and implemented through Children's Trust arrangements. The 'duty to cooperate' primarily facilitates multi-agency cooperation in the planning and commissioning of child and family-centred services. The essential features of Children's Trusts arrangements, which address the 'staying safe' outcome, include:

- integrated front-line delivery — professionals working together around the needs of children, not constrained by organisational boundaries
- integrated common processes — better assessments, information sharing and improved referrals mean children get the services they need quickly
- integrated strategy — joint commissioning of services and pooling of budgets and resources to drive multi-agency working
- interagency governance — setting a clear framework for strategic planning, resource allocation, and accountabilities (DCSF 2008c).

Universal services — Sure Start Children's Centres

Sure Start was in operation in the UK prior to the introduction of the *Every Child Matters* framework. However, in recent years, Sure Start has come to support the universal access agenda of *Every Child Matters*. The principle goal of Sure Start is to enhance the life chances of young children growing up in disadvantaged neighbourhoods in the UK (Sure Start 2008a). Sure Start is a nationally integrated service delivery model. It brings together health, family support, employment, and early education and care services provided by government and non-government agencies for the benefit of families with young children (under the age of five). It grew out of the recognition that deprivation was limiting the life chances of young children and families, especially those in disadvantaged neighbourhoods.

Sure Start was initially established in 1997, and within two years the first Sure Start Local Programmes (SSLPs) were set up. SSLPs were unique in that they were area-based interventions targeted toward families with a youngest child aged less than four years living in designated areas of disadvantage. From 2004 onward, Sure Start was delivered through Children's Centres, many of which merged with Children's Trusts in 2006.

Children's Centres are service hubs where families with a youngest child aged less than five years can receive seamless integrated services and information. The UK Government has committed that by 2010 every community will be served by a Children's Centre (Sure Start 2008a). The move away from targeted to universal access models represented a fundamental shift in thinking about service delivery best practice.

While directly addressing issues around child protection is not a 'core' function of Children's Centres, they do support families that may be vulnerable or where maltreatment has occurred by providing information, services and choices.

In the initial stages of implementation, Children's Centres ran concurrent to, but within the broader framework of, Children's Trust arrangements. However, by 2006, many Children's Centres had merged with locally run Children's Trusts.

The service model for Children's Centres is highly flexible; there is no universal approach (NESS 2008). This is because local authorities hold strategic responsibility for the delivery of services to Children's Centres in their area. The government has also contracted with a partnership of public and private sector organisations, called *Together with Children,* to provide delivery support for local authorities (NESS 2008). While centres differ greatly, a commonality exists across all local areas in that centres offer child protection intervention services, under the umbrella of family support services, at two prevention levels — primary and secondary.

Each centre has extensive local autonomy over how to fulfil its mission. Services are tailored to local needs while simultaneously ensuring that core domains, stipulated by governments, are covered. Core domains include outreach and home visiting; support to parents and families; support for good quality play, learning and child care facilities; primary and community health care; and support for children with special needs. Reaching the most disadvantaged children and families is a strong focus of Children's Centres, however recent evaluations have shown that they are not yet meeting this goal and further work needs to be done to engage effectively with 'hard to reach' families (NESS 2008). The services that centres are required to deliver vary according to the level of disadvantage in the area. Centres in high needs areas are required to provide more comprehensive services than those in comparably affluent areas. All centres are required to provide outreach and home visiting services to the most excluded groups. Box 11.1 details the upper and lower levels of service provision that centres are required to provide.

Box 11.1

SERVICES PROVIDED BY SURE START CHILDREN'S CENTRES

Children's Centres in the most *disadvantaged areas* will offer the following services:

- good quality early learning combined with full day care provision for children (minimum 10 hours a day, five days a week, 48 weeks a year)
- good quality teacher input to lead the development of learning within the centre
- child and family health services, including ante-natal services
- parental outreach
- family support services
- a base for a childminder network
- support for children and parents with special needs
- links with Jobcentre Plus to support carers into training or employment.

In *more advantaged areas*, although local authorities maintain flexibility of choice, all Children's Centres will have to provide a minimum range of services, including:

- support and outreach services to families in need
- information and advice on a range of subjects: local childcare, looking after babies and young children, early learning services for three and four year olds, support to childminders, drop-in sessions and other centre activities for children and carers
- links to Jobcentre Plus services.

Source: Sure Start 2008b.

Evaluations of Sure Start

To date, two waves of a comprehensive longitudinal evaluation of the Sure Start model have been conducted — with results delivered in 2005 (NESS 2005) and 2008 (NESS 2008). These evaluations tracked the outcomes of the same cohort of children and their families across two waves of data.

The 2005 evaluation compared the outcomes for families of children aged nine months and three years living in SSLP areas with families in comparably disadvantaged communities — that is, families in areas designated to become SSLPs. The evaluation showed a high level of variation in the effectiveness of SSLPs. The overall findings showed a number of modest effects on some aspects of child and family functioning. SSLP families who experienced disadvantage to a lesser degree benefited somewhat from SSLPs. In contrast, the most disadvantaged families experienced some adverse effects from living in SSLP areas.

The 2008 evaluation revisited over 9000 of the nine-month-old cohort (and their families) from wave one — now three years old. A particular focus of this study was to investigate if the apparent effects on the sample of three year olds from the first wave re-emerged from the new group of three year olds who had been exposed to Sure Start for a full three years.[6]

Unlike the 2005 evaluation, comparison between children and families living in Sure Start areas and those in similar areas without access to Sure Start revealed a variety of beneficial effects associated with living in Sure Start areas, and almost no evidence of adverse program effects. For example, in measuring child and family functioning outcomes, it was shown that children in Sure Start areas yielded positive results in seven of the 14 outcome measures. Families in Sure Start areas also exhibited less negative parenting behaviours, better home learning environments and higher usage of support services. While these results are promising in terms of the children and families who accessed the service, a key finding of the 2008 evaluation was that the program is not reaching the most disadvantaged children and families and further work is needed to design effective outreach strategies for that group (NESS 2008).

Interagency governance — Local Safeguarding Children's Boards

The objective of Local Safeguarding Children's Boards (LSCBs) is to coordinate and ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children (DES 2007). The core membership of LSCBs includes local authorities, health bodies, the police and others. LSCBs have been in operation since April 2006.

[6] The third wave of evaluations is planned for when the continuing cohort of children aged five.

Statutory authority and responsibility for child safeguarding services are given to LSCBs through the *Children Act 2004*. They hold strategic responsibility for developing policies and procedures for safeguarding and promoting the welfare of children. However, results from a Priority Review of LSCBs undertaken between September and December 2006 revealed that the structures and arrangements some LSCBs have adopted suggest they are operating at an operational, rather than at a strategic, level (DES 2007). The review also found that LSCBs were at various stages of making the transition from child protection to the wider safeguarding agenda covering prevention and promotional activity (DES 2007). In spite of this, the review reported optimism about the potential of LSCBs to make a difference, especially as the dissemination of good practice continues to permeate the system.

LSCBs have authority over an array of policies and procedures including:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention
- training of persons who work with children or in services affecting the safety and welfare of children
- recruitment and supervision of persons who work with children
- investigation of allegations concerning persons who work with children
- safety and welfare of children who are privately fostered
- cooperation with neighbouring children's services authorities and their board partners (LSCB Regulations 2006).

Through their board members, LSCBs can draw on a range of accumulated wisdom. It is for this reason that they play a key role in the coordination and planning of services for children in areas of the authority.

LSCBs are champions for the need to safeguard and promote the welfare of children in areas of authority. They raise awareness of how this can best be done and encourage communities to employ best practice approaches. Following the implementation of strategies and practices to address and enhance the welfare of children by local authorities, LSCBs continue to be involved in a monitoring capacity. They evaluate and monitor the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children, and advise them on ways to improve. LSCBs also undertake reviews of serious cases and advise the authority and their board partners on lessons to be learned.

Funding arrangements and resources available to LSCBs vary substantially between and within regions. LSCBs are generally funded by their partners who either make payments directly or contribute to a fund out of which payments may be made (DES 2007). While having a vested interest in LSCBs is advantageous for partners, it has also proved problematic because perceptions regarding contribution size and direct proportionality to levels of influence have emerged.

11.2 Review of system features

Governance and collaboration

Governance arrangements vary between *Every Child Matters* program instruments. However, all are managed through partnerships that reflect local need and diversity, and represent all agencies involved in delivery, as well as the users of services themselves. The overall objective of the *Every Child Matters* framework is to ensure the wellbeing of children is enhanced and supported within local communities. Indeed, through local and national collaboration, the provision of universal services and interagency governance (delivered, respectively, through Children's Trusts, Children's Centres and LSCBs), *Every Child Matters* has developed a series of partnership arrangements to effectively support the protection of children.

Decision-making processes at the planning level differ across and within regions. However, the philosophical underpinnings of service delivery are generally centred on collaborative or holistic approaches, which incorporate interagency and inter-professional joined-up working and thinking. Across the different program instruments *Every Child Matters* decision-making arrangements may vary, but typically include:

- a partnership or management board taking decisions about what to offer — involving representatives from service providers, parents and the wider community
- parent forums or other bodies to represent their views
- a centre manager and their senior team, making day-to-day decisions (Sure Start 2008a).

Under the 'duty to cooperate', enshrined in the *Children Act 2004*, local councils and other local service providers are required to work together to ensure children are protected from harm and neglect. Local authorities and their partners must also engage private and voluntary service providers and the citizenry, as far as is practicable. This legislation represents a comprehensive and coherent settlement between central and local government, local partners and communities.

Policy and legislative arrangements

The *Children Act 2004* provides the legal underpinning for the transformation of children's services as set out in the *Every Child Matters* framework. It supports the government's commitment to improve the outcomes for all children, protect them from abuse and neglect, and reduce inequalities between them by ensuring early childhood services are integrated to maximise access and benefits to all families. The Act requires that local authorities and service providers work together to provide wraparound services to all families. It also stipulates that local authorities and their partners must endeavour to engage private and voluntary service providers and the citizenry in the planning and delivery of early childhood services, as far as is practicable. This approach aims to ensure that local needs are identified and that families have access to a range of support services, which effectively facilitate the prevention of child neglect within local communities.

The *Every Child Matters* framework was developed in response to the need to enhance preventive child protection services throughout the UK. It is based on a whole-of-government approach and is underpinned by four key themes:

- increasing the focus on supporting families and carers
- ensuring necessary intervention takes place before children reach crisis point and protecting children from falling through the net
- addressing the underlying problems identified within children's services —weak accountability and poor integration
- ensuring that the people working with children are valued, rewarded and trained (DCSF 2007).

Accountability and performance management

As part of their system review, the UK identified issues of fragmentation surrounding the provision of public services for children and families. Indeed, help for children often cut across various government departments, as well as across the specialisations and interests of different professional groups. The resulting overlaps and conflicts generally resulted in fragmented services that were less than optimal for helping children and families in need.

Through its program instruments — Children's Trust arrangements, Sure Start Children's Centres and LSCBs — the *Every Child Matters* framework aims to protect children from harm and neglect. Since their various implementations, the *Every Child Matters* program instruments have been assessed through evaluation surveys and reviews. The objectives of these evaluation surveys and reviews differ in terms of scale and scope, but they share a similar focus of managing and evaluating the performance of program instruments and related outcomes. Table 11.1 provides a summary of the various evaluation methods used to assess the performance of *Every Child Matters* program instruments.

Table 11.1

SUMMARY OF EVALUATION METHODS USED TO ASSESS PERFORMANCE OF *EVERY CHILD MATTERS* PROGRAM INSTRUMENTS

Program instrument	Year instrument introduced	Evaluation type	Year(s) of evaluation
Children's Trusts	2004	National evaluation	2004–06
Sure Start		National evaluations:	
Local programs	1997	– impact studies	
Children's Centres	2004	– domestic abuse	2005, 2007, 2008
		Local evaluations	2007
			various
Local Safeguarding Children Boards	2006 (April)	Priority review	2006 (September to December)

Source: Various evaluations.

Enhanced citizen (in particular parents and communities) and stakeholder engagement in governance and decision-making processes has also had the effect of improving the performance and operation of program instruments, particularly Children's Centres. The regular inclusion of these bodies in decision-making has facilitated the:

- identification of local needs, which may not be evident without direct approaches to local parents and children

- identification of existing high quality services that can be better utilised, and so avoid duplication
- encouragement of people to volunteer skills and interests that can help in the development and delivery of services (NESS 2008).

Information sharing, referral and intake processes

A key goal of the *Every Child Matters* framework has been to improve information collection, sharing and management as a way to further improve outcomes for children. The Children Act Information Database (England) Regulation 2007 provides the legislative basis and framework for the operation of the UK's national information sharing index, ContactPoint. This regulation places a requirement on local authorities to participate in the operation and maintenance of information contained in the index.

The purpose of ContactPoint is to support practitioners who are bound by the 'duty to cooperate' to improve wellbeing, and the duty to safeguard and promote the welfare of all children in the UK. ContactPoint is a basic online directory that practitioners can use to ascertain who is working with the same child or young person (DCSF 2008d). It aims to make it easier for practitioners to deliver coordinated services to children and young people and minimise unnecessary duplication. ContactPoint holds basic information for all children, up to their eighteenth birthday. It includes:

- identifying information — name, address, gender, date of birth and unique identifying number based on the existing Child Reference Number/National Insurance Number
- identifying information about the child's parent/carer — name and contact details
- contact details for services working with the child — as a minimum school and GP practice, but also other services where appropriate
- the means to indicate whether a practitioner is a lead professional and if they have undertaken an assessment under the Common Assessment Framework (DCSF 2008d).

However, it is important to note that the *Children Act 2004* and supporting regulations prohibit the inclusion of any case information on ContactPoint. As may be expected, there is controversy surrounding the *level* of information exchange involved in ContactPoint and the policy is currently under review (Scott 2008).

Assessing the needs of children at an early stage and deciding on what action to take is integral to achieving the 'staying safe' objective defined within the *Every Child Matters* framework. The Common Assessment Framework (CAF) is a standardised tool that practitioners use to conduct an assessment of children's needs and decide on how to best meet them (CWDC 2007b). With consent, information obtained from the CAF assessment will be shared between practitioners.

The CAF framework takes a holistic approach to assessing the additional needs of children that are not being met by the universal services they are already receiving. Assessment criteria are grouped into three key themes: the development of the child, parents and carers, and family and environmental factors. Box 11.2 gives a more comprehensive list of the CAF criteria.

Box 11.2

CAF ASSESSMENT CRITERIA

Development of child

- Health:
  - general health
  - physical development
  - speech, language and communications development
- Emotional and social development
- Behavioural development
- Identity, including self-esteem, self-image and social presentation
- Family and social relationships
- Self-care skills and independence
- Learning:
  - understanding, reasoning and problem solving
  - progress and achievement in learning
  - participation in learning, education and employment
  - aspirations

Parents and carers

- Basic care, ensuring safety and protection
- Emotional warmth and stability
  - guidance, boundaries and stimulation

Family and environmental

- Family history, functioning and wellbeing
- Wider family
- Housing, employment and financial considerations
- Social and community factors and resources, including education.

Source: CWDC 2007c.

A principal objective of the CAF is to ensure that the necessary intervention takes place before children reach crisis point and to protect children from falling through the net. It is designed to address the accountability and integration of services that support and protect children. It is hoped that the CAF will help to eliminate the complexities involved in working across geographical and organisational boundaries. However, the 2005–06 early evaluation of the Common Assessment Framework revealed a number of inaugural issues that are described in Box 11.3.

Box 11.3

EARLY EVALUATION OF THE COMMON ASSESSMENT FRAMEWORK

Methodology

Prior to the April 2006 national rollout of the CAF, experiences of professional perspectives in the twelve Common Assessment Framework pilot areas were canvassed. The aim of the evaluation was to identify factors which 'helped or hindered' implementation. The evaluation took place between September 2005 and March 2006 and was undertaken using a mix of qualitative and quantitative methods. However, it is important to note that only a limited volume of CAF work was available to evaluate.

Findings

While some positive impacts in the areas of multi-agency working and family responsiveness were identified, the evaluation of the CAF was largely negative. In the pilot stage, concerns were raised about the lack of government prescription and local guidance in process arrangements. Professionals cited that they felt overwhelmed, confused and unsupported, which lead to a lack of professional confidence. Employment of the CAF also tended to be incorrect, with it often being used as a referral mechanism rather than as an assessment linked to referral. Problems around the CAF's impact on the workload of individual practitioners were also common, with increasingly unmanageable workloads becoming a recurring theme. Further, evidence suggested that multiple assessments were being undertaken and that only a partial willingness to cease this practice was exhibited. As such, the overall proliferation of the CAF as the single authoritative assessment tool experienced only moderate success. (Brandon et al. 2006).

Source: Brandon, M, Howe, A, Dagley, V, Salter, C, Warren, C and Black, J 2006.

Through its various policy instruments, the *Every Child Matters* framework utilises three tiers of child protection and intervention services. Children's Trusts and Sure Start Children's Centres tackle child protection through primary and secondary level strategies, while LSCBs tend to utilise tertiary level intervention methods.

For example, primary level strategies in place in local areas include posters, leaflets and regular drop-in information sessions at the local housing office. Secondary support is, however, provided when at-risk families are identified or brought to the attention of centres. Problems with abuse or neglect are usually identified in ante-natal visits or centre booking sessions by midwives or by concerned friends or neighbours. The onus is on centres to follow up with those families to assess need and formulate a care plan, which needs to be updated every six weeks. Children's Centres and midwives often refer families to external agencies and locally available services that may be able to assist. While Children's Trusts and Children's Centres do not directly implement tertiary level services, they are responsible for referring families to the Social Services Department when a child is in danger. Tertiary intervention takes place through LSCBs. Indeed, LSCBs are directly responsible for intervening where there are concerns about a child's safety or welfare.

Wraparound servicing arrangements, facilitated through the 'duty to cooperate', exist to assist families move between system and service streams. Central and local governments have developed a number of cross-agency connections with the National Health Service, the crime and justice agency, other relevant departments and voluntary organisations to support the individual needs of families and children.

Culture and capacity

Achieving good outcomes for children requires practitioners responsible for assessment and service delivery to work collaboratively. For effective collaboration to ensue, organisations and people must be clear about the roles, responsibilities and purpose of each person or agency involved; the legislative basis for the work; protocols and procedures, including information sharing processes; and any time lines or statues of limitation that may exist.

The introduction of the *Every Child Matters* framework has been a catalyst for the reform of children's servicing arrangements in the UK. For the last decade or so, the provision of child protection services has been delivered through integrated universal servicing arrangements executed at the local level. However, this is a drastic paradigm shift. Prior to the introduction of collaborative and universal servicing arrangements, children's services were plagued by fragmentation and were generally targeted toward specific geographic areas.

The *Every Child Matters* framework promotes collaborative working practices. Practitioners are required to work with other local agencies in areas that have often been dominated by fragmentation of services between agencies. Because of the tendency of work to transcend organisational and professional boundaries, all staff working for or involved with Children's Trusts, Children's Centres or LSCBs are provided with a job description denoting their roles and responsibilities. This is all underpinned by written agreements. Professionals are expected to generate a sense of mutual respect between organisations and develop a clear, shared understanding of purpose between stakeholders. This is because collaboration is the key to the success of the *Every Child Matters* agenda.

Although training requirements vary according to the specific agencies and practitioners involved, all training associated with *Every Child Matters* program instruments focuses on safeguarding and promoting the welfare of children. Training also creates an ethos that:

- values working collaboratively
- respects diversity
- promotes equality
- is child-centred
- promotes the participation of children and families in the processes.

Individual children's service employers are responsible for ensuring that practitioners are confident and competent in carrying out their responsibilities and that they are appropriately trained to recognise and respond to child safeguarding and wellbeing concerns. Guidance for practitioners must include multi- and interagency training to enforce collaborative working practices.

Local authorities and their partners are responsible for ensuring that workplace strategies are developed in the local area. This includes ensuring that training opportunities meet the needs of the workforce and are identified and met by LSCBs. LSCBs are required to work within locally developed workforce strategies to mange the identification of training needs, use the information to inform the planning and commissioning of training, and check and evaluate single-agency and interagency training.

Consultation and engagement

Consultation is an important way of ensuring that local areas get what they need in terms of service provision. Consultation is a continuous process and can be used as a means to build the confidence of local parents, develop and share the skills of the local community, enhance the professional skills of local workers and build partnerships, especially with parents.

Every Child Matters program instruments endeavor to consult everyone who benefits or could benefit from services on offer and all those involved in delivering services to families. These stakeholders generally include parents and children, as well as local voluntary organisations and the private sector.

Children's services stakeholders are bound by a 'duty to cooperate'. This duty gains legal force under the *Children Act 2004* and effectively facilitates information sharing and collaborative working processes among stakeholders. However, there is no universal approach across program instruments to engage parents or the community. Nevertheless, the use of a variety of methods has helped to provide the widest response from parents. Some methods include:

- semi-structured interviews — carried out by workers or parents and based on a small number of key questions
- groups — conducted by a facilitator and carefully recorded
- maps of the area — on which parents mark their house and the services they use
- timelines — on which parents note the services that were helpful (or would have been if they had been available) at points before their child's birth and in the early years.

Funding arrangements

Within the *Every Child Matters* framework, agencies can either pool budgets through legal agreements, or align budgets by sharing information on their resources and spending. Children's Trusts, Children's Centres and LSCBs are primarily funded through local authorities that have strategic responsibility for collaborating with service delivery partners and the private and voluntary sectors to determine fund allocation. Funding contributions are also negotiated locally from service partners. Because resource management is devolved to local level actors, funds are able to be allocated to areas of priority and need which inevitably allows for more astute decision-making in terms of identifying necessary services for each local area.

11.3 Conclusions

There are a number of lessons that can be learned from the program design of *Every Child Matters* that may be easily transferable to enhancing systems for protecting children in the Australian climate.

The *Every Child Matters* framework is underpinned by a common outcomes strategy which directs all service activity. In terms of child protection, the 'staying safe' outcome is key. The strength of the *Every Child Matters* approach is in its design — it is an integrated wraparound servicing model that extends itself to all families within a local area. While objectives of service delivery are based on common principles — safeguarding children and their wellbeing — local flexibility is encouraged to respond to local needs. *Every Child Matters* focuses on early intervention to ensure the wellbeing and safeguarding of all children in the UK. The overarching principle of *Every Child Matters* — community control, exercised through local partnerships — has had the effect of increasing the base of services available to all eligible families while simultaneously limiting fragmentation of service delivery. Indeed, this integrated approach has gone a long way toward addressing problems of social exclusion and child protection.

Enhanced citizen (in particular parents and communities) and stakeholder engagement in governance and decision-making processes has also improved the performance and operation of the *Every Child Matters* program instruments. By continually auditing the needs of local communities and responding to demands, decisions about which services should be offered were able to be made from a more informed perspective. In a similar vein, the freedom afforded to local authorities, in terms of program design and service delivery, has meant that services have been tailored to address areas of priority and need within each community.

The emphasis on evaluation and monitoring of the *Every Child Matters* program and its instruments from implementation is also a feature of the program design that has been advantageous. From these evaluations, program managers and local authorities have been able to deduce that, overall, the *Every Child Matters* model and its associated instruments are having a positive effect on local communities and child protection outcomes although reaching the 'hard to reach' remains a challenge (NESS 2008).

While wrap-around servicing and the absence of concrete service provision models have proved to be beneficial to program participants, they have not been without their problems. Transcending organisational and professional boundaries has been problematic in that professionals from a wide range of sectors — each governed by different management and practice styles — have had to work collaboratively to secure better outcomes for families and children. In particular, some mainstream services, such as social services and GPs, have experienced greater challenges in working collaboratively with Children's Trusts, Children's Centres and LSCBs than other professionals (NESS 2007). However, the origins of challenges have differed. In some cases they have derived from differing professional cultures, such as the traditional autonomy and relatively high status of GPs. In other cases, legislation such as child protection responsibilities of social workers has worked against the development of shared priorities (NESS 2007).

Continuity of service provision has also presented problems due to the lack of consistency of services offered between local areas. While this is not the case for all services on offer — as there is a minimum standard of services that must be provided — programs with a particular focus (such as preventing child abuse and neglect) may be lacking from area to area. This may be problematic for families who move from one area to another.

The availability of services has also presented barriers to specific groups of people. For example, fathers have felt that Children's Centres were 'women's spaces' and have been hesitant to utilise available programs. Working parents were also excluded from services since most were offered during school hours. Minority groups and families where English was not their first language reported barriers such as a lack of interpreters and unease about a professional's capacity to respect their cultural and faith preferences regarding services on offer.

Chapter 12

Community Partnerships for Protecting Children (US)

12.1 Introduction

In 1995, the Edna McConnell Clark Foundation invested in a new vision as the first step on the path toward developing better supports for children and families at risk of harm or neglect in the United States (CSSP 2005). From this, Community Partnerships for Protecting Children (CPPC) emerged as a new community-based initiative aimed at drawing together several reform strategies from child welfare, child and family services and community-building fields to protect children from, or reduce the incidence of them experiencing, abuse or neglect within the family unit. CPPC uses a family-centred approach to child welfare that is supported by the coordination role exercised by community support organisations together with child protective services agencies. It began in four cities — St Louis, Missouri; Cedar Rapids, Iowa; Jacksonville, Florida; and Louisville, Kentucky — and has since expanded to include 50 partnerships across the country.

The transferability of findings from this case study need to be considered carefully given the significant differences between child protection laws, structures and definitions between US states and Australia (e.g. lack of universal early childhood education/care and health services, extensive mandatory reporting laws and strong policies related to parental termination rights in the US). Additionally, CPPC is a 'bottom up', privately funded initiative based on community partnerships and does not necessarily reflect a policy shift by government.

The desired outcomes for CPPC are three-fold and encompass goals for families, participating agencies and the community. Box 12.1 elaborates on the desired outcomes framework of CPPC.

Box 12.1

CPPC DESIRED OUTCOMES

For families:

- Child abuse and neglect are reduced
- Services and supports are more accessible to principle carers and their informal support system

For participating agencies:

- Families receive quality services
- Service capacity is adequate to meet needs
- Services are tailored to match each family's strengths and needs
- Collaboration increases and duplication decreases

For the community:

- Residents are aware of and understand the child maltreatment challenges in their community
- Residents have an active voice in decision-making about community resources and investments to keep children safe
- Residents seek help from their neighbours and local service agencies
- Residents provide assistance and support to their neighbours

Source: CSSP 2007.

The focus of this review is on the outcomes for children and families. However, it will also touch on those for participating agencies and the community, as all three outcomes are intrinsically linked in protecting children from harm. The framework described below embraces a shared vision framework. It also focuses on harnessing a greater role for secondary and primary level prevention which is strengthened by the capacity of child protective services to intervene at a tertiary level if necessitated by any particular case.

Overview of program

In 50 communities around the US, partnerships of public and private agencies, professionals and residents are working together to prevent abuse and neglect, and reduce the reoccurrence where harm has already occurred. Each CPPC site implements the community partnership approach that involves four key strategies, which operate symbiotically to protect and improve the outcomes of children:

- individualised practice
- neighbourhood network
- child protective services policy, practice and cultural change
- shared decision-making.

CPPC offers a range of support and advocacy services provided at the local level through Neighbourhood Networks. Neighbourhood Networks are the mechanism through which public and private partnerships are formed between child and family welfare support services. Through these networks, the CPPC initiative provides support at the primary and secondary prevention level. Services may also access tertiary level support through child protective services if circumstances necessitate.

CPPC review — pilot program evaluation

The Chapin Hall Centre for Children at the University of Chicago undertook two assessments of the CPPC initiative. The first (Phase I), conducted between 1996 and 2000, documented implementation levels and made recommendations on ways to clarify the intent of the initiative to improve performance and focus. The second evaluation (Phase II), conducted between 2000 and 2004, focused on two objectives:

- to assess the impacts of CPPC in relation to positive effects on child safety and wellbeing
- to identify positive aspects of the initiative that may contribute to its future successes and assist in strengthening child welfare reform and community capacity building efforts (Daro 2005).

For the purposes of summarising evaluation results, the report will only look at the outcomes of the Phase II report.

The Phase II evaluation assessed the impact of the initiative within four domains: child safety, parental capacity and access to support, child welfare agency and network efficiency, and community responsibility for child protection.

The results of the evaluation across the four pilot sites — St Louis, Cedar Rapids, Jacksonville and Louisville — did not demonstrate consistent impacts on subsequent maltreatment reports. Among cases that received the most direct intervention, through individualised course action (ICA), modest but significant improvements were observed, both in terms of self-perception of progress and parental depression and stress. However, these individual improvements were not directly proportional to decreases in the number of child maltreatment reports. Further, the frequency of reports was generally consistent with those families who had not experienced ICA intervention. Similarly, within each of the four pilot communities, trends in the number of child abuse reports, subsequent reports and placement rates did not suggest vast improvements in spite of CPPC activities. The evaluation also reported minimal evidence of increased collaboration and no evidence of improvements in the quality or availability of services.

In spite of the apparently dismal outcomes of the Phase II evaluation, it is important to note that the initiative has not been formally evaluated since its pilot program phase (1996–2000 and 2000–04). Since its pilot program era, the CPPC initiative has undergone extensive expansion (in terms of its scale, concepts and maturity) and has yet to benefit from independent evaluative data. Therefore, the findings should be considered in this regard.

12.2 Review of system features

Governance and collaboration

Creating opportunities for stakeholder engagement and input into decisions that affect them is at the heart of the CPPC initiative. The CPPC framework emphasises the importance of collaboration in addressing children's needs generally and protecting them, specifically. The overarching outcomes framework for this initiative stipulates that 'keeping children safe is everybody's responsibility'. This credo further establishes the importance of collaboration in fulfilling the shared goal of ensuring children are protected from harm and that, for those children who have experienced harm or neglect, instances of reoccurrence are mitigated.

The specific combinations of child protection issues prevalent within individual communities are often unique to that community. It is for this reason that the CPPC governance model is established at the local level and that each local area exercises a large degree of autonomy in making decisions about program and services arrangements. Indeed, the partnerships that are formed within communities to protect children and the ability of providers to build on local strengths to address local problems are the greatest strengths of the CPPC initiative (Barwinski 2005).

The aims of the CPPC initiative are realised through cross-agency collaboration with each other, families and children. Collaboration begins at the local level and is supported by Neighbourhood Networks. Neighbourhood Networks comprise a governing body consisting of child welfare, community, parent and public, private and civic service representatives (CSSP 2005). Each Neighbourhood Network site has one or more 'hub' or family resources centres where families can go to access services. Neighbourhood Networks bring together a wide range of child and family service providers — such as domestic violence services, substance abuse treatment, mental health services, emergency economic assistance and many others — that may be able to contribute to reducing harm and neglect through both formal and informal supports, services and resources. They aim to provide continuity and familiarity through a local access continuum of tailored support.

Further collaboration within Neighbourhood Network sites is facilitated through shared decision-making processes. Each site has a decision-making board which utilises evaluation information to inform decisions regarding strategies, funding and staffing (CSSP 2008). Decision-making boards are comprised of a mix of professionals and community residents, who work together to make the best choices for their community.

Policy and legislative arrangements

The CPPC initiative is not governed by legislative arrangements. Instead, it rests on a whole-of-community desire to address issues of abuse and neglect, and improve the way in which services operate to increase quality and availability.

Accountability and performance management

A core assumption of the CPPC initiative is that prevention efforts are a strong component of the community's response to child abuse and neglect (CSSP 2005). On account of the historic differences and separation between domestic violence advocates and child welfare services, the development of local networks of support and collaboration was viewed as necessary to enhance support to and secure better outcomes for children at risk of or experiencing neglect or harm (Rosewater, 2006). According to the Centre for the Study of Social Policy report *Lessons, Opportunities, and Challenges*, prior to the introduction of the CPPC initiative 'no one — whether legislators, administrators, social workers, community members, or families themselves — defend[ed] the status quo' (2005). CPPC practices and processes are underpinned by the overall outcomes framework for child protection in the US — keeping children safe is everyone's business.

Each Neighbourhood Network service hub site is required to undertake internal evaluations (quality service reviews or QSRs) to assess program and service functioning and effectiveness. The overarching framework for individual site evaluation is 'you shouldn't expect what you don't inspect' (Barwinski 2005). The value of QSRs is most significant in analyses of longitudinal data, which assesses and informs on performance over time.

QSRs utilise internal staff, trained as reviewers, to assess case records and interview all parties involved. A large number of reviews are conducted each year, with an average of 170 annually. This ongoing self-evaluation capacity allows strategies to have more immediate feedback owned by participants, rather than solely by external evaluators. This reflects a huge departure from tradition and an overwhelming willingness to effect stakeholder engagement.

Information sharing, referral and intake process

Prevention of neglect or harm is a core assumption of the CPPC. Neighbourhood Networks service hubs were charged with building an understanding of abuse and neglect at the local level and identifying families who needed help in a timely manner. Families at risk of neglect or harm were also identified to CPPC service hubs in a number of ways. They may be referred by day care centres, schools, churches, GPs, friends or family, or even attend services of their own volition. For more serious cases where families are already involved with child protective services, referrals may come from caseworkers.

Neighbourhood Networks bring a range of service providers together to collaboratively support families. These service hubs manage the service continuum for families experiencing, or at risk of, neglect or harm. Service hubs act as a one-stop-shop for integrated child and family welfare and support services. Support services do not only address issues of harm and neglect, they also address issues that may contribute to, or surface as a consequence of, this harm or neglect. Such services may address issues of mental health, depression, anxiety or parental practice. CPPC services families from prevention right through to intervention. It includes both primary and secondary prevention, as well as early intervention. However, prevention is a key focus of the continuum of services available to families.

A key factor to assist families to move from one service provider to another is inherent in the collaborative nature of CPPC. Because Neighbourhood Network service hubs bring together a range of service providers to assist families, transitions between services are able to follow clear assistance pathways. The practice of information sharing between professionals is also integral to this process. To aid in seamless transitions between services, it is necessary that providers have access to client information. Information sharing mainly took place at an informal level. However, guidelines outlining the importance of confidentiality and information sharing issues also exist to assist providers (Rosewater 2006).

Culture and capacity

CPPC brings together pre-existing supports with communities and has established new ones where circumstances have necessitated them. However, the overarching CPPC framework changed the way in which — traditionally fragmented and disengaged — community and government child and family service providers operated. Under CPPC, a culture of collaboration was established. New roles and responsibilities were envisioned for social workers, child protective services and community organisations, as well as new interactions between these organisations, other partners and families themselves (Barwinski 2005). Changes have been particularly pertinent within agencies that have statutory authority for child safety, permanency and wellbeing — generally child welfare (Rosewater 2006). These agencies have had to modify their work practices to incorporate new ways of partnering with and being open to participation of families and communities (Rosewater 2006).

Human capital effectively strengthened by the enhanced workforce capacity of CPPC staff has been integral to the success of the initiative. In bringing a variety of service providers together under the umbrella of Neighbourhood Network hubs, training supported by the mentoring, coaching and modelling of staff, together with the clear delineation of roles and responsibilities has assisted in the integration of work practices (Barwinski 2005).

In assisting families, individual courses of action (ICA) practices have been adopted. ICAs act as case practice frameworks to guide providers in tailoring services to the particular circumstances and needs of each family. ICAs engage five key elements:

- engaging the family
- assessing strengths and needs
- developing and implementing individualised response
- tracking progress over time and responding to new concerns
- sustaining change.

To ensure all agencies assisting a particular family are culpable, and that services are of the highest standard, all jurisdictions incorporate a quality service review of a sample case. The QSR is a powerful self-evaluation tool that enables agencies to work and support one another so that there are no gaps within the system.

Consultation and engagement

The community partnership approach to child protection in the US is underpinned by a paradigm shift in ownership so that everyone in a neighbourhood — residents, service users, and private and public child welfare service providers — believe that they have a role to play in keeping children safe.

Collaboration between providers within the Neighbourhood Network is the cornerstone on which stakeholder engagement rests. In each service hub area a partnership or council exists, with representation from public agencies and key stakeholders to facilitate decision-making processes. These partnerships work together to realise a common vision to reduce the incidence of child neglect and abuse. Similarly, shared decision-making arrangements exist to assist in the development of a protective action plan to effectively assist families. These arrangements come together in the form of Family Team Meetings. The meetings are designed so that families can work collaboratively with service providers to develop an action plan to achieve safety and stability within their lives and the lives of their children.

In a move that represents a drastic change in the way that child protection is facilitated, the CPPC initiative allows for the involvement of the perpetrator in the plan development process. The perpetrator is provided with their own case plan which heavily emphasises the need for behavioural change. It may involve referrals or requirements to participate in intervention programs and educational courses.

Neighbourhood Networks also engage with community members who may not be using services. The rationale for this engagement is that the more people there are who know about the services, the more likely they are to access them in times of need (Rosewater 2005). Networks also promote awareness about the inherent dangers of abuse and neglect so that residents can assist each other.

Funding arrangements

Existing national, state and local resources cover the majority of costs associated with Community Partnerships. However, the Clark Foundation's funding available to each local Community Partnership was instrumental in the development of new and improved practices and in providing sites with greater flexibility to respond to local needs through locally based solutions.

12.3 Conclusions

The CPPC approach rests on the notion that 'keeping children safe is everyone's business'. Indeed, this approach represents a significant shift in the way that services act to protect children. It aims to impart the view that child safety is everyone's business and that everyone in a neighbourhood has a role to play.

The strength of the CPPC approach is its collaborative focus of consulting local residents to ascertain the needs of families at a local level. As such, through Neighbourhood Network service hubs, families are able to access a broad range of services which have been specifically designed according to local needs. This approach has the effect of increasing the base of services available to all families in need, while simultaneously limiting fragmentation of service delivery. Indeed, this integrated approach has gone begun addressing the needs of families experiencing, or at risk of, abuse or neglect.

The emphasis on self-evaluation and monitoring of the CPPC program through QSRs, at provider level, is also a feature of the program design that has been advantageous. From these evaluations providers have been able to determine what is working and make improvements before problems become too deeply entrenched. However, the self-evaluation capacity of providers is limited. Indeed they often found it difficult to maintain adequate staffing and resources to execute evaluations.

Problems also existed with services being provided at the local level. The lack of universal servicing arrangements meant that if families move from one geographical location to another, they may not be able to continue to access the services they need.

While the initiative denotes prevention as its main goal, the social and economic advantages that may be gained from early intervention seem to have been overlooked. A significant problem with the current approach is that it often begins to assist families once the harm or abuse has already occurred.

The collaborative approach is instrumental to the functioning of the initiative. However, the CPPC initiative's engagement with secondary service providers such as schools, and mental and maternal health services is limited. Furthermore, the fact that CPPC is not underpinned by legislation may also be problematic as there is no legal requirement for service providers to engage with one another. At present, the collaborative approach is merely facilitated by the goodwill of providers.

Finally, while the principles of practice embodied within the CPPC initiative yield the potential for better servicing arrangements, the Phase II evaluation indicated that the results were not actually transferred to the communities in which CPPC was operating.

Part IV

Conclusion

Chapter 13

Setting the stage for systems change

13.1 Introduction

Part II and Part III of this report have provided a significant amount of information about the Australian systems for protecting children, and case studies of systems change. But what conclusions can we draw from this analysis?

This chapter provides a brief overview of the project objectives, change goal and conceptual framework. It then describes key elements required to achieve the desired change goal. In addition, this chapter provides a synopsis of the key system issues identified through the project that are levers for change.

Project objectives

In drawing the conclusions it is important that they link back to the project objectives and reflect the conceptual framework from Part I. As noted in Chapter 1, this report has two key objectives:

- to describe the current service systems for protecting children across Australia in terms of primary, secondary and tertiary prevention — addressed in Appendix C of this report
- to identify the organisational strategies and processes that could lead to more effective approaches to prevent child abuse and neglect — addressed in Parts II and III of this report through the systems analysis and the case studies of systems change.

Sources of information for the report

The information in this report is based on a literature review, consultations with stakeholders and analysis of relevant case studies (Box 13.1).

Box 13.1

INFORMATION SOURCES

Literature Review — the literature review for the project involved querying the literature to better understand:

- ways in which systems for protecting children are arranged in selected other countries in systems and organisational terms and the ways in which they collaborate in order to reduce the incidence and prevalence of child abuse and neglect
- ways that shifts towards prevention strategies have been, or can be, managed within systems, in order to reduce the need for tertiary service interventions and associated ever-expanding costs.

Three case studies were selected for detailed analysis. Each of the chosen case studies used collaborative strategies and demonstrated a movement towards a preventive model for protecting children. Case studies included in the analysis were:

- every child every chance and Child FIRST in Victoria
- Every Child Matters/Sure Start in the UK
- Community Partnerships for Protecting Children in the US.

In addition, relevant academic literature was reviewed and included in the systems analysis.

Consultations — discussions with strategic stakeholders were centred around *how* to shift from a tertiary dominated model for protecting children to a model that incorporates primary and secondary prevention.

13.2 A systems change model

This project took a *systems-based approach* to child protection by examining the ways that systems and organisations can collaborate to deliver the best outcomes for children. The report does not attempt to answer the question 'how do we prevent child abuse?' in terms of evidence-based interventions or policy directions. Instead it focuses on describing *how* to move to a collaborative *system,* which uses a public health model of primary, secondary and tertiary prevention to ultimately assist in reducing the incidence of child abuse and neglect in Australia.

The change goal — the public health model

Simply stated, the desired change goal is the development of a system for protecting children that prevents child abuse and neglect based on the public health model. The public health model provides a conceptual model which, if realised, would shift child protection systems to a more preventive and collaborative model by accessing three levels of prevention: primary, secondary *and* tertiary.

Under a public health model, child protection interventions that aim to prevent the occurrence or re-occurrence of child abuse and neglect are classified into three levels (Holzer 2007).

- *Primary (or universal) interventions* are strategies that target whole communities or all families in order to build public resources and attend to the social factors that contribute to child maltreatment.
- *Secondary or targeted interventions* target vulnerable families or children/young people who are at risk for child maltreatment — that is, those with special needs or who are in need of greater support.

- *Tertiary interventions* target families in which child maltreatment has already occurred. Tertiary interventions seek to reduce the long-term implications of maltreatment and to prevent maltreatment recurring. They include statutory care and protection services.

Child protection — a wicked problem

Chapter 2 outlines the definition of 'wicked problems' and argues that child protection fits the typology of high complexity and diversity making it a 'very wicked problem'. Wicked problems share a range of characteristics — they go beyond the capacity of any one organisation to understand and respond to, and there is often disagreement about the causes of the problems and the best way to tackle them.

Defining child protection as a wicked problem provides a methodology to address the issue by using approaches that are appropriate for these highly complex problems — collaborative approaches. The report argues that current approaches in child protection are largely authoritative, rather than collaborative and that systems change is required to overcome barriers to collaboration.

The report acknowledges that *systems change* to advance collaborative strategies will not alone solve this wicked problem. New and systematic ways of thinking about the problem to identify solutions and drive *policy change* and the development of evidence-based programs and interventions is also required. While these issues are beyond the scope of this project, our approach argues that collaboration will enhance the policy-making process.

Conceptual framework

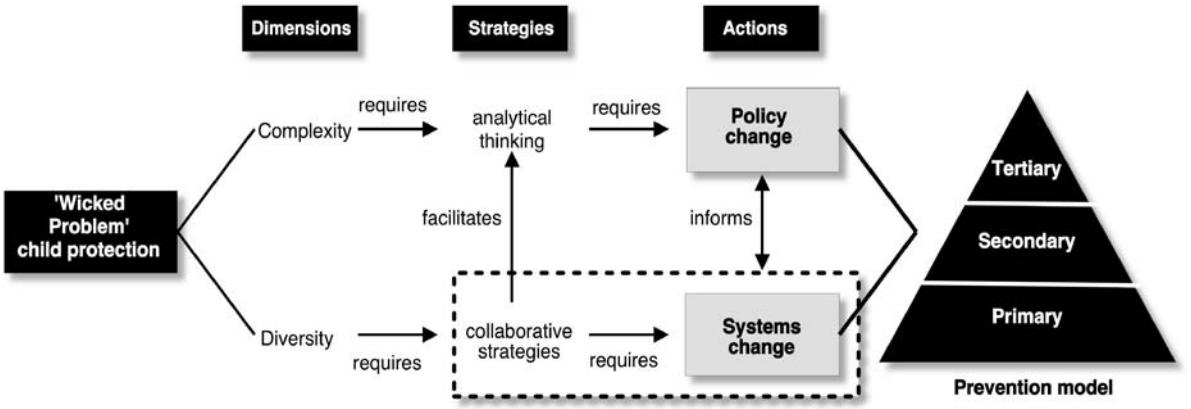
In the conceptual framework for this project, child protection is characterised as a 'wicked problem' as described above. There are two dimensions to wicked problems — complexity and diversity — which require different strategies:

- responding to the *diversity* dimension of wicked problems — the number and range of stakeholders involved — requires collaborative approaches and systems change (the focus of this report)
- responding to the *complexity* of wicked problems requires analytical thinking and policy change.

Clearly, the policy change and systems change are interlinked as the system will need to reflect the policy, and the policy will need to reflect the system realities and constraints. A diagram representing the conceptual framework for this project is in Figure 13.2.

Figure 13.2

CONCEPTUAL FRAMEWORK



Source: Allen Consulting Group.

Our conceptual framework also assumes agreement that the best way to protect children is to prevent child abuse and neglect from occurring in the first place — the public health model is our change goal. However, there may be a range of policy options for achieving this goal. The case studies of systems change all reflect the same goal — to prevent child abuse and neglect and intervene earlier with at-risk families.

However, the three case studies present three quite different structural models for bringing about this change, which reflects different policy responses to the problem (see Box 13.1 for a summary). In essence, there is no one clear model for reaching the change goal.

Box 13.1

SUMMARY OF STRUCTURAL MODELS IN THE CASE STUDIES

The Integrated Family Services (IFS) reforms

The IFS reforms in Victoria involved significant investment in the family support system *enhancing secondary prevention* activities. It is characterised by a community-based intake model that creates a dual pathway and seeks to divert vulnerable families from the tertiary child protection system. Community-based intake is managed through local Child and Family Information, Referral and Support Teams (Child FIRST) who link families with services in local areas.

Every Child Matters

The Every Child Matters framework focused on creating wraparound services for children with integrated planning and front line delivery of services providing *primary and secondary prevention* through Children's Trusts. The Sure Start model supplements Children's Trusts and provides *enhanced and integrated universal services* for children, based on the Children's Centre model. Local Safeguarding Children's Boards were also established to ensure that all agencies were acting upon their responsibilities in safeguarding children.

Community Partnerships for Protecting Children (CPPC)

The CPPC model focuses on enhancing secondary prevention of child abuse and neglect through integrated Neighbourhood Network service hubs of child and family welfare and support services. CPPC targets families experiencing, or at risk of, child abuse and neglect. It has a strong focus on building community responsibility for protecting children.

Despite these differences in policy design, the system reform in all three case studies reflects a collaborative approach. This indicates that regardless of the policy approach adopted, collaboration is required to build shared understanding and responsibility among the diverse stakeholders involved in protecting children.

13.3 Key elements of a collaborative model

The current systems for caring for and protecting children in Australia are complex. Covering primary, secondary and tertiary prevention, Australian Government, state, territory and local government, and non-government organisations are all involved in planning, funding and delivering services (Holzer, 2007). The current systems are also heavily focused on statutory responses through tertiary child protection services, which, although necessary, simply do not address the problems early enough to protect children from abuse and neglect.

Some critical changes are required to enhance systems for protecting children in Australia. These changes need to centre on shifting the focus to prevention and early intervention. This will require increased coordination and collaboration across the range of primary, secondary and tertiary services that aim to prevent the occurrence or re-occurrence of child abuse and neglect (Allen Consulting Group 2003). Additionally, strategies for preventing child abuse and neglect need to be multi-faceted and span a variety of systems across organisational, jurisdictional and government and non-government lines. Sustainable change can only be achieved if there is long-term collaboration and coordinated delivery of services across all organisations and systems that effect children and youth.

The recent Report of the Special Commission of Inquiry into Child Protection Services in NSW (Wood 2008) supports the premise of shifting child protection to a prevention approach that uses a range of services to achieve that goal. The report states:

> child protection systems should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion. They should be delivered by a mixture of the non-government sector and state agencies, with DoCS being a provider of last resort.
>
> Wood 2008, p. v

This project has identified a number of key elements required to move the system to a more preventive focus. These key elements include:

- articulation of a shared vision
- building a supportive culture
- integrated governance arrangements
- legislative support.

These elements are not necessarily sequential, although several stakeholders suggested that a strategic framework is a necessary precursor to change. The elements also interact and overlap — for example, culture is influenced by, and influences, the effectiveness of integrated governance arrangements. Each of these elements is described below.

Articulation of a shared vision

A shared vision provides a platform for building shared responsibility and accountability for protecting children. A shared vision would enhance collaboration and coordination between organisations and sectors. It would do this by facilitating integrated governance for joint planning of policies, programs and services among and between government agencies, NGOs and others who have responsibility for providing services and supports to children and families.

Articulating a shared vision should include identifying desired outcomes for children and families, common goals and strategic objectives for the 'whole' system. An outcomes-based approach provides the opportunity to redefine goals and objectives in terms of actual improvement in children's lives (for example, improved life chances for all children, families getting the right help at the right time) as opposed to measurement of system processes and outputs. Several key stakeholders strongly supported outcomes-focused performance measurement as an essential component of an effective system for protecting children. They pointed out that many child protection 'reforms' around Australia have focused solely on processes and outputs with virtually no mention of outcomes for children and families. Several jurisdictions have already developed or are in the process of developing a shared vision, or common outcomes for children and families in their jurisdiction.

This review found that in all case studies of systems change *common outcomes or a shared vision* were articulated to build shared responsibility for protecting children. In addition, all case studies also had a strong focus on *clarifying and defining the roles and responsibilities* of system players to improve accountability for protecting children.

Both Victoria and the UK implemented a common outcomes framework for all children built around wellbeing as part of their reforms. In both frameworks, 'safety' is one aspect of wellbeing but all workers have a responsibility within their respective roles to work towards all outcomes. In the UK reforms, the common outcomes framework was considered 'a driver for professional unification around this agenda for change' (DCSF 2008, p .3). However, as one stakeholder from Victoria noted in consultations, 'developing a wellness framework is a starting point. It might not drive change but it is a necessary precursor'.

Some jurisdictions have taken the common vision, outcomes, goals and objective one step further by developing comprehensive, whole-of-government children's plans that include child safety as an integral component. In the UK the Children's Plan has contributed to achieving the aims of the *Every Child Matters* framework and has set out the government's plan for the next ten years under each strategic objective of the Department of Children, Schools and Families.

Building a supportive culture

A preventive model for protecting children requires a supportive culture. This is a culture that is embodied by:

- collaboration between organisations and services
- mutual respect and trust between professional groups and providers
- shared responsibility for vulnerable families and children rather than risk aversion
- focus on the needs of the child and working with, rather than on, families.

The findings from Chapter 5 of this project indicate that, in order achieve the change goal, significant cultural change would need to occur within organisations. The concept of shared responsibility for protecting children needs to be translated into action through this cultural change. This requires consideration of which system players are best placed to deliver strategies — some systems players will need to 'step up' whilst others may need to 'let go' and transfer responsibility. Changing the inherent culture within and between organisations is not an easy task and its difficulty should not be underestimated. It will take time, perseverance, and readiness on the part of the organisational members.

Stakeholders reported a number of mechanisms that were effective in building a collaborative culture between agencies and services. These are:

- liaison officers who are embedded in another agency and can reflect the values, practices, concerns and ideas of their home agency
- joint training between professionals
- training from child protection agencies to other professional groups that work with children and families to showcase their role and practices
- common assessment frameworks and integrated case management
- co-location and integrated services, such as wraparound child and family centres which bring together a number of key services (including child protection officers in some cases).

In addition, building shared responsibility and overcoming a culture of risk aversion will require the development of shared responsibility for protecting children using integrated governance arrangements (discussed below). The media and political response to child protection crises also plays a significant role in shaping culture and strong leadership can assist in providing responses that support the change goal, rather than erode it.

The case studies (the UK and CPPC reforms in particular) demonstrate the critical importance of cultural change as a driver of wider systems change and in improving prevention and early intervention efforts. In the UK, Children's Trust arrangements were established in 2005 with the specific goal of integrating all services for children in order to overcome fragmentation of responsibilities that was associated with failing child protection systems. In particular, Children's Trusts set out to better integrate universal and specialist services for children with recognition that the key challenge for systems change in the UK reforms was building a culture for shared responsibility for children's outcomes (including safety):

> The Children's Trust should be at the centre of a cultural shift which unites all people working with children and young people around a common purpose, language and identity, while keeping the strong and distinctive professional ethos of different practitioners. It should enhance inter-professional trust and greater willingness to work outside traditional service areas and share information.
>
> DCFS 2008, p. 14

However despite introducing significant structural change, statutory guidance for Children's Trusts released in 2008 notes that:

> Real progress had been made in implementing the structural and systemic changes needed to drive improved outcomes. This has been variable across the country, however, and the cultural changes needed to drive these changes through to demonstrable improvements in outcomes have yet to be sufficiently embedded.
>
> DCFS 2008, p. 4

This recognises how challenging cultural change is in efforts to integrate services for children across government agencies, professional groups and sectors. It also illustrates that systemic and structural changes do not translate into improved outcomes for children without cultural change.

Integrated governance

Establishing integrated governance structures to provide oversight of a comprehensive system for protecting children is an important step in moving towards the change goal. Integrated governance is described as:

> the structure of formal and informal relations to manage affairs through collaborative (joined-up) approaches, which may be between government agencies, or across levels of government (local, state and national) and/or the non-government sector.
>
> IPAA 2002

Integrated governance arrangements permit, support and facilitate cooperation and collaboration among different agencies. The concept of integrated governance incorporates an element of 'mutuality', as opposed to individual action. This is mutuality in terms of consultation as well as shared responsibility and accountability for policy and program development, planning, implementation and evaluation.

Integrated governance is supported by structures and processes that encourage collaboration. The structures and relationships that are appropriate in a particular case should be determined by what is necessary to achieve the agreed shared vision, outcomes and objectives, taking into account the specific local conditions. That said, there are some elements that are consistently reported by stakeholders and in the literature as critical to integrated governance arrangements. These are:

- leadership
- funding and accountability arrangements.

Integrated governance arrangements are a feature of all case studies, although the structures vary in different models. In Victoria, regional child and family services alliances bring together a range of providers of secondary prevention with the child protection agency for planning and implementation. In addition, the Victorian model is characterised by partnerships between government and the non-government sector. The UK framework has wide-ranging integrated governance arrangements that bring together the key providers of services to children within a local area for planning and commissioning, and require local engagement with community and families. A distinctive feature of the UK model is that there is legislation that *requires* certain players to collaborate.

Funding and accountability arrangements

The establishment of new funding arrangements are crucial to attaining the change goal within a collaborative strategy. Current processes for allocating funding both within government and with service providers are counterproductive to the change goal. Traditional vertical accountabilities in government 'ring-fence' funding to create silos, which provide no incentives (and some disincentives) for collaborative prevention efforts. At the service level, single input categorical funding of services and contracting processes that require service providers to compete also undermine collaboration.

The case studies provide some possible models to overcome these barriers:

- Children's Trust arrangements in the UK require joint planning and commissioning of services at the local level with budgets to be shared by agencies in accordance with shared service plans
- Victoria introduced collaborative contracting for service providers, a model which was strongly supported by stakeholders in many jurisdictions.

In addition, stakeholders and the literature strongly supported government accountability and funding processes that prioritise and reward collaboration and cross-agency efforts.

Leadership

Strong leadership is an essential component of any significant organisational change process and is certainly essential to achieving the change goal set forth for protecting children. While it can be easier to focus on leadership and integrated relationships at the local level this is not adequate for *real* systems change. Each level of relationship integration is hindered if there is a lack of leadership and integration above it. Therefore, leadership and commitment at the top of the organisations are critical to successful integration and collaboration, with formal structures for ongoing dialogue in place to clear the barriers embedded into the process (IPAA 2002). The Management Advisory Committee report *Connecting Government* also recognises the importance of the leadership role in building the culture and capability for whole-of-government working (APSC 2007).

Children's Trust arrangements in the UK require an integrated governing board representing all key partners at a senior level. These arrangements 'require sophisticated leadership of a high order to secure a genuinely joint outcome-focused vision, full engagement of all stakeholders and clear lines of accountability' (DSCF 2008, p. 19). Despite this requirement, recent guidance notes that most Children's Trusts do not yet reflect this vision of integrated governance and that it is a 'very challenging goal' (DSCF 2008).

While challenges exist in establishing strong leadership roles within an integrated structure, the fact remains that strong leadership is essential if the change goal is to be achieved. The Wood Inquiry supports this strategy and offers two specific recommendations related to leadership in an integrated environment. The two recommendations pertain to high level organisational leaders (human service and justice agency CEOs and DoCS Director General, Deputies and Regional Directors) having a requirement in their performance agreement that obliges them to 'ensure interagency collaboration in child protection matters and providing for measurement of that performance'.

Legislative support

Legislative support *may* be required to give effect to collaborative relationships among the relevant government and non-government agencies. In consultation, there were differing views on whether legislation would help or hinder the establishment of collaborative relationships for protecting children. Victorian stakeholders reported that legislation was key to implementing their Child FIRST reforms. The *Children, Youth and Families Act 2005* incorporates child protection and community services for children into one Act and embeds the role of secondary family support services in legislation. Victorian stakeholders reported that this provided assurances to the NGO sector of their role in protecting children. It also delivered a unifying legislative framework for protecting children that went beyond the tertiary system.

In the UK, legislative support provided the legal underpinning for the transformation of children's services and was seen as an essential element of the change process. The *Children Act 2004* requires that local authorities and service providers work together to provide wraparound services to all families. It also stipulates that local authorities and their partners must endeavour to engage private and voluntary service providers and the citizenry in the planning and delivery of early childhood services, as far as is practicable. This approach aims to ensure that local needs are identified and that families have access to a range of support services, which effectively facilitate the prevention of child neglect within local communities.

13.4 Levers for change based on the system analysis

The elements of a collaborative model discussed above are relevant to any model for protecting children. This section provides insight into the current systems for protecting children *in Australia specifically* to guide decision-makers when considering the system reforms proposed above. Table 13.1 identifies levers for change from the system analysis in Part II. Levers for change are either system characteristics that support the change goals — and therefore should be enhanced — or characteristics that do not support the change goals and need to be changed if system reform is to be successful.

The levers in the table below reflect the full list of barriers and enablers that stakeholders reported to this project. As such, not all levers apply to all jurisdictions, although the themes were highly consistent. The table also only includes levers for change at a *whole of system level*. Practices, policies and paradigms at the subsystem level would also need to shift to support a collaborative prevention model — for example, risk assessment processes. A detailed discussion of the levers in Table 13.1 is included in Part II of the report.

Table 13.1

LEVERS FOR CHANGE

System dimension	Elements that are incompatible with the change goal and need to be shifted	Elements that support the change goal that could be strengthened
Norms	Values underpinning the statutory child protection process are not conducive to identifying families 'in need' even with differential responses	Values underpinning the universal and family support systems are compatible so change should be driven in these subsystems but this would require — some system players to 'step up' (e.g. universal systems to accept the more complex cases and an expanded role) — some system players to 'let go' (e.g. statutory services relinquishing some control of family support services)
	A culture of systemic risk aversion in protecting children needs to change to build shared responsibility and accountability among organisations	There is shared understanding of the problem but shared responsibility needs to be built. Shared understanding can be leveraged to build shared responsibility
	Media coverage and the politicisation of child protection contributes in large part to the risk averse culture surrounding child protection	Broad *sentiment* of shared responsibility and a willingness to be part of the solution
	The culture of mistrust between professional groups makes building shared responsibility and accountability difficult	Strong commitment from some system members for an increased role in protecting children
	Resistance from some professional groups to accept that family support is part of their 'core business'	Australian Government commitment to play a role in the solution
Resources		
Human	Weaker capacity (knowledge and skills) in some professional groups for an enhanced role	Strong capacity (knowledge and skills) in some professional groups for an enhanced role
	Perception of lack of capacity in the NGO sector for an increased role in secondary prevention	NGO skills and expertise working in the community and a commitment for expansion of role in secondary prevention
	Skills and capacity for collaboration need to be built	
Social	Information and data sharing arrangements	Formal commitment to interagency working
	Capacity for collaboration	Good (albeit mostly isolated) experiences of collaborative interagency working in most states and many models in implementation
	Poor relationships between NGOs and government in some states (culture, consultation and resourcing)	
	Professional values and philosophies	
Economic	Resources available to the secondary system	Possible reallocation of resources from tertiary subsystem
	Inadequate coverage of universal services	
Regulations	Mandatory reporting	Overarching principles in policy and legislation
	Privacy legislation	Differential intake responses
	Siloed funding and accountability arrangements	Broad stakeholder support for community-based intake models or dual pathways
	Competitive tendering	
	Referrals for support through tertiary system	
Power	Fragmented governance and funding arrangements	Models of formal integrated planning in place in all states and territories
	Lack of engagement with NGOs	Proliferation of integrated service delivery models that require joint governance

Source: Allen Consulting Group.

The levers for change represent system parts that could be utilised by policy-makers in bringing about systems change. This point highlights — as is clear in Figure 13.2 — that the weight of change required to achieve the change goal does not fall on systems change alone. Systems change will be significantly directed and influenced by — and in turn influence — policy change. Thus, the relative importance of the levers would depend in large part on the chosen policy approach. For example, in a reform like the UK reform — that sought to shift the system to prevention through an integrated approach to planning and service delivery — integrated governance and funding arrangements are very important. In a reform like the Victorian reforms, intake and referral processes are critical.

Furthermore, across all possible policy approaches, it is important to note that some levers would be key drivers of system reform, whereas other levers are enabling levers only. For example, the importance of enhancing the capacity of the NGO sector presents a significant lever that would have ramifications across the whole system. In comparison, resources and regulations would enable the change.

13.5 Next steps

This report provides ARACY with a solid foundation to move forward with a systems change agenda for protecting children. However, as future work progresses we believe that additional research to address the limited scope of this project should occur. Specifically further research is needed to explore:

- the broader family, community and societal influences (and strategies) that have a significant role to play in shifting to a preventive model for protecting children
- the appropriateness of the proposed systems changes in relation to Indigenous children and families.

Following release of this report ARACY is planning to identify and consult with appropriate stakeholders able to implement a sustainable systems change for protecting children. This plan offers the opportunity to work with many provider groups, including those consulted during this project and others involved in protecting children.

References

Allen Consulting Group 2003, *Protecting Children: the Child Protection Outcomes Project*, Victorian Department of Human Services, Melbourne.

Australian Institute for Family Studies (AIFS) 2008, *Child Abuse Statistics*, Resource Sheet Number 1 March 2008, Melbourne.

Australian Institute for Family Studies (AIFS) 2008, *NCPASS comparability of child protection data – Project report*, Melbourne.

Australian Institute of Health and Welfare (AIHW) 2008, *Child Protection Australia 2006–07*, Canberra.

Australian Public Service Commission (APSC) 2007, *Tackling Wicked Problems: a public policy perspective*, accessed 2 April 2008, <http://www.apsc.gov.au/publications07/wickedproblems.htm>.

Barwinski, S 2005, *Community Partnerships for Protecting Children: Lessons Learned: From the Field – For the Field,* accessed 1 November 2008, <http://www.cssp.org/uploadFiles/Community%20Partnership.pdf>.

Brandon, M, Howe, A, Dagley, V, Salter, C, Warren, C & Black, J 2006, *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation in 2005–06*, accessed 4 December 2008, <http://www.dcsf.gov.uk/research/>.

Bromfield, L & Holzer, P 2008, *A National Approach for Child Protection: project report*, National Child Protection Clearinghouse, Commonwealth Government, Canberra.

Cashmore, J, Scott D & Calvert, G 2008, *Submission to the Special Commission of Inquiry into Child Protection Services in NSW*, New South Wales Commission for Children and Young People, Sydney.

Centre for the Study of Social Policy (CSSP) 2008, *Neighbourhood Network,* accessed 1 November 2008, <http://www.cssp.org/centre/agenda.html#individualizedPractice>.

Centre for the Study of Social Policy (CCSP) 2007, *What is the Community Partnerships for Protecting Children Approach?* CCSP, Washington DC.

Centre for the Study of Social Policy (CSSP) 2005, *Community Partnerships for Protecting Children: Lessons, Opportunities, and Challenges: A Report to the Field.* CSSP, Washington DC.

Children's Workforce Development Council (CWDC) 2007a, *Common assessment framework for children and young people: frequently asked questions*, accessed 23 October 2008, <http://www.everychildmatters.gov.uk/deliveringservices/caf/>.

Children's Workforce Development Council (CWDC) 2007b, *Common Assessment Framework for Children and Young People: Practitioner's Guide,* CWDC, Leeds.

Children's Workforce Development Council (CWDC) 2007c, *Common Assessment Framework Fact Sheet*, accessed 1 November 2008, <http://www.everychildmatters.gov.uk/_files/6BBECBCDA1B29282A8EB7971C41440F4.pdf>.

Connolly, M 2005 'Differential Responses in Chid Care and Protection: Innovative Approaches in Family-Centered Practice', in *Differential Response in Child Welfare*, American Humane Association, Vol. 20, Numbers 2 & 3, p. 17.

Daro D, Budde S, Nesmith A & Harden A 2005 *Creating community responsibility for child protection: findings and implications from the evaluation of the Community Partnerships for Protecting Children Initiative*, Chapin Hall Center for Children, Chicago.

Department for Children, Schools and Families (DCSF) 2008, *Children's Trusts: Statutory guidance on inter-agency cooperation to improve the wellbeing of children, young people and their families*, accessed 2 November 2008, <http://www.everychildmatters.gov.uk/aims/>.

Department of Children, Schools and Families (DSCF) 2008a, *Aims and Outcomes*, accessed 2 November 2008, <http://www.everychildmatters.gov.uk/aims/>.

Department of Children, Schools and Families (DCSF) 2008b, *Every Child Matters*, accessed 2 November 2008, <http://www.everychildmatters.gov.uk/>.

Department of Children, Schools and Families (DCSF) 2008c, *Children's Trusts*, accessed 2 November 2008, <http://www.everychildmatters.gov.uk/aims/childrenstrusts>.

Department of Children, Schools and Families (DCSF) 2008d, *Contact Point,* accessed 2 November 2008, <http://www.everychildmatters.gov.uk/deliveringservices/ contactpoint/>.

Department of Children, Schools and Families (DCSF) 2007, *The Children's Plan: Building Brighter Futures*, DCSF, Norwich.

Department of Education and Skills (DES) 2007, *Local Safeguarding Children Boards: A review of Progress*, DES, London.

Department for Education and Skills (DfES) 2003, *Every Child Matters,* accessed 24 October 2008, <http://www.everychildmatters.gov.uk/>.

Department of Housing and Community Services (DHCS) 2007, *Presentation for Children and Young People*, Canberra.

Department of Human Services (DHS), Victoria 2008a, *Family Services Program*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/family-services/family_services>.

Department of Human Services (DHS), Victoria 2008b, *Innovation Projects – Family Support*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/family-services/innovation>.

Department of Human Services (DHS), Victoria 2008c, *How to Make a Referral or Report*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/child-protection-family-services/how-to-make-a-referral-or-report>.

Department of Human Services (DHS), Victoria 2008d, *Child FIRST*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/family-services/child-first>.

Department of Human Services (DHS), Victoria 2008e, *Policy, Planning and Funding*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/policy-planning-funding/home>.

Department of Human Services (DHS) Victoria 2007, *A Strategic Framework for Family Services*, accessed 2 November 2008, <http://www.cyf.vic.gov.au/__data/assets/pdf_file/0008/44864/fs_strategic_framework_for_family_services_20042007.pdf>.

Department of Human Services Victoria 2006 (DHS), *The State of Victoria's Children Report: Every Child Every Chance*, accessed 2 November 2008, <http://www.education.vic.gov.au/ocecd/docs/state_of_victorias_children_report_2006v2.pdf.pdf>.

Department of Human Services (DHS) 2002, *An integrated strategy for child protection and placement services*, Community Care Division, VDHS, Melbourne.

Department of Premier and Cabinet (DPC) 2008, *Submission to Special Commission of Inquiry into Child Protection Services in NSW*, accessed 22 October <http://www.lawlink.nsw.gov.au/lawlink/special_projects/ll_splprojects.nsf/pages/cpsi_cpsi_sub_received>.

Doyle, J 2007, 'Child protection and child outcomes: measuring the effects of foster care', *American Economic Review*, Vol. 97, no. 5, pp. 1583–1610.

Foster-Fishman P, Nowell B & Yang H 2007, 'Putting the system back into systems change: a framework for understanding and changing organisational and community systems', *American Journal of Community Psychology*, Vol. 39, pp. 197–215.

Gillingham P 2006 'Risk assessment in child protection: problem rather than solution?', *Australian Social Work*, Vol. 59, no. 1, pp. 86–98.

Graycar A 2006, 'Public Policy: core business and by-products', *Public Administration Today*, July–September 2006, pp. 6–10.

Harries, M & Clare, M 2002, *Mandatory Reporting of Child Abuse: Evidence and Options: Report for the Western Australian Child Protection Council*, Department for Community Development, Perth, WA, and online, accessed 24 October 2008. <http://web.archive.org/web/20030406062544/http://fcs.wa.gov.au/_content/miscellaneous/mandatory_reporting.pdf>,

Harris, N & Wood, J 2008, 'Governing beyond command and control: A responsive and nodal approach to child protection', in Deflem, M (ed) *Surveillance and Governance: Crime Control and Beyond*. Emerald, pp. 329–346

Head B & Alford J 2008, 'Wicked problems: the implications for public management', Paper presented to the International Research Society for Public Management 12th Annual Conference 26–28 March, Brisbane.

Head B & Stanley F 2007, 'Evidence-based advocacy. The Australian Research Alliance for Children and Youth', *International Journal of Adolescent Medical Health,* Vol. 10, no. 3, pp. 255–262.

Higgins D, Bromfield L & Ricardson N 2006, *Mandatory reporting of child abuse resource sheet,* National Child Protection Clearinghouse, AIFS, Melbourne.

Holzer, P 2007, *Defining the public health model for the child welfare services context*, Child Abuse Prevention Resource Sheet, No. 11, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne.

Institute of Public Administration Australia 2002, *Working Together — Integrated Governance*, accessed 2 November 2008 <http://www.ipaa.org.au>.

Katz, I 2008, 'From the Director', Newsletter no. 98, Social Policy Research Centre, March 2008, p. 3.

Karoly L Kilburn R & Cannon J 2005, *Early Childhood Interventions: proven results, future promise*, RAND Corporation, California.

Local Safeguarding Children Boards Regulations 2006, accessed 2 November 2008 <http://www.opsi.gov.uk/si/si2006/20060090.htm>.

Management Advisory Committee (MAC) 2004, *Connecting Government: whole of government responses to Australia's policy challenges*, Commonwealth Government, Canberra.

National Evaluation of Sure Start (NESS) 2008, *The Impact of Sure Start Local Programmes on Three Year Olds and Their Families*, Institute for the Study of Children, London.

National Evaluation of Sure Start (NESS) 2007, *Understanding Variations in Effectiveness amongst Sure Start Local Programmes*, Institute for the Study of Children, London.

National Evaluation of Sure Start (NESS) 2005, *Implementing Sure Start Local Programmes: An in-depth study*, Institute for the Study of Children, London.

NSW Council on Social Services (NCOSS) 2008, *Submission to the Special Commission of Inquiry into Child Protection Services in New South Wales*, accessed 22 October, <http://www.lawlink.nsw.gov.au/lawlink/special_projects/ll_splprojects.nsf/pages/cpsi_cpsi_sub_received>.

O'Donnell M, Scott D & Stanley F 2008, 'Child abuse and neglect — is it time for a public health approach', *Australian and New Zealand Journal of Public Health*, Vol. 32, no. 4.

Roberts N 2000 'Wicked problems and network approaches to resolution', *International Public Management Review*, Vol. 1, Issue 1.

Rosewater, A 2006, *Community Partnerships for Protecting Children: Lessons about Addressing Domestic Violence,* Chapin Hall, Chicago.

Rubin, D, O'Reilly, A, Luan, X & Localie, R 2007 'The impact of placement instability on behavioural well-being for children in foster care', *Pediatrics,* Vol. 119, pp. 336–344.

Schene P 2005 'The emergence of differential response', *Protecting Children*, Vol. 20, no. 2–3, pp. 4–8.

Scott D 2005, 'Inter-organisational collaboration in family-centre practice: a framework for analysis and action', *Australian Social Work*, Vol. 58, no. 2.

Scott, D 1995, 'Child protection: Paradoxes of publicity, policy and practice', *Australian Journal of Social Issues*, Vol. 23(2), pp. 5–14.

Sure Start 2008a, *Sure Start Children's Centres*, accessed 2 November 2008, <http://www.surestart.gov.uk/surestartservices/settings/surestartchildrenscentres/>.

Sure Start 2008b, *What's on Offer*, accessed 2 November 2008, <http://www.surestart.gov.uk/surestartservices/settings/surestartchildrenscentres/provison/>.

Thomas, S 2007, *The Victorian Family Support Innovation Projects: Final Evaluation Overview Report*. Monash University, Melbourne.

Thorpe, R 2007 'Family inclusion in child protection practice: building bridges in working with (not against) families', *Communities, Children and Families Australia*, Vol. 3, no. 1.

Tomison, A 2004, Current issues in child protection policy and practice: Informing the NT Department of Health and Community Services child protection review, National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne.

United Kingdom Cabinet Office 2000, Wiring it Up: Whitehall's Management of Cross-cutting Policies and Services, The Stationary Office, London.

Victorian Child Death Review Committee, Annual Report of Inquiries into Child Deaths Child Protection 2002, accessed 22 September 2008, <http://www.dhs.vic.gov.au>.

Victorian Child Death Review Committee, Analysis of Adolescent Child Protection Client Deaths 1994-1998, accessed 22 September 2008 <http://www.dhs.vic.gov.au>

Lord Laming (Chairman) 2003, The Victoria Climbie Inquiry: Summary and Recommendations, accessed 22 September 2008, <http://www.victoria-climbieinquiry.org.uk>.

Vinson, T & Hornibrok, J 2001, Visible Signs of a Well-Functioning Community Service System: The Clarence Valley Research Project in Northern New South Wales — 'Working Together', pp. 2–3, accessed 22 September 2008, <http://www.communitybuilders.nsw.gov.au/download/NRAHS_Book.pdf>.

Western Australian Commissioner for Children and Young People 2008, *Submission to Inquiry into Collaborative Approaches in Government*, provided by the Commissioner.

Winkworth, G & McArthur, M 2007, 'Collaboration and systems of support for vulnerable children and their families: improving the interface between primary, secondary and tertiary intervention', *Communities, Children and Families Australia*, Vol. 3, no. 1, pp. 45–55.

Wood, J 2008, *Report of the Special Commission of Inquiry into Child Protection Services in NSW,* State of NSW through the Special Commission of Inquiry into Child Protection Services, Sydney.

Appendix A

Consultation guide

Background to the project

Project overview

The Australian Research Alliance for Children and Youth (ARACY) has commissioned the Allen Consulting Group to develop a research report on *Enhancing Systems for Protecting Children*.

The research report has two key objectives:

- to describe the primary, secondary and tertiary child protection systems across Australia
- to identify the organisational strategies and processes that could lead to more effective approaches to prevent child abuse and neglect.

This project will take a *systems-based approach* to child protection by examining the ways that systems and organisations can collaborate to deliver the best outcomes for children.

The purpose of this paper is to provide an overview of the project approach to achieve the objectives, and briefly set out some key issues for the consultation process.

Describe the child protection systems in Australia

To describe the primary, secondary and tertiary child protections systems in Australia, the Allen Consulting Group will review how existing systems for protecting children in Australia operate. This will include mapping the strategies, institutional roles and processes within and between jurisdictions. This task will also involve identifying the cost of the systems and the impact on outcomes for children.

The description of existing child protection systems will use the public health model of primary, secondary and tertiary prevention as the framework — described in Box 1. When applied to child protection, the public health model spans the full continuum of services received by children and families to protect children.[7]

This task will be based primarily on publicly available information, however the Allen Consulting Group will seek to confirm and verify the mapping with key stakeholders in the consultation process.

[7] Holzer, P, Higgins, J, Bromfield, L, Richardson, N and Higgins, D 2006, 'The effectiveness of parent education and home visiting child maltreatment prevention program', *Australian Institute of Family Studies Child Abuse Prevention Issues*, no. 24, Autumn.

Box 1

THE PUBLIC HEALTH MODEL FOR PROTECTING CHILDREN

There are three types of interventions in a public health model for protecting children:

- *Primary (or universal) interventions* are strategies that target whole communities or all families in order to build public resources and attend to the social factors that contribute to child maltreatment. The aim of primary prevention programs is to prevent the occurrence of situations leading to maltreatment.
- *Secondary or targeted interventions* target families or children/young people who are at risk of child maltreatment — that is, those with special needs or who are in need of greater support. Secondary approaches prioritise early intervention, generally involving early screening to detect children who are most at risk, followed by a combination of interventions and supports to enhance family functioning and to address the risk factors for child maltreatment.
- *Tertiary interventions* target families in which child maltreatment has already occurred. Tertiary interventions seek to reduce the long-term implications of maltreatment and to prevent maltreatment recurring. They include statutory care and protection services.

Source: Holzer, P, Higgins, J, Bromfield, L, Richardson, N & Higgins, D 2006, 'The effectiveness of parent education and home visiting child maltreatment prevention program', *Australian Institute of Family Studies Child Abuse Prevention Issues*, no. 24, Autumn.

Identify organisational strategies and processes that could lead to a more effective approaches to prevent child abuse and neglect

To identify organisational strategies and processes that could lead to a more effective approach to child protection, the Allen Consulting Group will:

- undertake an international review of strategies and systems for protecting children with a strong focus on preventing child abuse and neglect
- consult with key stakeholders to examine
  - effective organisational strategies and processes within and between child protection systems in Australia
  - barriers and challenges to collaborative approaches within and between child protection systems.

The consultation process

Consultations with key stakeholders will be conducted across Australia with representatives from government departments, non-government service providers, and Children's Commissioners. The consultations will be jointly facilitated by ARACY representatives and the Allen Consulting Group.

Questions about the consultation process can be directed to:

Dr Geoff Holloway — Research Manager, ARACY
Phone: (02) 6232 5261, email: geoff.holloway@aracy.org.au

The next section outlines key issues for the consultations, including some questions to guide the discussion.

Key issues for consultation

Child protection systems in Australia

The current child protection systems in Australia are complex — covering primary, secondary and tertiary services — with national, state and territory and non-government organisations all involved in planning, funding and delivering services.[8] The current systems are also heavily focused on the role of tertiary child protection services, which, although necessary, simply do not address the problems early enough to protect children from abuse and neglect.

Significant changes are required to enhance systems for protecting children in Australia. These changes need to centre on shifting the focus to prevention and early intervention in child protection systems. This will require increased coordination and collaboration across the range of primary, secondary and tertiary services that aim to prevent the occurrence or re-occurrence of child abuse and neglect.

Collaboration and coordination

Enhancing child protection systems by refocusing on prevention and early intervention is already underway in many jurisdictions. However, from a national perspective, there are four overlapping levels of division in child protection systems where collaboration and coordination are needed to help prevent child abuse and neglect. These divisions are:

- *Between systems:* between different child and family service systems — primary, secondary and tertiary — that have a role in the developmental wellbeing of children and young people. It is essential that the objective of securing the wellbeing and safety of children and young people is grounded at the primary level of services — for example, public health (primary health care) and education — which is well integrated with the secondary and tertiary levels. We need to know how these services work together and how they can work together better.
- *Between organisations:* child protection systems require 'transformation from a single child welfare agency to a system of shared responsibility and mutual support'.[9]
  - This means improving cross-agency collaboration within government between core child protection agencies and those agencies providing services for families and children more broadly, including primary and secondary services.
  - It also involves improved collaboration between non-government providers that deliver the wide range of community-based supports to families and children.

[8] Holzer, P 2007, *Defining the public health model for the child welfare services context*, Child Abuse Prevention Resource Sheet, no. 11, Australian Institute of Family Studies, Melbourne.

[9] Daro, D, Budde, S, Nesmith, A and Harden, A 2005, *Creating community responsibility for child protection: findings and implications from the evaluation of the Community Partnerships for Protecting Children Initiative*, Chapin Hall Center for Children.

- *Between jurisdictions:* all governments — the Australian, states and territories, and local governments — are engaged in child protection systems. Child protection has traditionally been a state responsibility, however the Australian Government funds and delivers a range of primary and secondary services that aim to assist in preventing child abuse and has primary responsibility for welfare payment systems. To varying degrees in different states, local governments also provide services to support children and families.
- *Between sectors:* between the government and non-government sectors. The non-government sector is a large provider of services for children, including in some states as a provider of tertiary child protection services.

Questions for discussion

The focus of these consultations is the strategic policy and planning level. We are asking policy advisers and service providers to consider the role of child and family service systems in protecting children from abuse and neglect — and how to improve it — and in particular the role of primary/prevention/universal services.

These questions are a guide for the consultations but we are interested in your views on how systems can best protect children from abuse and neglect.

Looking at the issues from a systems perspective, ideally what role should primary and secondary prevention services play in preventing child abuse?

What role do primary and secondary prevention services currently have in the reduction of child abuse and neglect in your jurisdiction?

This may include the role of health, education and family support services, among others.

What can be done to shift the focus more to primary and secondary prevention services?

In your experience, what organisational strategies and processes have been effective in enhancing systems to prevent child abuse and neglect?

This may include within and between: organisations, jurisdictions, sectors, and primary, secondary and tertiary service systems.

What are the factors that assist in developing collaborative models for preventing child abuse and neglect?

What are the barriers and/or challenges to developing collaborative models? How can these barriers be overcome?

Some issues to consider may include:

- *agreement about goals and objectives*
- *governance and decision-making mechanisms*
- *how roles and responsibilities are defined and articulated within and across organisational, jurisdictional and sectorial boundaries*

- *processes for sharing client and service data*
- *referral processes to allow clients to move between services and systems*
- *accountabilities and incentives*
- *legislative arrangements*
- *funding arrangements*

Appendix B

Jurisdictional stocktakes of services for protecting children

Contents

Chapter 1

Introduction

1.1 Introduction

This appendix contains stocktakes of the services available in each state and territory, and nationally (provided by either the Australian Government or a national non-government organisation) that play a role in preventing and responding to child abuse and neglect. Services in the stocktakes have been organised by sector, namely:

- health
- family support
- education and care
- child safety
- specialist services for parental risk factors defined as
  - substance abuse
  - mental health
  - family violence.

In addition, services have been classified as primary, secondary or tertiary prevention services. As noted in the main report Chapter 1.2, using the public health model to describe *services* has limitations and these are noted again here.

First, some services may provide interventions at the primary, secondary and tertiary prevention levels so distinctions between the levels are artificial in many cases. For example, a maternal and child health service may deliver health promotion activities to all families, work with parents with an identified risk factor such as those experiencing family violence, and may also actively treat serious neglect such as failure to thrive which is a tertiary prevention strategy. Second, prevention strategies are broader than just 'services' and can include community-wide measures such as social marketing campaigns, and policy contexts such as paid parental leave.

With this caveat in mind, the stocktakes were designed to provide an overview of the range of prevention services available and the project team has identified services as primary, secondary and tertiary based on that service's main service delivery stream.

The Australian Institute for Family Studies (AIFS) released a report on 12 December 2008, commissioned by the National Child Protection and Support Services Data Group. This report, *NCPASS comparability of child protection data — Project report,* provides a detailed analysis and description of jurisdictional child protection data and is a key document which complements the information presented in the stocktakes.

Information collection

The information for the stocktakes was collected from publicly available information including data reported in:

- the *Report on Government Services*
- websites, annual reports and budget papers of relevant organisations and departments
- other information provided to us from the reference group and from government and non-government staff in some jurisdictions.

In the original brief, the Australian Research Alliance for Children and Youth (ARACY) sought to obtain a baseline of funding for each of the systems described above.

The funding amounts for tertiary child protection services were collected from the *Report on Government Services* (ROGS) and were considered accurate by most states and territories. Funding amounts for primary and secondary services were originally sourced from budget papers in each state and territory, although these figures were not sufficiently disaggregated to be meaningful. Jurisdictions were then asked to further breakdown these figures, however most declined this request. As such, funding is only included for statutory child protection services based on publicly available information in the *Report on Government Services*.

Verification of stocktakes

All draft stocktakes were forwarded to key consultation participants in each state and territory with a request for verification of the content. This process had varying degrees of success with many of the stocktakes not verified by all — or in some cases any — of the relevant departments in each jurisdiction. Some jurisdictions provided additional information, which was incorporated into the stocktake and this accounts for the varying levels of detail provided for each jurisdiction.

The verification status of each stocktake is clearly labelled on the first page of each chapter.

Other limitations

The data for the stocktakes was collected from publicly available sources which do not necessarily reflect current activities. In many instances we found, during the verification process, that websites were out of date and that changes in service provision had not been documented publicly. In some cases, jurisdictions provided up to date information for inclusion in the stocktakes however this was not true with all jurisdictions. As noted above, many of the stocktakes have not been verified by all — or, in some cases, any — of the relevant departments in the jurisdictions.

Also noted above, most jurisdictions did not provide any detail on the funding associated with the provision of primary and secondary prevention services. Many states and territories correctly pointed out the difficulty inherent in separating out small program expenditures from the larger budgeted amounts within systems.

In addition to the limitations listed above, the stocktakes do not take into account important factors such as *quality, coverage, intensity* and *access*. In most cases the stocktake is unable to define the quantity or availability of the service (how often is it offered or whether there are limitations on the number served), the extent of waiting lists for the service and whether the service exists statewide or only in dedicated locations within the jurisdiction.

Because of these significant limitations, the stocktakes should be interpreted and utilised with caution.

Chapter 2

Australian Capital Territory

2.1 Verification status

This stocktake has not been verified.

2.2 Stocktake of service systems

The table below provides a summary of the service systems available for protecting children in the Australian Capital Territory. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — AUSTRALIAN CAPITAL TERRITORY

Sector	Primary	Secondary	Tertiary
Health	Community care — Child, Youth and Women's Health Program Antenatal and maternity services Family planning and sexual health	Specialist parenting support centres Therapy ACT pediatric services School nursing in special schools Child and adolescent mental health services (CAMHS)	Community health — Child At Risk Health Unit
Family support	Child and family centres Playgroups ParentLink Parentline ACT Parents as Teachers (PAT)	Interventions for families and children with behavioural issues Support for families at risk Intensive family support and intervention services Youth Services Program Integrated family support project	
Education and care	Preschools (and Indigenous preschools) Licensed children's services Schools as Communities Early childhood schools (from 2009) Schooling School counsellors and social workers	Schools as communities Early intervention programs Individual learning plans	
Child safety		Integrated Family Support (IFS) project — trial Birth to Two project — trial	Child protection services Out-of-home care Children's Court

Sector	Primary	Secondary	Tertiary
Specialist services for parental risk factors: substance abuse mental health family violence	Well Women's Clinics	Drug and alcohol services Mental health services Family violence support services	

Primary prevention

Health

Community care — Child, Youth and Women's Health Program

The Child, Youth and Women's Health Program offers a number of services for maternal and child health. These are:

- maternal and child health clinics — drop-in and by appointment services that provide developmental checks in line with the baby's personal health record, information, support, advice and education on parenting and development, and health checks and screening
- immunisation clinics — providing child immunisations in line with the National Immunisation Program at immunisation clinics
- school immunisations — a school health immunisation team of nurses offers age-appropriate vaccinations at school.

Antenatal and maternity services

Comprehensive antenatal and maternity services, including midwifery, are provided at Canberra Hospital and Calvary Hospital.

Family planning and sexual health

Sexual Health and Family Planning ACT provides a range of services in the Australian Capital Territory. These services include clinic and counselling services, emergency contraception, disability programs and services, education and health promotion including programs in schools, and a library and resource centre.

Family support

Child and family centres

Child and family centres are a Department of Disability, Housing and Community Services (DHCS) early intervention and prevention program for children from birth to age five and their families. The program provides a range of universal and targeted parenting information and support services, specialist clinical services, and community development and community education programs. Services are delivered in partnerships with other agencies, local community organisations and service providers.

The centres work with families in two Canberra communities to determine the services they require and the best way these services can be provided to achieve the optimum outcomes. Services can be provided in a number of different outreach settings such as the family home, the child's school or a community setting.

Specifically, the child and family centres provide three integrated areas of service delivery:

- services for children and families, including maternal and child health clinics, speech and physiotherapy drop-in services for children, and early childhood services with links to the early childhood education and care sector
- individual case coordination for families and counselling support for children and their families

- community development and education, including universal parenting projects that aim to increase awareness regarding child and parenting issues, initiatives which seek to strengthen community capacity, and targeted early intervention and prevention programs.

A child protection worker is also provided in each centre to provide guidance, support and where necessary statutory child protection work.

Playgroups

Playgroups are provided by Playgroups ACT, in various community locations and are partly funded by the Australian Capital Territory Government and the Commonwealth Government.

ParentLink

ParentLink provides a service designed to increase parents' confidence and skills by supporting and linking them with a network of information, ideas and community services through parent guides and a comprehensive website. ParentLink is provided by DHCS.

Parentline ACT

Parentline ACT is a free, confidential telephone counselling, referral, information and support service for parents, grandparents and carers in the Australian Capital Territory and surrounding districts. Calls are answered by professional workers. Parentline is a community service funded by the DHCS.

Parents as Teachers

The Parents as Teachers (PAT) program is a universal program funded by the DHCS. The PAT program is predominantly a monthly home visiting program where PAT Advisors help parents recognise everyday learning opportunities. Emphasis is placed on the key areas of development in which parents gain information and knowledge to foster the areas of social-emotional, language, motor and intellectual development.

All families with children under the age of six months are able to access the program. Participation for families encourages parents to stay on the program until their child turns three years of age.

Education and care

Preschool

The Australian Capital Territory Government, through the Department of Education and Training (DET), provides one year of public sessional preschool education for children of Australian Capital Territory residents in the year prior to entry into primary school. From 2008, all Australian Capital Territory public preschools will be amalgamating with their local primary school to support the continuity of learning for children throughout their public schooling from preschool onwards.

Preschool programs for Aboriginal and Torres Strait Islander children operate at various Australian Capital Territory Government preschools. An early childhood Indigenous program is offered to help prepare children for primary school.

Licensed children's services

Children's services licensed by the Australian Capital Territory Government comprise:

- centre-based children's services — education and care for children from birth to eight years in a long day care or occasional care centre
- family day care — a network of individuals who provide child care in their own homes for other people's children. Family day care services are supported by a coordination unit
- independent preschools — these are non-government preschools for children aged three to six years
- playschools — program for children aged three to six years on a sessional basis
- school age care services — care and recreation activities for primary school age children.

Although primarily funded by the Australian Government and through service fees, the Australian Capital Territory Government through DHCS provides funding:

- to assist in the provision of support for children with disabilities accessing children's services
- for casual, permanent part-time and emergency early childhood places
- for behaviour management support for families and children's services.

Early childhood schools

In December 2006, the Australian Capital Territory Minister for Education and Training announced that four new early childhood schools would open in 2009. These schools would be located on four existing school sites across Canberra.

It is envisaged that these schools will develop as early learning and development centres. They will become regional hubs, providing integrated services for children (birth to eight years) and their families. In addition to preschool to year 2 classes, these services could include child care, family support services and other services that support children's learning, health and wellbeing.

Schooling

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

School counsellors and social workers

School counsellors provide appropriate psychological services to students that address educational, social, emotional and behavioural needs, either individually or in groups. Working collaboratively with families, school communities and external agencies are integral to the role. School counsellors work proactively and responsively within the principles of a promotion, prevention and early intervention framework.

School counsellors in the Australian Capital Territory are required to be registered with the ACT Psychologists Board. They are also required to have teaching qualifications.

In addition, DET has created new social worker positions in schools to work with students with complex needs and their families.

Child safety

None.

Specialist services for parental risk factors

Well Women's Clinics

Community Health's Well Women's Clinics offer information on issues concerning women such as menstrual cycles, menopause, sexuality and relationship and pregnancy issues. The clinics also offer early detection services, such as pap smears, breast checks and blood pressure checks. Well Women's clinics are a universal and free service.

Secondary prevention

Health

Specialist parenting support centres

Community Health offers day stay services across two locations for parents with babies under four months for assistance with settling and feeding issues.

In partnership with ACT Health, the Canberra Mothercraft Society operates the QEII Family Centre, which offers treatment and support for families with children up to three years of age in a residential setting. Services are by referral only, and are available to families with complex lactation and other feeding problems, failure to thrive, unsettled babies, postnatal depression, children at risk, special needs, parenting support and behavioural problems in children/families.

Therapy ACT

The paediatric program with Therapy ACT is a free DHCS therapy and support service that offers assessment, information and advice for families on children's developmental needs, therapy, and counselling and support for families.

Therapy ACT early identification and intervention services are for:

- children who have delays in their development, are at risk of delayed development or have a developmental disability
- families and carers of these children
- preschool and schools
- other community agencies.

School nursing

ACT Health provides school nurses in all special schools.

Child and adolescent mental health services

Child and adolescent mental health services (CAMHS) are provided in two locations in Canberra. In addition, ACT Health funds the Youth and Wellbeing Program delivered by Centacare. This program supports young people in the community between 12 and 25 years of age who have a mental health condition and/or drug and alcohol concerns, anger and behavioural concerns, and related issues. Outreach House is a community-based medium- to long-term residential program for young people (aged thirteen to seventeen years) who have psychological or behavioural disturbances and are currently unable to live at home.

Family support

Interventions for families and children with behavioural issues

There are a number of services provided by the non-government sector to provide support for children with behavioural issues and their families. Two services are:

- the Behaviour Support Workers at Belconnen Community Service. They are available to work with children with behavioural issues, their families and child care staff in the child care setting, schools and in the family home in north Canberra
- the Behavioural Guidance Program (BGP) at Tuggeranong (South Canberra) — Communities@Work — supports families and individuals facing difficulties in the parenting role and/or with their child's behaviour. BGP offers a group program, home support, the Managing Children's Program and a supported playgroup.

Support for families at risk

A number of small community-based support services are provided to at-risk parents including:

- Canberra one parent support services — provides single parent families with personal support, advocacy, information, referral and transport for appointments. Coordinates Kids Club (Kids In Divorce & Separation), a group for boys and girls aged 6–12
- Young mothers support groups — most youth centres run young mothers or young expecting mothers support groups
- Noah's Ark Resource Centre — offers a range of services for families and their children with priority given to children with special needs and their families including
  - — play school for three and four year olds with support available for children with special needs
  - — support for parents/carers of children with special needs
  - — 'My Time' — a support group for parents/carers of young children with a disability or chronic illness.

Intensive family support and intervention services

Intensive family support and intervention services are provided by a range of non-government organisations in the Australian Capital Territory. These services provide programs for families that need additional support for a range of reasons. Some of the key services are listed below.

Two targeted family centres operate in Canberra providing a mix of secondary and tertiary services including family support and out-of-home care services:

- Barnados child and family support centre (including outreach) provide a range of services for disadvantaged children, adolescents and their families in the Australian Capital Territory and surrounding areas. These services include
  - support for teenagers and young mothers needing help with parenting. The Barnados centres also arrange respite care for parents who need a short break from the children and have exhausted family arrangements
  - foster care and permanent foster care
  - homelessness support for young people
  - mentoring programs for disadvantaged children.
- Marymead Child And Family Centre supports children and families in various ways
  - assisting parents in the care of their children and themselves through family skills and relationship courses
  - preventing family breakdown by providing family support, intensive therapeutic intervention, respite and crisis care for children and young people
  - providing caring, stable and responsible foster and residential care for children who cannot live with their family of origin
  - Indigenous family support
  - recognising the special needs of and providing support to families with a family member who has a disability
  - supporting separated families and children who require a safe and understanding environment for contact and changeover arrangements.

In addition, Centacare provides a number of intensive services listed below.

Adolescent mediation and family therapy program (known as FACES) — a counselling service for young people (aged between 10 to 21 years) and their parents or care givers. The aim of the program is to help improve the communication between parents and their children. The counsellors work towards helping families develop skills to resolve these difficulties. FACES is partially funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Canberra Family Support Service — a service for families with children up to 12 years old who are experiencing difficulties and are in need of practical support. The service aims to help families use and further develop their existing skills and resources as well as providing links into the community. The service is funded by the DHCS.

Family Relationship, Education, Skill and Training (FREST) — provides in-house as well as outreach parenting programs during school terms. The two-hour presentation offers parents information on a range of topics in the areas of communication and relationship building.

The Parent and Family Effectiveness Training Course (PET/FET) — a skill-based training course offered to parents and adult members of families. Based on Dr Thomas Gordon's Effectiveness model, the course emphasises and teaches relationship building, communication skills and strategies.

Youth Services Program

The government funds a range of services to meet the broad spectrum of young people's needs, ranging from prevention through to tertiary intervention services. Within the Office for Children, Youth and Family Support, the Youth Services Program (YSP) provides funding to 19 community organisations to deliver 26 services, including youth centres, youth support services, youth development services and the youth peak body.

YSP funds early intervention approaches to support young people at risk aged 12 to 25 years, with a primary focus on the 12 to 21 years age range. The definition of 'at risk' relates to young people who may be jeopardising their physical, emotional or social development or becoming disconnected from the community.

In addition, the Turnaround program is delivered by the DHCS for youth with very high and complex needs. Each young person in the program identifies the people and agencies that are important to be members of their 'support team' (on referral Turnaround clients have an average of seven different agencies involved with them). Regular case conferences are held between the young person and their support team to identify goals and case plans and also address any problems that are facing the young person.

Education and care

Schools as Communities

This program assists schools and families to tap into the network of health and community services in the Australian Capital Territory through a team of community outreach professionals, working in one high school and seven nominated primary schools plus their on-site preschools. Community outreach workers are DHCS workers who work with children and young people at risk and the families and communities that support them.

Community outreach workers have a dual role, working with both families and the broader community as a whole through home visiting, providing information about parenting and local health and community services, arranging appointments and assisting with transport where necessary.

Community outreach workers engage with parent bodies and communities to develop local initiatives, which care for children, reduce parental isolation and provide parents with new knowledge and skills. This might mean playgroups at the school for parents who lack transport, health professionals working on site at schools, a local church community providing a breakfast program, a fruit and vegetable cooperative, or a young parents group sponsored by a service club.

Early intervention programs

DET offers a number of early intervention programs for children between the ages of two and five years who have a disability or developmental delay, in collaboration with Therapy ACT. These programs are:

- Developmental playgroup*s* — developmental playgroups operate in local preschools and/or Therapy ACT. There are several programs that focus on different issues such as developmental skills, ages and complexity of issues
- Early Intervention Units (EIU) — categorised as general, autism or language development programs. These group educational programs focus on developmental skills, social interaction and independence and are held in preschool classrooms. EIUs are run by teachers and are targeted at children of different ages and abilities.

Individual learning plans

Individual learning plans are developed for children at risk of poor educational outcomes. This includes Indigenous children, children with a disability or developmental delay, and children and young people in out-of-home care and the youth justice system.

Child safety

Integrated Family Support Project — trial

The Integrated Family Support Project is a joint initiative between government and non-government organisations in the Australian Capital Territory, targeting at-risk children in vulnerable families. Its aim is to divert families away from the care and protection system. The project will work with children from birth to eight years, focusing on issues of neglect and parenting capacity. The operational principles of the project are collaborative practice and integrated service delivery, with a case coordinator nominated by each family as the prime contact and organiser of services. The practice principles of the project include child-centredness, family focus, family empowerment, being prepared to experiment and innovate, open communication, respect and trust across agencies and across professions.

The project has attracted three-year funding from FaHCSIA for a trial to proceed. At the end of the trial the Australian Capital Territory will have an evaluated model for improving service delivery to families who present with concerns but where ongoing statutory intervention is not warranted.

Birth to Two project — pilot

Development and implementation of a joint pilot project from child and family centres with children from birth to two years of age and their families. This project commenced in October 2006 and targets two groups of families:

- those reported to care and protection services and no further action is taken
- those families reported to care and protection services and ongoing casework is required.

This project continues to be refined to meet the needs of families who present with multiple and often complex needs.

Specialist services for parental risk factors

Drug and alcohol services

Australian Capital Territory Government Community Health offers information, advice, referral, intake, assessment and support 24 hours a day for individuals, their family and friends, general practitioners (GPs), other health professionals, and business and community groups. All referrals and initial contact with Community Health's alcohol and other drugs services are made through the 24-hour helpline ((02) 6207 9977). The helpline is staffed by professional workers from the alcohol and drug program, and provides:

- information on alcohol and other drug and associated issues
- advice on assisting and managing people who may have alcohol and other drug issues
- support to people affected directly or indirectly by alcohol and drug use.

Directions ACT is the primary non-government provider of drug and alcohol support services in the Australian Capital Territory. They provide a range of services and programs for people affected by alcohol and drug issues, their families and the wider community. These services and programs include drug and alcohol treatment and rehabilitation services and counselling and support groups, as well as a range of community education and harm minimisation services.

Mental health services

ACT Health provides a range of community-based mental health services operating from four regional health centres. Multidisciplinary teams in each centre provide assessment and treatment for adults and children with mental health needs. Rehabilitation services include clinical programs, pre-vocational programs and supported community involvement. There is also a range of clinical and non-clinical support services for mental health provided in the non-government sector.

Specialist mental health services for postnatal depression are:

- Perinatal Mental Health Consultation Service (PMHCS) — a consultation and liaison service specialising in the assessment, diagnosis and short-term treatment of women affected by moderate to severe mental health needs in the preconception, antenatal and postnatal period. This service consists of a one day a week psychiatry clinic staffed by a psychiatrist, registrar and a psychologist. PMHCS does not offer clinical management or provide crisis assessments.
- Post and Antenatal Depression Support and Information Inc (PANDSI) — a facilitated support group for women experiencing postnatal or antenatal depression including free childcare and playgroup in two locations in Canberra. PANDSI also includes a telephone support program, video and book libraries, information packs and newsletter for members.

- IMPACT Program — a coordination service for pregnant women, their partners and their young children (less than two years of age) who are clients of Mental Health ACT and/or are receiving opioid replacement therapy and require assistance to manage their involvement with multiple services. The IMPACT program assists clients to select a key worker (from a number of government and non-government agencies), makes a service plan and brings together professionals and agencies to offer support through pregnancy and until the child is two years of age.

Family violence support services

Includes crisis services, emergency housing, women's information and referral services — all provided by the non-government sector.

Tertiary prevention

Tertiary prevention services are predominately child safety services, although a specialist health program that provides medical assessments for children who have been subject to abuse supports these services.

Community health — Child At Risk Health Unit

The Child At Risk Health Unit (CARHU) is part of the Child, Youth and Women's Health Program of Community Health. The unit provides medical examinations and family assessments where there are concerns of child abuse, neglect and/or domestic violence.

Child protection services

Through three regional offices and an after-hours service, care and protection services in the DHCS have a statutory responsibility to protect children and young people from abuse and neglect and to promote their safety within the family unit. Where a child is at risk within the family home, care and protection services is responsible for supporting the child in out-of-home care.

Care and protection services receive, record and assess allegations of abuse, neglect and/or harm to children and young people. A risk assessment by professional staff determines whether an appraisal (investigation) of the allegation is required. The service also initiates legal action where necessary, provides case management support and refers clients to family support and other relevant services.

Aboriginal and Torres Strait Islander Services within care and protection services provide:

- advice on policy and practice issues as they relate to Aboriginal and Torres Strait Islander children, young people and their families
- Indigenous family support services
- an Aboriginal and Torres Strait Islander Kinship and Foster Care Service.

Out-of-home care

Following from the introduction of the *Children and Young People Act 1999*, reform in the area of out-of-home care now means that the non-government sector is responsible for the delivery of all foster care programs in the Australian Capital Territory.

Although the Office for Children, Youth and Family Support at the DHCS no longer delivers foster care services directly, it continues to play a role in establishing stable arrangements and overall care plans for children in care and for monitoring the overall quality of the care system. As a quality control mechanism, contracts entered into by out-of-home care agencies with the Office for Children, Youth and Family Support for the provision of out-of home care are now governed by a set of out-of-home care standards.

The out-of-home care agencies take responsibility for supporting carers to make any practical arrangements that are needed for the child. These might include providing transport, and arranging dental and medical appointments. The roles and responsibilities of the Office for Children, Youth and Family Support and agencies will depend on the existence and nature of any court orders made by the Children's Court.

Children's Court

The Australian Capital Territory Children's Court makes decisions on care and protection orders. The DHCS Integrated Court Services coordinates legal matters for child protection and provides a court liaison officer for all Children's Court care matters.

2.3 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN THE AUSTRALIAN CAPITAL TERRITORY

Service	2002–03 ($'000)	2003–04 ($'000)	2004–05 ($'000)	2005–06 ($'000)	2006–07 ($'000)
Child protection and OOHC	19 456	25 945	35 738	31 716	29 637

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, Australian Capital Territory received 8710 notifications of alleged child abuse and neglect regarding 4567 children. In the same year, 852 substantiations of child abuse and neglect were made pertaining to 558 children. The rates of notifications, investigations, substantiations and care and protection orders have more than doubled in the Australian Capital Territory since 2002–03. However, there is a recent downwards trend — finalised investigations and substantiations decreased between 2005–06 and 2006–07 and children on care and protection orders remained stable in this same period.

AUSTRALIAN CAPITAL TERRITORY CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications (children)	1483	20.2	2716	37.5	3430	47.9	4099	57.6	4567	63.7
Finalised investigations	662	9.0	843	11.6	1652	23.1	1578	22.2	1455	20.3
Substantiations	263	3.6	485	6.7	857	12.0	853	12.0	558	7.8
Care and protection orders (0–17)	288	3.7	353	4.6	464	6.1	558	7.4	574	7.5

Source: ROGS 2008, Table 15A.136, using AIHW data.

AUSTRALIAN CAPITAL TERRITORY CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	2124	5325	7275	8064	8710
Substantiations	310	630	1213	1277	852

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 3

New South Wales

3.4 Verification status

This stocktake has been verified by the New South Wales Department of Community Services (DoCS) and the Department of Health.

3.5 Stocktake of service systems

The table below provides a summary of the primary, secondary and tertiary systems for protecting children in New South Wales. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — NEW SOUTH WALES

Sector	Primary	Secondary	Tertiary
Health	Supporting Families Early – Safe Start – home visiting policy including universal health home visiting (UHHV) Mental Health Access Line Aboriginal Maternal and Infant Health Strategy (AMIHS) Early childhood health services Women's health services Child, adolescent and family health services Prenatal reports (NSW Health and DoCS pilot) Midwifery continuity of care	Child and adolescent mental health services Youth-specific drug and alcohol services Family care centres Youth health centres NSW Refugee Health Services and NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) Integrated Perinatal and Infant Care (IPC) Program Specialist child and adolescent mental health teams Community-based residential units Mental health services in paediatric hospitals	NSW Health sexual assault services NSW New Street Adolescent Service Child Protection and Sex Crime Squad Child protection units The NSW Pre-Trial Diversion Program Child and adolescent mental health — tertiary referral units
Family support	Family worker services Supported playgroups Volunteer home visiting services Schools as community centres	Residential family care services The NSW Parenting Program for Mental Health Brighter Futures Better Futures Early Intervention Program DoCS intensive family based services	Victims Services (Attorney General) Victims Advisory Board Victims of Crime Bureau Victims Compensation Tribunal
Education and care	Children's services Kindergarten Schooling Child protection education	The NSW Health School-Link program	
Child safety	Blue Light Unit	Helpline (DoCS) and Child Protection Casework	Child Protection Services Out-of-home care (OOHC) services

Sector	Primary	Secondary	Tertiary
Specialist services for parental risk factors substance abuse mental health family violence		NSW Family and Carer Mental Health Program DoCS Domestic Violence Line Children of Parents with Mental Illness (COPMI) Adult mental health services Drug and alcohol services Child protection training for drug and alcohol workers Families and Carers Training (FACT) Project Specialised drugs in pregnancy services Sponsoring and partnering with the NGO sector Partnering with government agencies Information and educational campaigns and resources for families Services for families and new parents NSW Strategy to Reduce Violence Against Women Staying Home, Leaving Violence program Community drug action teams projects	Physical abuse and neglect of children services
Legal			Joint investigation response teams (JIRTs)

Primary prevention

Health

Health

The New South Wales health system and health workers play a key role in assisting children and families to achieve health and wellbeing.

NSW Health provides a range of health care services to children and their families. Health services specifically provided for children and their families include:

- early childhood health services
- family care centres
- residential family care centres
- parent help telephone lines
- child and family teams in community health services
- child and adolescent mental health services
- children's wards in general hospitals
- specialist children's hospitals.

GPs are major providers of care within the primary health care system. They are key partners in the provision of health services for children and their families.

Supporting Families Early

The Supporting Families Early (SFE) package consists of:

- the Maternal and Child Health home visiting policy
- Safe Start Strategic Policy
- Safe Start Guidelines: Improving Mental Health Outcomes for Parents and Infants.

The package contains policy and guidelines for the identification of vulnerable families from a universal platform of primary health care services in a non-stigmatising way. This is through the comprehensive primary care assessment model, SAFE START, and the provision of maternal and child primary health care services including Universal Health Home Visiting.

All mothers in New South Wales have access to screening and support services through local area health services. Women have access to services that support parental wellbeing and enhance parenting skills.

SFE also supports maternity and child and family health workers to be better equipped in identifying emotional issues, mental health problems and supporting women to get the right support.

The primary health model of care in the perinatal period consists of the following elements:

- comprehensive primary health care assessment
- determination of vulnerabilities and strengths

- team management approach to case management and care planning
- determination of level of care required
- review and coordinated follow-on care.

This is supported by, and delivered in partnership with, other health staff who provide care to infants and their families through a team approach. The integrated approach to perinatal and infant care aims to achieve the following key results:

- improved child health and wellbeing
- enhanced family and social functioning
- provision of services that meet the needs of children and families
- improved continuity of care.

Health home visiting

Health home visiting is not delivered in isolation but forms part of the continuum of care and network of services for families with young children, beginning in pregnancy. Comprehensive assessment and coordinated care provide the platform for health home visiting, which has a number of models. It is mandatory for area health services to provide universal health home visiting (UHHV). This is the offer and the provision of a home visit by a child and family health nurse to families with a new baby within two weeks of the birth of the baby.

The objectives of UHHV are:

- to improve access to services by contacting and offering a home visit to all families with newborns
- to introduce families to the concept of health home visiting in a non-stigmatising manner
- to actively engage those families that do not traditionally access maternity and early childhood health services and that need extra support
- to engage families with the child and family service system and to provide support early, within two weeks of birth
- to better determine families' needs for ongoing care by adding depth and context to the assessment by conducting it in the family home and in partnership with the family
- to better provide ongoing care to clients where value is added by providing intervention in the home when need for this is indicated
- to ensure an introduction to, and connection with, community-based child and family services within Health and across other government and community organisations, for families that may not have readily accessed these services.

Mental Heath Access Line

The Mental Health Access Line is a 24-hour statewide access telephone line staffed by mental health professionals. This links into the National Health Call Centre agreed to by the COAG (NSW Health 2006).

Aboriginal Maternal and Infant Health Strategy

The Aboriginal Maternal and Infant Health Strategy (AMIHS) aims to decrease Aboriginal perinatal mortality by providing accessible, culturally appropriate maternity care programs for Aboriginal families across New South Wales. AMIHS commenced in December 2000 with recurrent NSW Health funding. The strategy includes:

- seven targeted antenatal/postnatal programs for Aboriginal women and infants across Greater Western, Hunter New England and North Coast area health services, representing 20 local government areas (LGAs)
- a statewide training and support program for midwives and Aboriginal health workers (NSW Health 2006).

AMIHS is a community-based primary health care model through which a midwife and an Aboriginal health or education officer work in equal partnership to provide maternity care in a culturally safe environment to pregnant Aboriginal women. AMIHS maintains strong links to relevant services such as early childhood health, mental health, drug and alcohol, and provides advocacy and support for the woman and her family within mainstream services. There is a strong focus on education and development of a 'culture of antenatal care' within Aboriginal communities.

AMIHS has been operating in seven sites across New South Wales since 2000, providing advocacy and support for pregnant Aboriginal women and their families. The strategy funds health promotion and community development activities. An Aboriginal women's reference group guides service delivery with the philosophy of Aboriginal participation and ownership.

Early childhood health services

Early childhood health centres provide support to families and a range of services relating to the health and development of infants and children aged birth to five years, which are delivered in accordance with the principles of NSW Families First.

Early childhood health centres are staffed by health professionals (including registered nurses) who specialise in child and family health. Child and family health nurses work in multidisciplinary teams comprising allied therapists and psychosocial clinicians. These teams are based in community health centres.

New South Wales community health centres may assess and manage some developmental delay, emotional and behavioural problems for children and young people. Services may also include generalist counselling services and counselling to victims of domestic violence and adults experiencing other problems that may affect their ability to parent. There are 500 community health centres in New South Wales.

Women's health services

Women's health services provide health promotion programs for women, such as mental health, violence prevention and pregnancy services and physical activity, smoking cessation and health improvement programs.

Child, adolescent and family health services

Child, adolescent and family services include youth health, paediatric allied health (physiotherapy, occupational therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, postnatal programs, early intervention and school surveillance services.

Prenatal reports (NSW Health and DoCS pilot)

The New South Wales Ombudsman's *Report of Reviewable Deaths in 2005 Volume 2: Child Deaths* contained a recommendation that NSW Health and DoCS jointly develop a system by which hospitals can alert DoCS about the birth of a baby if needed.

The *Children and Young Persons (Care and Protection) Miscellaneous Amendments Act 2006* came into effect on 30 March 2007. The amendments affect information sharing between NSW Health and DoCS regarding prenatal reports as an extra risk factor that must be taken into account when assessing risk of harm to a child.

NSW Health has developed and circulated policy directive 'PD2007_023 Prenatal Reports' to assist NSW Health staff to understand the legislative changes and their obligations in relation to prenatal reports. A pilot at a limited number of sites is currently underway.

Midwifery continuity of care

Under this model, care is provided where possible by the same midwife or small group of midwives across the antenatal period, birth and early postnatal period. There is evidence that women receiving continuity of care have reduced worry levels, greater sense of control, a more positive birth experience and high levels of satisfaction compared to those receiving standard care. These results accord well with existing theory and research evidence on social support in maternity care. Reduced levels of worry may have important implications for maternal and infant health. A confident mother is believed to be prepared for early parenting.

Continuity of care builds relationships which facilitates effective access to services, advocates for women when they are unable to advocate for themselves, and prevents some women 'falling through the gaps' in the service.

Family support

Families NSW is a whole-of-government strategy targeted at families expecting or caring for children younger than eight years. Families NSW is based on research that demonstrates the way in which families are supported in the early years of their children's lives has lasting effects on the children's development and later education, health and economic outcomes. The two underpinning principles of the Families NSW strategy are:

- a strengths-based approach to working with families, inclusive of all cultures and family types
- a planned, coordinated service system that is responsive to the needs of families.

The Communities Division of DoCS administers the strategy in partnership with the other human service agencies of NSW Health, Department of Education and Training, Department of Disability, Ageing and Home Care, and the Department of Housing.

Projects have included:

- providing more than 250 000 home visits for new parents and babies. More than 70 000 families are offered a home visit each year by child and family health nurses
- establishing 51 schools as community centres statewide, to help link families with schools from early childhood
- establishing more than 180 supported playgroups across New South Wales
- playgroups being coordinated by a trained professional to give parents an informal way to share experiences and build confidence in parenting
- establishing local antenatal programs to assist with the early identification of vulnerable families and the development of care pathways to improve access to services.

Over the next four years the New South Wales Government will build on these efforts in providing:

- assessment for every pregnant and postnatal woman in New South Wales to identify issues with which she may need extra help, including depression and other emotional problems
- early literacy and numeracy assessment for all children as soon as they start school. This will allow teachers to determine how well a child can read, write, speak and count and provide additional support if required
- the Triple P Positive Parenting Program® for all parents with a child three to eight years. Triple P is an evidence-based parenting program, aimed at equipping parents with the tools and skills they need to build a positive relationship with their child
- a 24-hour parenting helpline for parents with children and adolescents (birth to 18 years). Trained counsellors will be available to answer a range of questions, from sleeping in infancy and managing discipline to parenting a teenager.

Family worker services

Family worker services are a Families NSW service model. Family worker services involve skilled professionals working with a range of groups (such as teenage parents, fathers and Aboriginal parents) within local communities to provide support and assistance to parents in developing social networks, and life and parenting skills (DoCS 2006).

Supported playgroups

Supported playgroups are facilitated by qualified workers and provide an informal way for parents to learn from each other, the facilitator and invited professionals about child development and play. The supported playgroup can be a point of access for parents in gaining information about services, issues and general parenting advice and support (DoCS 2006). Supported playgroups are currently being evaluated.

Volunteer home visiting services

Volunteer home visiting services involve volunteers visiting parents of newborn babies and toddlers in their home to provide practical advice and support. Volunteers also assist parents in linking up with services and supports within their local community (DoCS 2006).

School as community centres

Schools as community centres are located in primary schools and provide a range of early childhood services and projects, including supported playgroups, parenting skills courses, breakfast clubs and transition-to-school projects. One of the main aims is to promote interagency collaboration in breaking down barriers to children successfully entering school (DoCS 2006).

Education and care

Children's services

Access to quality early childhood services is a vital plank of the New South Wales Government State Plan, released in November 2006 — see *Priority F6: Increase the proportion of children with skills for life and learning at school entry*. This priority is based on a wealth of research regarding the importance of early childhood services in promoting good outcomes for children and families. Research evidence also clearly points to early childhood services as an essential component of case planning for children who have been abused or harmed.

'Children's services' covers preschool, long day care, occasional care and family day care which are available for children under five years, as well as out of school hours care and vacation care services available for older children before and after school and in school holidays.

DoCS licenses over 3300 children's services in New South Wales, providing an estimated 146 120 places for children under the age of six years each day. Of the total number of services, 91 per cent are centre-based services — preschools and long day care (DoCS 2008).

Community preschools

DoCS licences all New South Wales preschools, and funds the operation of a significant number of them (about 800). The preschools are for children aged three to five years. DoCS estimates that around 85 per cent of children in New South Wales experience a preschool program through the range of children's services that are offered, including schools and long day care centres.

In-school preschools

DoCS licences preschools in 100 public schools across New South Wales. These are conducted by the Department of Education and Training. Preschools in public schools provide educational programs for children for one year prior to enrolment in Kindergarten. Twenty-four of these preschools are in communities with high Aboriginal populations. Children in geographically isolated areas may be eligible for a preschool program through the Dubbo School of Distance Education.

The Department of Education and Training employs an early childhood trained teacher and a teacher's aide in each preschool class. Teachers plan an educational program that nurtures each child's self-esteem, wellbeing and development. The preschool program is designed to stimulate children's thinking, communicating, investigating, exploring and problem-solving skills. Children are encouraged to join in physical activities and to develop good health and safety habits.

The program includes play-based activities that help children learn how to interact positively with other children and to recognise and accept their own feelings and those of others. The program also supports the development of early language, literacy and numeracy skills.

Long day care

Long day care is usually open for 10 or more hours per day, five days per week. Long day care usually takes children from six weeks to under six years of age. The regulatory requirements for long day care centres are that it must be licensed by DoCS under the *Children and Young Persons (Care and Protection) Act 1998* and related Children's Services Regulation 2004 as a centre-based children's service.

Occasional care

Occasional care offers an opportunity for parents to leave their child for short periods of time, either on a casual basis or as a temporary booking. Care may be for short periods of time, depending on the service. The regulatory requirements for an occasional care centre is that it must be licensed by DoCS under the *Children and Young Person's (Care and Protection) Act 1998* and related Children's Services Regulation 2004 as a centre-based children's service. Occasional care centres take children from birth to six years of age for variable hours up to five days per week.

Family day and home-based care

Family day care schemes coordinate care provided by family day carers in their own homes. Family day care carers operate alone with the support of the scheme. Carers can take up to five children from babies up to under six years of age and two school-aged children who need before and after school or vacation care. Home-based care is provided in the home of the carer for children. They are unsupported by a family day care scheme licensee.

Similarly to other care funded by DoCS, the regulatory requirements for a family day care and home-based schemes are that they must be licensed by DoCS under the *Children and Young Persons (Care and Protection) Act 1998* and related Children's Services Regulation 2004. Family day carers register with the licensed scheme. Family day care takes children from birth to 12 years of age. Home-based carers are licensed directly by DoCS.

Out of school hours care

Services are usually provided before and after school hours and during school holidays for children who attend school. The regulatory requirements for an out of school hours care centre are that it must be registered with DoCS under the *Children and Young Persons (Care and Protection) Act 1998* and related Children and Young Persons (Care and Protection) Regulation 2000. This service is available for school-aged children.

Kindergarten

Children may enter kindergarten at the beginning of the school year in government schools if they turn five on or before 31 July in that year.

The Best Start kindergarten initiative is run by the Department of Education and Training and commenced in 2008. The initiative is an assessment that includes aspects of:

- writing
- reading
- comprehension
- speaking
- phonics and phonemic awareness
- understanding concepts about print
- counting skills or awareness
- arithmetic strategies
- units
- pattern recognition.

In 2008, the Best Start kindergarten assessment was rolled out to more than 400 schools. A further 600 schools will be implementing the program in 2009 and all 1700 primary schools participating by 2010.

Best Start not only assesses early literacy and numeracy development, but also:

- provides early learning plans for students in the early years of school using the information obtained from the new assessment
- allows, over a period of four years, an extra 200 reading recovery teachers to provide struggling students with the one-on-one tuition they need
- increases the support for teachers through the provision of time for literacy and numeracy leaders in every primary school
- provides practical advice and information to parents about how they can best support their child's early development and reinforce in the home what is being taught in the classroom.

Schooling

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

Child protection education

As part of the personal development, health and physical education curriculum, students in New South Wales public schools participate in child protection lessons. These lessons help children identify dangerous or uncomfortable situations and to seek help from trustworthy adults. The child protection lessons were developed by the Department of Education and Training and are an important priority for schools.

The child protection classes are introduced and discussed with parents prior to the lessons beginning.

Child safety

Blue Light Unit

The Blue Light Unit began in New South Wales in 1983 and has provided a strong Police and Community partnership ever since. Blue Light aims to provide young people with entertainment in an environment free from drugs, alcohol, intimidation and antisocial behaviour in partnership with the NSW Police and the wider community.

Blue Light has evolved to include both off duty and on duty police working together with community volunteers to provide events. There are currently 43 branches operating throughout NSW providing events such as discos, movie marathons, pool parties, camps, debating, markets and stalls and much more.

Secondary prevention

Health

Specialist child and adolescent mental health services

The great majority of children and young people with mental health problems who receive treatment do so in a community setting. For many, assistance is provided outside specialist child and adolescent mental health services, through other professionals including GPs, school counsellors and paediatricians.

CAMHS provide specialist assessment and treatment services for children and young people with developing mental health problems or disorders, a considerable proportion of whom are likely to have experienced abuse or neglect. CAMHS play an important role in the provision of assessment and treatment for children and young people at risk of harm or who have experienced abuse or neglect. CAMHS also provide consultation to and liaison with other services and agencies.

There are now eight geographic area health services across New South Wales; Justice Health and the Children's Hospital at Westmead are other public health organisations with specialist statewide roles. CAMHS differ widely in the distances across their geographic catchments and in their current staff configurations. Although CAMHS staff are not distributed across all towns, all area health services have some specialist community CAMHS capacity during office hours.

Specialist program — Redbank House, Sydney West Area Health Service, has an alternative care clinic that provides mental health services exclusively for children in out-of-home care. It works closely with the DoCS Metro West Intensive Support Services.

Child and adolescent mental health inpatient care — CAMHS include acute inpatient care in declared units (which can provide involuntary care under the *Mental Health Act 2007)* for patients up to the age of 18 years. There are 55 specialist child and adolescent mental health acute beds in New South Wales, 47 of which are in declared facilities, with more in the planning and design phase. The six specialist acute inpatient CAMHS are:

- Redbank House Acute Adolescent Unit (Westmead Hospital) — 9 beds
- Gna Ka Lun (Campbelltown Hospital) — 10 beds
- Nexus Unit (John Hunter Hospital, Newcastle) — 12 beds
- Hall Ward (the Children's Hospital at Westmead) — 8 beds

- Lismore Hospital — 8 beds
- Sydney Children's Hospital — 8 beds, not declared

The unit at Sydney Children's Hospital is funded for eight acute beds but the unit is not declared under the *Mental Health Act 2007* and cannot provide involuntary treatment. South Eastern Sydney/Illawarra Area Health Service is planning a transfer of beds to a new unit on the Randwick site to fill a higher acuity role with increased occupancy.

A longer term CAMHS inpatient development program is underway with planning for Hornsby, Shellharbour, Orange inpatient services, and a Sydney Children's Hospital rebuild.

High intensity long stay unit (Concord) — the unit is completed but not yet operational. It is designed for the treatment of those young people with significant impairment who require treatment in an inpatient setting due to continuing risk and/or unremitting symptoms that are slow to respond to treatment (length of stay is usually 6–12 months). It will utilise a recovery framework treatment delivered in a developmentally appropriate way and in partnership with educational and vocational services. It is not intended to take urgent assessments or patients requiring acute care. Beds will be declared. The unit will have capacity for 12 young patients and accommodate two parents/carers to improve care planning, treatment and transition.

Non-acute inpatient units (Redbank House, Rivendell at Concord) — these inpatient programs provide comprehensive assessment, therapy and treatment recommendations. They operate on a Monday to Friday basis, with a strong special education focus and patients are accepted for a period of months (often based on school terms). These units are not declared.

Intensive family intervention units:

- Coral Tree Family Service, Northern Sydney, Central Coast Area Health Service — is a time-limited admission of families which provides a means for more intensive family-oriented assessment and treatment for children with difficult and complex behavioural issues, particularly where there are associated mental health and parenting problems. Generally of a five day/four night duration, the program includes the targeted individual, family and parent interventions.
- Redbank House, Sydney West Area Health Service — is an example of a therapeutic intervention provided through mental health services to support families. The Child and Family Unit at Redbank House provides day patient and inpatient programs for primary school children aged five to 12 and their families; some outpatient services are also provided. The inpatient service is a family residential admission program, in which families stay at the unit for one to three weeks.

Day programs (Redbank House, Rivendell, Pine Lodge at Orange, Lismore and Shellharbour are planned) — providing intensive treatment in a community-based setting and, often co-located with inpatient units, this level of care can provide a 'step-up or step-down' approach between hospital and community treatment and incorporates a structured special education program.

Justice Health interventions — Justice Health has been responsible for the coordination of health care, including mental health and drug and alcohol services, to young people detained in custody since 2003. As part of a number of strategies to address these issues, Justice Health has established the Adolescent Health Community Integration Team, which will assist in coordinating the ongoing care of young people with mental health and/or drug and alcohol problems leaving custody in New South Wales. This team aims to coordinate care prior to and during the critical post-release period, increasing the likelihood of their successful integration back into the community and connection with appropriate specialist and general community services.

Justice Health established a specialist Forensic CAMHS (the Justice Health Adolescent Court and Community Team) in 2006 to improve the coordination of mental health and drug and alcohol service provision to young people in contact with the criminal justice system. The service has now been expanded to a number of the other New South Wales Children's Courts including Parramatta, Bidura (Glebe) and Campbelltown. The Justice Health Adolescent Court and Community Team has shown a high level of diversion from custody into treatment. The Adolescent Court and Community Team also offers expert advice to other service providers, such as the Department of Juvenile Justice, Department of Community Services and CAMHS, on the management of young people with high-risk behaviours who have concurrent mental health problems.

An Aboriginal mental health worker trainee has been employed as part of the Justice Health Adolescent Court and Community Team. This position will develop links with the wider Aboriginal and non-Aboriginal Community and provide support to Aboriginal young people in the context of the work of the Justice Health Adolescent Court and Community Team.

It is important to be aware that despite the expansion of specialist services, the vast majority of young people with mental health problems and a history of offending, or at-risk behaviours, will present to and be managed within 'non-forensic' CAMHS. Justice Health is developing a program to upskill area health service staff, including CAMHS staff, in risk assessment and management.

Forensic adolescent unit (not open) — the new unit in Malabar will have a statewide specialist service role with the capacity to treat both forensic (mostly transferees) and civilian patients who pose a risk of harm to others and who cannot be managed safely in conditions of lower security. The unit has capacity for six female and ten male adolescents. Young people will be considered to be eligible for admission to the Unit if they are aged between 14 and 21 at the time of referral, are detainable under either the *NSW Mental Health Act 2007* or the *NSW Mental Health (Criminal Procedure) Act 1990*, present a risk to others and require treatment in a high secure facility. The service model under development is multidisciplinary and recovery-based, with strong community partnerships to achieve discharge and ongoing safe care.

Youth-specific drug and alcohol services

The Nepean Youth Drug and Alcohol Service (NYDAS) provides specialist treatment for young people aged 12 to 20 years presenting with drug and alcohol problems. This is a statewide service based in Western Sydney and provides young people with access to a broad range of strategies from prevention and early intervention to inpatient and long-term care.

Services include clinical assessment, specialist adolescent drug and alcohol medical services, inpatient and outpatient detoxification treatment, opioid substitution treatment, psychology and counselling interventions, and assertive case management.

Furthermore, NYDAS has been designed to ensure strong partnerships with other services involved in the care of marginalised and at-risk adolescents and young people. The initiative reflects the importance of partnerships with emergency and longer term accommodation services, adolescent rehabilitation services, youth outreach and neighbourhood programs.

Referrals for NYDAS are accepted from anywhere in the state. With minimal availability of detoxification places for young people in the state, NYDAS provides an important statewide function in the treatment of substance abuse for young people.

Adolescent consultation liaison services at Children's Hospital Westmead provides specialist clinical care to young people aged 12 to 18 years who present with drug and alcohol related issues. This service provides a broad range of services that focus on early intervention, harm minimisation and management of the health consequences associated with drug use. In addition, adolescent consultation liaison provides specialist services including medical services, health promotion, specialist drug and alcohol counselling, case management and consultation around detoxification services, and opioid substitution treatments. The service works within a multidisciplinary model of care acknowledging the complex range of concerns and issues facing young people.

Family care centres

Family care centres facilitate the wellbeing of families by providing an intensive and long appointment or day stay model at a secondary level of health care. They provide day stay facilities for the more complex developmental, behavioural, feeding, sleeping and adjustment problems of infancy. Family care centres are non-inpatient facilities. Karitane and Tresillian are family care centres that provide inpatient residential programs as well as day stay programs.

The philosophy of care is family focused with an emphasis on and recognition of the interests and wellbeing of children as paramount.

The service liaises, communicates and cooperates with early childhood health services, local maternity hospitals, GPs, pediatricians, psychiatrists, pediatric allied health services, and child and family health and other community services to promote continuity of care for families.

Youth health centres

Youth health centres provide counselling, outreach and needle exchange services for young people aged 12 to 24 years. They also target young people who are homeless or at risk of becoming homeless (DoCS 2006).

NSW Refugee Health Services and NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

STARTTS is a statewide service catering for the growing needs of traumatised refugees, particularly those who have been tortured as part of their ordeal. STARTTS provides a range of psychological and psycho-social interventions to people from refugee and refugee-like situations within individual, family and community contexts. It also promotes capacity building among service providers working with this client group through its training program.

STARTTS programs operate on a number of levels of the social system including individual, family, refugee community, and mainstream society and service providers. STARTTS programs are of a holistic nature and include counselling and psychotherapy, youth program, the Families in Cultural Transition (FICT) program and a variety of community development initiatives. STARTTS receives funding from a number of sources including the New South Wales Department of Health, Department of Immigration and Multicultural Affairs (DIMA), the Australian Government Department of Health and Ageing, and the Department of Employment and Workplace Relations.

Integrated Perinatal and Infant Care Program

The New South Wales Integrated Perinatal and Infant Care (IPC) Program uses an internationally innovative model of assessment, prevention and early intervention to identify the mental and physical health needs of parents and their infants during pregnancy and after birth.

This is then linked to providing appropriate care and support to mothers, families and infants at risk of adverse physical and mental health outcomes. Several area health services are implementing this initiative with much of the early developmental work provided by South Western Sydney AHS and Royal Hospital for Women.

Specialist child and adolescent mental health teams

These are based on an area or regional catchments and consist of multidisciplinary specialist teams, based in the community or attached to general hospitals offering assessment, treatment, referral, consultation and case supervision to primary care services, community residential facilities and other agencies. The emphasis is on early intervention and treatment within the family and community setting.

Community-based residential units

Supported accommodation outside the natural, extended or alternate family may be necessary for some children and adolescents with mental illness. Placement in a group home where management and supervision is supported by specialist mental health staff may be desirable in these circumstances.

Mental health services in paediatric hospitals

Children and adolescents suffering from mental health problems secondary to a variety of physical disorders should receive mental health assistance in close association with their physical treatment. Major paediatric hospitals have developed separate wards for adolescent patients. All such hospitals have access to child psychiatry consultation services.

Family support

Residential family care services

NSW Health provides four residential family care services in Sydney. These specialist services, through Tresillian and Karitane, provide intensive specialist support and care for complex parenting issues. Services include day stay services, outreach services, group programs, home visiting, 24-hour crisis telephone services and education programs, as well as the residential parenting services.

The NSW Parenting Program for Mental Health

The NSW Parenting Program for Mental Health was established to promote evidence-based parenting initiatives with the aim of preventing behavioural and emotional problems in young children. There are dedicated parenting positions based in eight area mental health services — Northern Sydney/Central Coast, South Eastern Sydney/Illawarra, Sydney South West, Sydney West, Greater Southern, Greater Western, Hunter region/New England and the North Coast.

Parenting programs can prevent the onset of, and provide early intervention and treatment for, mental health problems and disorders for children and parents. The NSW Parenting Program for Mental Health involved:

- the development of a New South Wales parenting partnerships framework for mental health service involvement in promotion, prevention and early intervention through parenting initiatives
- training for parenting programs
- clinical access to programs
- an interagency advisory committee that provided advice on the development and implementation of the framework and cross-agency involvement and collaboration.

Parenting programs are established in area health services and some current parenting initiatives have been implemented as cross-agency or whole-of-government programs (for example, Triple P).

Brighter Futures

A DoCS flagship early intervention program, Brighter Futures is directly modelled on research evidence. In partnership with funded non-government agencies, it provides integrated services targeted to families with children in the birth to eight age group, with a priority for birth to three years (including prenatal referrals) with particular identified vulnerabilities (DoCS submission to Wood Inquiry 2008).

The Brighter Futures program provides case management, home visiting, parenting programs and children's services for children aged birth to eight years who are at risk of being referred to statutory child protection services. The objective of the program is to prevent family issues from escalating to the point at which they may require protective intervention. Brighter Futures is intended to be fully implemented end of 2008.

A key aspect of Brighter Futures is the focus on early intervention workers. Each child is assigned an early intervention worker, who works in partnership with families to address the individual needs of the child. In this way, parents and families are brought into the centre of decision-making regarding their and their children's experience of the child and family service sector.

Better Futures

The Better Futures program provides early intervention services to children aged between nine and 18 years. The program includes a mix of prevention as well as early intervention services. The program provides a range of services that aim to encourage youth participation, increase school retention, improve educational outcomes and build young people's resilience Early Intervention Program

This Early Intervention Program is a voluntary targeted program designed for families encountering problems that affect their ability to care for their children. The program identifies children and families who are vulnerable or likely to be at risk of harm, and provides them with targeted supports before further problems arise or become serious.

There are two pathways into the program:

- one pathway is through a report of risk of harm to the Department of Community Services helpline and then through to a local community services centre. A screening is completed on low to medium level risk of harm reports to determine the suitability of the family for referral to the program
- the other pathway is via a community referral to a lead agency, directly from another agency or person. Lead agencies are funded to undertake referral, intake, assessment and ongoing case management with families.

Eligibility for the program is determined by DoCS for all the families entering the program from either pathway. Families may be case managed by either a DoCS early intervention caseworker or by the lead agency. Lead agencies will case manage all families referred via community referral, and the DoCS early intervention team will also transfer some families to the lead agency for case management.

The program uses a strengths-based practice approach that recognises and fosters family strengths and responds to the individual, familial, social, cultural and environmental factors that affect a family. Early intervention caseworkers work closely and over an extended period with families and community agencies to identify and review family strengths and needs, facilitate support and build the parent–child relationship and the wellbeing of the family unit.

A key component of the Early Intervention Program is that families can access the full range of services and supports they require through a single entry point, either through a DoCS early intervention team if there has been a report of risk or harm, or through the lead agency. This is intended to promote efficient and consistent service provision and a more collaborative approach to service delivery.

DoCS intensive family based services

DoCS currently funds seven intensive family support services, known as intensive family based services (IFBS) with one of these in the establishment phase in the Hunter/Central Coast region. They are intensive 24-hour, seven-day, time-limited home-based programs for families whose children are at imminent risk of being placed in out-of-home care.

The seven DoCS IFBS services are Aboriginal specific with caseworker support available at any time. In addition, there is a generalist service (Burnside in Campbelltown), which has round the clock support. All offer services on a case-by-case basis for families where reunification plans are in place (although this is not the main focus of these programs).

Education and care

The NSW Health School-Link program

NSW Health's School-Link program is a collaborative initiative between NSW Health and the Department of Education and Training. It was established in 1999 to improve the mental health of children, adolescents and young people across New South Wales. It is one of a number of initiatives of NSW Health under National Mental Health Reform Incentive Funding.

School-Link has three main areas of focus:

- strengthening formal and informal links at local and area level between TAFE, schools, school counsellors and local child and adolescent mental health services
- developing and implementing training programs for mental health workers and school and TAFE counsellors to enhance skills in the recognition, intervention planning, treatment, support and prevention of mental health problems in adolescents
- supporting the implementation of programs such as adolescents coping with emotions (ACE), resourceful adolescent programs (RAP) and MindMatters in schools for the prevention of or early intervention in mental health problems.

NSW Health has appointed School-Link Coordinators in each area health service to work with schools, CAMHS, youth mental health services and other health services for children and adolescents.

Child safety

DoCS Helpline and child protection casework

Suspicion that a child or young person is at risk of being neglected or physically, sexually or emotionally abused is reported via the DoCS Helpline. Once an initial assessment has been conducted, a report may be referred to a community service centre (CSC) for further investigation or casework. Child protection caseworkers are based at 85 CSCs across New South Wales. Twelve of these offices now also have early intervention casework teams, and many also have out-of-home care teams. A report can also be referred directly to a joint investigation response team (JIRT), made up of NSW Police, DoCS staff and NSW Health.

If a child is safe, but the family is having difficulties or has special needs, the caseworker may assist the family to get specialist help, such as counselling, parenting programs, respite care or family support services.

Specialist services for parental risk factors

NSW Family and Carer Mental Health Program

The NSW Family and Carer Mental Health Program was established to fund NGOs and mental health services to provide education and support for families and carers. This $3.6 million statewide program is the first of its kind in Australia. It is an evidence-based program to guide support for, and partnerships with, families and carers of people with mental illnesses and disorders across New South Wales.

Since 2006 the program has been extended to provide:

- specialist clinical advice and a comprehensive range of support services for families and carers

- education and training for families and carers
- information for new carers about their rights and responsibilities
- involvement of families and carers in assessment, care planning and discharge planning of a loved one
- Better access and referrals for families and carers to other community support services (NSW Health 2006).

DoCS Domestic Violence Line

DoCS Domestic Violence Line is a statewide free-call number and is available 24-hours, seven-days. It provides telephone counselling, information and referrals for those who experience or who have experienced domestic violence.

Trained female caseworkers provide the telephone counselling. The caseworkers are sensitive to the needs of people who have experienced domestic violence. The service has an extensive list of contacts, people and services across New South Wales who can further help victims of domestic violence such as referrals to women's refuges. The service also makes referrals to family support services, counselling, the police and courts, lawyers and hospitals and helps with transport, emergency accommodation and other relevant support.

The Domestic Violence Line services the special needs of Aboriginal women and women from other cultures, as well as those living in rural and remote areas.

Children of Parents with Mental Illness

In New South Wales there are dedicated Children of Parents with Mental Illness (COPMI) positions based in the eight area mental health services that focus on children whose parents have mental health problems and disorders. In order to provide a systematic approach to identifying problems early for children whose parents have mental health problems, *The NSW Mental Health Service Framework for Children of Parents with a Mental Illness* has been developed.

The framework identifies and sets out strategic directions for an integrated approach for area mental health services with NSW Health partners to improve the mental health and wellbeing of children and young people in New South Wales who have a parent with a mental illness. The framework aims to:

- promote the wellbeing and reduce the risks for infants, children, adolescents and their parents/carers
- identify and provide responsive services for families where a parent has a mental illness
- strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.

Adult mental health services

Whilst the focus of the adult mental health services is on adults, they also have a role to play in the assessment of children and young people who may be at risk as a result of their carers having a mental illness. The services can also intervene to ensure that children and young people are safe and protected.

NSW Health has developed a risk of harm assessment tool to assist mental health staff to identify and address child protection issues when conducting mental health assessments of adults. All staff must, at first point of contact, establish and document which adults who are referred to mental health services have contact with, or are carers of, dependent children. They must apply the assessment tool to determine whether there is a need for reporting risk of harm to DoCS.

A written plan, which details follow up care, should be completed for all clients responsible for the care of children. The care plan will address parenting substance use issues, child behaviour issues and whether child and family specific services are involved or need to be involved.

Drug and alcohol services

Again, while these services focus on adults, they clearly have a role to play in the assessment and identification of children and young people who may be at risk of harm as a result of their parents or carers having substance abuse problems. Such services also have a responsibility to intervene to protect and ensure the safety of children and young people.

Child protection training for drug and alcohol workers

NSW Health has engaged the Education Centre Against Violence to develop and undertake a comprehensive training program for drug and alcohol workers on child protection risk factors associated with children living in families characterised by parental substance use and dependence.

As part of the program, training will be provided to 1500 drug and alcohol workers across all area health services and the non-government sector over the next two years. The training will focus on a number of key areas including the intersection of domestic violence, neglect and parental substance use issues. The training will support drug and alcohol workers to build capacity around child protection issues, including how to make an assessment of risk of harm to a child, when and how to report any child protection concerns, and to identify and address the broader needs of the family and the child. In addition, it will also help to address Parental Responsibility Contract issues (see Services for new parents and families, below), provide information on drug testing, and reporting on both antenatal and postnatal risks.

This training will also aim to address the likely impact of chronic and dependent substance use on the capacity of individuals to cope with children. This will be weighed up against the parent's long-term needs as a client of drug treatment services.

Families and Carers Training Project

To ensure that health workers are trained in how to provide information to families and carers and involve them more in treatment, the Families and Carers Training (FACT) Project was established. Available in six community languages, FACT is a resource 'package' for generalist and community health workers to give family members and carers of drug users simple information about drug and alcohol issues, treatment options and self care skills.

Specialised drugs in pregnancy services

The drugs in pregnancy services focus on pregnant women and mothers of newborn to five-year-olds with drug abuse problems. NSW Health is in the process of conducting a 'Drug use in Pregnancy Services: Services and Linkages Review'. The aim of this review is to explore three critical areas including:

- strategies to identify, establish and implement common minimum standards in New South Wales
- ongoing statewide coordination and development of the drugs in pregnancy services
- strategies to evaluate the effectiveness of the Drugs in Pregnancy Services program.

NSW Health is in partnership with the South Australian Department of Health to develop the *National Clinical Guidelines for the Management of Drug Use in Pregnancy, Birth and the Early Development of the Newborn.* These guidelines review current research and best practice, draw on leading national expertise and evidence, and provide key recommendations for the prevention, treatment and care of women and babies with drug and alcohol problems.

Sponsoring and partnering with the NGO sector

NSW Health funds the NGO sector to improve information provision to families and carers. For example, financial support was provided to the Network of Alcohol and other Drug Agencies' (NADA) conference on families, children, alcohol and drugs. Also, funding to the statewide Alcohol and Drug Information Service (ADIS) and Family Drug Support (FDS) was increased. ADIS and FDS provide 24-hour, seven-day telephone assistance, advice and support for families affected by drug use.

NSW Health has also funded services that directly increase the involvement of families in treatment. For example, 12 new non-government drug and alcohol residential rehabilitation beds for parents accompanied by children were sponsored in 2006 and 2007. Financial support enables NSW Health to directly leverage the existing networks and efforts of groups already making a difference.

Partnering with government agencies

NSW Health acknowledges that increased partnership between agencies is required to better support families and carers. NSW Health has partnered with DoCS to help to facilitate information sharing between New South Wales opioid treatment prescribers and DoCS caseworkers, and a *NSW Health and DoCS Information Sharing Protocol* has been developed. This has helped to facilitate more informed assessments of risk of harm to children (particularly in relation to takeaway food) when one or more of the parents are in opioid treatment.

Information and educational campaigns and resources for families

A number of information and educational campaigns have been launched by NSW Health specifically to help empower the families and carers of persons in drug and alcohol treatment. For example, *the Family Matters* drug and alcohol information booklets contain tips for parents and carers on how to talk to their children about drugs and alcohol.

Also, specifically for Aboriginal families, *No Shame, No Blame* information and education resources were prepared to provide information and education, coping and self care skills for Aboriginal families concerned about the drug or alcohol use of someone close.

The *Kids and Drugs Don't Mix* education campaign was launched in late 2006. It targets prescribers, dosing points and patients on the opioid treatment program. The campaign provided advice on the safe storage of methadone, safe sleeping practices and information on settling babies.

Services for families and new parents

The unique needs of parents that are raising a family and undergoing drug and alcohol treatment have also been acknowledged through the introduction of Parental Responsibility Contracts. These bind parents who are DoCS clients to three drug and alcohol treatments and counselling sessions a week. Conversely, Parent Risk Assessments are conducted for drug and alcohol clients where parental substance use is a child protection concern.

The information needs of families and carers are also increasingly being addressed. For example, the Alcohol and Other Drug Overdose Prevention Program works with both drug users and their families to help them recognise and treat the symptoms of an overdose. This program has now been broadened to include Aboriginal and culturally and linguistically diverse (CALD) communities in rural and regional areas of New South Wales.

NSW Strategy to Reduce Violence Against Women

The NSW Strategy to Reduce Violence Against Women was established in 1997. It is managed by the Violence Against Women Specialist Unit, Communities Division, and the Department of Community Services. The program works with an interagency partnership approach and focus on prevention, recognising that there are many forms of violence and diverse response needs.

The strategy is a partnership of seven government agencies — DoCS, the Attorney General's Department of NSW, NSW Health, NSW Police, the Department for Women, the Office for Women, NSW Premier's Department, the Department of Housing and the Department of Education and Training.

The strategy works within three key structural elements:

- the Violence Against Women Specialist Unit — located in the Communities Division of the Department of Community Services, its role includes providing project management and conducting strategic liaison with other agencies
- a regional violence prevention specialist program — identifies violence against women issues in their region, develops violence prevention plans with the relevant agencies, and facilitates community education programs and capacity building
- a state management group — promotes, markets and monitors the implementation of the strategy within its corresponding organisations.

Staying Home, Leaving Violence program

The Staying Home, Leaving Violence program is a family and domestic violence initiative — one of the community strengthening strategies coordinated by DoCS Communities Division (DoCS 2008).

Community drug action teams projects

The community drug action teams (CDATs) are part of the Community Builders, which is one of the community strengthening strategies coordinated by the Communities Division of DoCS. CDATs have run many innovative projects since the start of the program that address drug and alcohol issues in their local communities. CDAT activities generally relate to:

- drug information and education
- information gathering and research
- safe environment, prevention and alternatives
- service/community cooperation/partnerships.

Tertiary prevention

Tertiary prevention services are predominately child protection services. These services are supported by several specialist health programs that provide intensive counselling and support, and an education program for children and young people in out-of-home care (OOHC) with high needs.

Health

NSW Health sexual assault services

NSW Health sexual assault services provide free counselling, information and medical services for anyone who has been sexually assaulted. They can provide testing and prevention for pregnancy and STIs. These services are based in certain hospitals across New South Wales.

NSW Health New Street Adolescent Service

The New Street Adolescent Service is an early intervention program for young people who have experienced sexual abuse. It is part of an interagency child protection response to the issue of child sexual abuse. The New Street Adolescent Service aims to assist the young person to address their past abusive behaviours and the harm these behaviours have caused, and to develop safe, respectful and responsible ways of behaving.

The program is designed for young people between the ages of 10 to 17 years who sexually abuse. Priority is given to those children aged 10 to 14 years. Parent/care giver participation is essential in the support of responsible and appropriate behaviours and lifestyles for these young people.

The services offered as part of the program are:

- individual counselling
- counselling and support for family and care givers
- group work
- consultation with agencies
- community education.

Child Protection and Sex Crimes Squad

The Child Protection and Sex Crimes Squad was established to ensure the provision of a specialist child protection service across New South Wales. These services are offered in partnership with the Department of Community Services and the Department of Health.

The aim of the squad is to:

- identify crime trends, and develop operational strategies, programs and policies, as well as investigate crimes
- maintain the Child Protection Register in accordance with legislative and policy requirements
- provide consultancy in local investigations if necessary

The squad includes:

- the Child Exploitation Internet Unit — investigates child sexual abuse and exploitation of children that is facilitated through the use of the internet, related computer and telecommunication devices.
- Child Protection Register — the Child Protection Registry has been established to monitor and maintain the New South Wales Police Child Protection Register, as per the *Child Protection (Offenders Registration) Act 2000*. Under this Act, persons convicted of a nominated violent or sexual offence against a child will be required to register at the police station in the locality in which they reside within 28 days of sentencing, release from custody or entering New South Wales after being found guilty of a registrable offence in another jurisdiction. Registrable persons will be required to provide police with certain personal information, travel plans and any changes to this information. The period of registration is for a minimum of eight years for an adult, four years for a juvenile offender and it is an offence not to register or to provide police with false information.

Child protection units

Child protection units are located at Sydney Children's Hospital (Randwick), Westmead Children's Hospital and the John Hunter Children's Hospital (Newcastle), and provide a specialist response to children and young people who have experienced abuse and their families. Services provided include a 24-hour crisis counselling and medical service, specialist assessment, forensic medical assessment, ongoing therapeutic and counselling services, medical treatment, complex consultations and expert testimony in court (DoCS 2006).

The NSW Pre-Trial Diversion Program

The Pre-Trial Diversion Program, which operates in New South Wales, is an innovative treatment program for the protection of children. It began operation in 1989 and is run by the Department of Health.

The Pre-Trial Diversion Program allows for certain categories of child sexual assault offenders to be diverted from the criminal justice process into a two year treatment program. The diversion occurs after charges have been filed but before the matter proceeds to conviction or entry of judgement. A conviction is recorded after the offender has been assessed 'suitable' and enters an undertaking at the District Court to participate.

During the two years, the offender is bound by the conditions of the treatment program. If the offender breaches these conditions, he will be returned to the criminal justice system for sentencing. If the offender completes the program successfully no further action against him will take place.

Pre-trial diversion is an alternative form of prosecution which attempts to increase the effectiveness of the criminal justice system. Its goals are the protection of children and the prevention of further child sexual assault in families where this has occurred.

Child and adolescent mental health — tertiary referral units

Run by the Department of Health, child and adolescent mental health targets children and adolescents at the community level. In particular, Tertiary Referral Units provide short-term crisis management, assessment and stabilisation of inpatient admissions. Inpatients range between four and 11 years for children's units and 12 to 18 years for adolescent units. Inpatient units have a supra-regional/area responsibility, but can also be linked to regional or area primary care and secondary referral services.

Family support

Victims Services (Attorney General)

Victims Services is part of the Attorney General's Department of NSW and consist of the Victims Compensation Tribunal and the Victims of Crime Bureau. Victims services also provides support to the Victims Advisory Board. The three bodies work together to help victims of crime in New South Wales access services and entitlements to assist in their recovery.

The Victims of Crime Bureau also coordinates support to families and friends of missing people and, to implement this role, the Families and Friends of Missing Persons Unit was established.

Victims Compensation Tribunal

The tribunal was established under the *Victims Support and Rehabilitation Act 1996* and consists of:

- magistrates (including the chairperson) who determine appeals against determinations and make orders for the recovery of monies from convicted offenders
- compensation assessors who make determinations in compensation claims and approve counselling applications
- tribunal staff that provide administrative support in the processing and determination of compensation and counselling claims, appeals and the restitution process.

Victims of Crime Bureau

The Victims of Crime Bureau was established under the *Victims Rights Act 1996* to provide a critical link between victims of crime and service providers throughout New South Wales. Services provided by the Bureau include:

- providing a 24-hour victims support line
- administering the approved counselling scheme and accrediting counsellors

- monitoring the Charter of Victims Rights
- hosting an interagency forum of key stakeholders in victims' services
- publishing the newsletter, the *Victims of Crime Chronicle*
- providing information and develop resource materials relating to support services for victims of crime.

Victims Advisory Board

The Victims Advisory Board was established under the *Victims Rights Act 1996* to consult community and government support agencies on issues and policies concerning victims of crime, and advise the Attorney General on policies and reforms relating to victims compensation and support services.

Child safety

Child protection services

Child protection services are provided by DoCS. They aim to assist at-risk children such as those living with domestic violence or with drug or alcohol affected parents.

At-risk children have a higher probability of suffering psychological and physical harm. DoCS' intensive and statutory intervention services protect children from risk of harm. These services include:

- assessment and investigation of reports of cases of child abuse and neglect
- intervention when children and young people are in need of care
- protection.

Referring at-risk children to child protection services is the responsibility of several bodies such as schools and health care providers.

Out-of-home care

Out-of-home care is key in achieving the overarching DoCS' goals of sustaining safer, healthier and more resilient children, families and communities by providing children and young people who cannot live with their birth families a safe and nurturing environment for a period of time, or permanently.

OOHC placement and support services are part of a continuum of integrated service provision to children and families in New South Wales — with early intervention and prevention at one end of the continuum and OOHC services at the other. OOHC services range from family restoration, general and intensive foster care, residential care, wraparound services including respite, supported independent living services, leaving and aftercare, and adoption. The placements can be emergency/crisis, short-term, long-term and permanent. OOHC supports all children up to the age of 18 years (DoCS 2007).

Specialist services for parental risk factors

Physical abuse and neglect of children services

Physical abuse and neglect of children (PANOC) services are run by NSW Health. All clients are referred by the Department of Community Services, who have identified children that are registered clients of DoCS service. These children's situations have been investigated and physical, emotional abuse and/or neglect has been proven and clients are being supervised by the department.

The PANOC services provide:

- counselling
- group work
- family work
- support and advocacy for children and families
- education for health professionals
- community education
- information about child protection
- community work.

Legal

Joint investigation response teams

Joint investigation response teams (JIRTs) are made up of DoCS, NSW Police and NSW Health professionals who undertake joint investigation of child protection matters. Joint investigations link the risk assessment and protective interventions of DoCS with the criminal investigation conducted by Police.

There are nine metropolitan JIRTs where police and DoCS officers work together in the same offices. In rural areas JIRTs are not usually co-located, but police and DoCS officers still work collaboratively. The Department of Health provides medical examination, counselling and therapeutic services to children or young people and their non-offending parents or carers, when required.

3.6 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN NEW SOUTH WALES

Service	2002–03 ($'000)	2003–04 ($'000)	2004–05 ($'000)	2005–06 ($'000)	2006–07 ($'000)
Child protection and OOHC	430 945	492 578	510 682	531 751	605 184

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, New South Wales received 189 928 notifications of alleged child abuse and neglect about 98 662 children. In the same year, 37 094 substantiations of child abuse and neglect were made pertaining to 13 690 children. The tables below provide an overview of the number of children subject to notifications, finalised investigations, substantiations, and care and protection orders from 2002–03 to 2006–07. It shows that the rate of children subject to notifications and finalised investigations has increased steadily since 2002–03. The rate of children subject to a substantiation, and on care and protection orders has also increased overall, despite a slight decrease in 2004–05.

NEW SOUTH WALES CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	65 621	43.3	70 571	46.7	77 262	51.3	84 356	56.2	98 662	64.9
Finalised investigations	17 811	11.8	na	na	26 909	17.9	37 206	24.8	46 227	30.4
Substantiations	11 434	7.5	na	na	9 198	6.1	12 627	8.4	13 690	9.0
Care and protection orders	8 975	5.6	na	na	8 620	5.4	9 213	5.8	10 639	6.6

Source: ROGS 2008, Table 15A.34, using AIHW data.

NEW SOUTH WALES CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	109 498	115 541	133 636	152 806	189 928
Substantiations	16 765	Na	15 493	29 809	37 094

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 4

Northern Territory

4.7 Verification status

This stocktake has been verified by the Northern Territory Department of Education and Training and Department of Health Services.

4.8 Stocktake of service systems

The table below provides a summary of the service systems for protecting children in the Northern Territory. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — NORTHERN TERRITORY

Sector	Primary	Secondary	Tertiary
Health	NT HealthDirect Well Baby Assessments and Clinics Maternal, Child and Youth Health (MCYH) Health Promotion Strategy Unit Women's Health Strategy Unit School health services Urban community health services Remote health program	Growth Assessment and Action (GAA) program The Strong women, Strong Babies Culture program Targeted maternal, child, youth health services	Sexual assault referral centres
Family support	7 steps to safety Playgroup Association NT Parentline	Family support services Our Family Our Kids	Crimes Victims Services Unit
Education and care	Schooling Safe Schools NT Children's Services Unit Drug Abuse Resistance Education	Special education consultants Special education and wellbeing programs The School Attendance and Enrolment Pilot	
Child safety		Safe houses Remote regional family and community workers team	Statutory child protection NT Families and Children's child protection Mobile child protection team

Sector	Primary	Secondary	Tertiary
Specialist services for parental risk factors substance abuse mental health family violence	Postnatal home visits	Parental responsibility orders Home Strength Web-based alcohol and other drug services Aboriginal Substance Abuse Program (ASAP) Mental health program policy and program management Crisis help lines: mental health on call team, family counselling and support crisis help line Services for young mothers Alcohol and other drugs service	Police Domestic Violence Unit

Primary prevention

Health

NT HealthDirect

NT HealthDirect is a telephone health advice and information line for Territorians and tourists. It is a free, completely confidential, 24-hour, seven-day telephone service. The service gives callers access to an experienced registered nurse who can provide information on symptoms, health concerns, advice on when to see a doctor or health service, and where to find them.

Well Baby Assessments and Clinics

Well Baby Assessments and Clinics provide regular check-ups for babies, along with parenting information such as breastfeeding, nutrition and safety. The service also provides workshops and groups, such as 'Meet Other Parents'. The service can also be accessed in a number of remote areas.

Parents can utilise this service for children up to five years of age and the latest developmental assessment is offered at four years of age. Child and family health nurses provide this service.

The health centres/clinics are open five days a week (Monday to Friday) from 8am to 5pm. The schedule is appointment-based for developmental assessments and specific issues. Drop-in clinics operate at different times, depending on the centre.

Immunisations take place at special immunisation clinics within the health centres, running up to five days a week in larger centres.

The Department of Health and Families also runs Well Baby Clinics (weights and measures/brief intervention) in rural areas or where it is known that support can be required when transport is difficult. The clinics operate in these areas for a morning session enabling parents to attend at times convenient for them. Some developmental assessment is offered at these clinics, by appointment only.

Maternal, Child and Youth Health

Maternal, Child and Youth Health (MCYH) provides program support, training and practical assistance to remote area health centres and communities for core programs such as pregnancy care, Growth Assessment and Action (GAA), and Healthy School Aged Kids (HSAK). In addition, the Strong Women, Strong Babies, Strong Culture Program is supported in 15 communities and funding has been allocated to support community-based child health workers to boost local child health capacity. The MCYH program is working collaboratively with the non-government Aboriginal Medical Service.

Health Promotion Strategy Unit

The Health Promotion Strategy Unit is leading the development of a structured systems approach to improving the design, delivery and evaluation of health promotion interventions with the aim of enhancing the effectiveness of health promotion and prevention strategies. This includes the development of a health promotion audit tool to capture evidence of the delivery and quality of community-based health promotion interventions.

These services are funded through an identified program within the Northern Territory Department of Health and Families.

Women's Health Strategy Unit

The Women's Health Strategy Unit develops strategic directions in partnership with community stakeholders. Specific focus in the past year included domestic violence screening tools, drink spiking education, maternal health services development, and female genital mutilation.

These services are funded through an identified program within the Department of Health and Families.

School health services

School health services provide expertise to school curriculum, in particular the middle years of schooling for wellbeing, nutrition/physical activity, sexual health education, alcohol and other drugs, and chronic diseases. They provide health and wellbeing education and support to students, and the school community, including parents and staff.

These services are funded through an identified program within the Department of Health and Families.

Urban community health services

Urban community health services provide a range of health promotion strategies, primary health care, including palliative care, community nursing, home birthing, child and family services to all residents of major Northern Territory centres, including Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Services are provided from community health centres and in the community including in clients' homes.

These services are funded through an identified program within the Department of Health and Families.

Remote health program

Primary health care (PHC) services are delivered to the remote population of the Northern Territory through a network of 54 remote health centres. Core PHC services include 24-hour emergency services, primary clinical care, population health programs, access to retrieval services, medical and allied health specialist services, and the provision of essential medications.

These services are funded through an identified program within the Department of Health and Families.

Child health, GAA, HSAK and child immunisations are all part of the core primary health services provided in remote communities. The child health program provides assessment, monitoring, care and advice for well children. In addition, treatment is provided for sick children. Some child health programs in remote areas have the additional resources of the Strong Women, Strong Babies, Strong Culture Program.

Family support

7 steps to safety

The Department of Family and Community Services sponsors an online information service for families with children. The program, 7 steps to safety, is information for families and carers on what is needed to feel safe and be safe at home.

Playgroup Association

The Playgroup Association of the Northern Territory is a non-profit community service organisation, which administers and supports playgroups across the Northern Territory. The Playgroup Association targets children aged birth to five years. It is a gathering place where parents and carers with babies and young children can meet regularly for fun and learning experiences in a social setting. Playgroup NT offers programs and services to playgroup members for children of all ages.

Parentline

Parentline is a confidential telephone counselling service providing professional counselling and support for parents and all those bringing up children. It is a 24-hour service for any family concerned about any issue or relating to any parent inquiry. This service is sponsored by the Department of Health and Families.

Education and care

Schooling

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

Safe Schools NT

Safe Schools NT provides online information for parents, students and teachers on how to keep schools safe:

- parents — information to help parents deal with some of the complex issues that face children in schools including bullying and harassment, safe play and cyberbullying
- students — information to help students deal with issues they may face in schools including bullying and harassment, safe play and cyberbullying
- teachers — information and resources to assist teachers to develop policy and delivery Professional Learning Modules.

Children's Services Unit

The Children's Services Unit is sponsored by the Department of Education and Training. It is largely an administrative unit that assists child care services to meet the Northern Territory Family and Children Services legislative obligations relating to child care provision. The unit encourages and advises these services to strive for a quality of care, which is beyond the minimum licensing requirements, and also makes recommendations regarding service delivery. It ensures minimum licensing requirements are continually met, makes further recommendations regarding service delivery, regularly inspects licensed child care centres to ensure they meet minimum licensing requirements and investigates complaints about licensed child care services.

Drug Abuse Resistance Education

The Drug Abuse Resistance Education (DARE) program is currently being taught by 20 school-based constables. The program is taught across all high schools and 81 per cent of primary schools. The program is administered by the Northern Territory Police, Fire and Emergency Services.

The scheme — which has the catch phrase, 'DARE to Say No' — is a primary prevention program aimed at children who have yet to have their first drug experience. Its goal is to reduce the incidence of drug abuse by children through presentation of a prevention curriculum by specially selected and trained uniformed police officers.

The DARE lessons focus on four major areas:

- providing accurate information about alcohol and drugs
- teaching students decision-making skills
- showing them how to resist adverse peer pressure
- giving them ideas for alternatives to drug use.

Specialist services for parental risk factors

Postnatal home visits

Postnatal home visits are physical checks of mother and baby after early discharge from the hospital. These visits provide support, education and information on issues ranging from breastfeeding to family relationships. Postnatal visits are usually arranged for prior to leaving the hospital but can be accessed from a local community health care centre. The service is run by the Department of Health and Families.

Secondary prevention

Health

Growth Assessment and Action Program

The aim of the Northern Territory Government's Growth Assessment and Action program is to improve the growth and nutritional status of children from birth to five years living in remote communities. GAA involves regular monitoring of growth and implementation of early action if growth falters.

The GAA is administered through the Department of Health and Families and has three main objectives:

- timely and accurate growth and anaemia monitoring of individual children
- appropriate and timely intervention of growth faltering, i.e. ‘Action Plans’
- reporting nutritional status, including anaemia prevalence at community, district and territory level.

The Northern Territory Growth Assessment and Action report currently provides population level information on the growth status of Indigenous children under five in remote communities across the Northern Territory. Usually around 80 communities participate in each collection. The report includes details of the program coverage, reporting the number of children measured compared with the number of resident children. The report also provides rates of stunting, wasting, underweight and anaemia for the whole Northern Territory and by broad geographical regions.

While the report measures growth from around 80 communities each year, all Northern Territory communities participate in measuring children's growth and implement required measures for faltering growth.

The Strong Women, Strong Babies, Strong Culture Program

The Strong Women, Strong Babies, Strong Culture Program was set up in 1992. It first began operating in three communities in the Top End and was the result of many years of sharing information between dieticians, remote area nurses, Aboriginal health workers and other Aboriginal women in remote communities.

The Strong Women, Strong Babies, Strong Culture Program aims to improve the health of children in the newborn to three year age group. The project is now extending from the three original communities to a number of other communities in the Northern Territory.

One feature of the program is the Strong Women's Story. The Strong Women's Story reflects how Aboriginal women see their situation. The whole idea of antenatal care was woven into a holistic picture of women as nurturers of their culture. The Strong Women's Story validates and encourages women's cultural practices and encourages Aboriginal women to:

- reinstate traditional ceremonies related to pregnancy and young infants
- create their own form of pictorial presentation of the project to share with other Aboriginal women
- access antenatal care much earlier than they did previously
- encourage women to eat healthy food in order to increase pregnancy weight gains.

Targeted maternal, child and youth health services

Child health services such as growth promotion and monitoring, vaccination, and general child health advice and support are provided by registered nurses in town-based community care centres and by nurses and Aboriginal health workers in remote community health centres. Remote health staff are supported by visiting child health nurses, Aboriginal health workers and district medical officers, and some communities have a resident community child health worker.

Antenatal care is available in all remote health centres and enhanced by the Strong Women, Strong Babies, Strong Culture Program. Outreach midwives boost pregnancy care in remote communities. Their role includes staff training and support and clinical services.

These services are funded by the Department of Health and Families.

Family Support

Family support services

A range of family support services are funded by the Department of Health and Families. The services aim to assist families and individuals by helping them achieve independence and improved wellbeing. Families and individuals are assisted to participate in the community, provided with support through times of crisis and are taught to protect their children from harm. Help is provided by the service to increase families' access to community-based and specialist services.

Our Family Our Kids

The Our Family Our Kids program aims to support men and women as they adjust to parenthood and increase parents' confidence around raising young children prior to preschool (about four years). Our Family Our Kids workers provide counselling, home visits and general support. Workers and parents explore the families' current situation and together identify factors that can impact on parents' capacity to care for their children and build on what is working well for the family. Child development information, parenting strategies and linking families with wider community networks are essential parts of the program.

Families with babies and young children are the main users of this service. It operates from an office in Darwin and can be accessed by either self-referral or referral by other agencies. Our Family Our Kids is funded by the Department of Health and Families.

Education and care

Special education consultants

Special education consultant teachers provide consultancy services to schools in support of students with disabilities and diverse learning needs from year 1 through to the final year of schooling. Special education consultant teachers work with the school and with other student services advisory teachers to assist schools, senior staff, individual teachers, including support assistants and parents.

Special education and wellbeing programs

A range of provision and support services is available in the Northern Territory for children with disabilities and additional learning needs. The types of educational options available are:

- inclusion in regular classrooms with consultative support, additional support and withdrawal support
- special educational facilities.

The School Attendance and Enrolment Pilot

The Northern Territory Government will provide $36.4 million over three years to undertake and evaluate two welfare payment reform pilots – one of which is the School Attendance and Enrolment Pilot.

The School Attendance and Enrolment Pilot will operate in six Northern Territory communities, and two metropolitan locations. From January 2009, welfare recipients in these areas will be required to notify Centrelink of their child's school enrolment details. State education authorities or schools will be able to notify Centrelink in cases where parents fail to take reasonable steps to ensure their children attend school. Centrelink will then advise parents that taking reasonable steps to ensure school attendance is a condition of their income support. Parents who do not comply with the requirements of the pilot may have their income support suspended, with payments restored and back-paid when parents take necessary corrective action.

Child safety

Safe houses

Safe houses provide safety for families and children experiencing violence, and support them in breaking the cycle of violence. The Northern Territory Government has been working with communities to establish and expand safe houses in Alice Springs, Alyangula, Angurugu, Apatula, Darwin, Hermannsburg, Kalkarindji, Lajamanu, Maningrida, Nguiu, Ngukurr, Peppimenarti, Ramingining, Ti Tree, Pmara Jujunta, Beswick, Yarralin and Yuendumu.

Remote regional family and community workers team

The aim of the remote regional family and community workers team is to expand culturally appropriate and relevant child protection services to Indigenous communities by creating a remote Northern Territory Families and Children (FAC) Aboriginal child protection workforce staffed by local Aboriginal people.

The role of the team is twofold — one is to provide better support to FAC clients and families identified at risk in remote areas, and the other is to respond to the protective issues identified by the community.

Thirteen communities across the Northern Territory have been identified for the positions. At this stage, eight communities have received positions. These communities are Daly River, Boroloola, Galiwinku, Beswick, Ti Tree, Hermannsburg, Elliott and Oenpelli.

Specialist services for parental risk factors

Parental responsibility orders program

In the parental responsibility orders program, parents are required to enter a contract to prevent their child from engaging in antisocial behaviour and youth crime.

Parents may be required to attend parenting guidance counselling, support groups or rehabilitation programs. They may have to ensure their child attends school, ensure their child is home by a certain time or that the child avoids contact with a particular person or place. Parents have assistance to access support programs.

This service is currently under development.

Home Strength

Home Strength is an intensive intervention family support program funded by the Department of Health and Families. Home Strength supports at-risk families to care for and take responsibility for their children so that the children remain with their families. Help is provided to increase families' access to community-based and specialist services and increase their participation in the community.

In order to access this service, families must be referred through the Family and Children's Services. Home Strength operates from Darwin only.

Web-based alcohol and other drug services

The alcohol and other drugs program aims to minimise harm associated with the use of alcohol, tobacco and other drugs, through a range of prevention, education, treatment and community action initiatives.

The material found on the alcohol and other drugs website is intended for public use and reproduction. It is an effort to assist the community in making informed decisions about and managing alcohol and other drug issues. It provides general information, plus clinical links to reputable sites with the intent to inform and educate.

There is a sub-site that is primarily for individuals, families and communities who are affected by alcohol and other drug issues, who are seeking general information about alcohol and other drugs, and issues specifically relating to the Northern Territory.

Aboriginal Substance Abuse Program

The Aboriginal Substance Abuse Program (ASAP) is currently being developed to bring relevant drug education to remote Aboriginal communities. This program will be delivered by trained Aboriginal community police officers.

Mental Health Program Policy and Program Management

The Mental Health Program's policy and program management team is a small team based in Darwin that operates across a range of local and national priority areas.

The team works in partnership with health services, clinicians, consumers and their carers to develop mental health services that can provide the best outcomes for Territorians. The team also has a primary responsibility for implementing, monitoring and reporting progress on all National Mental Health Strategy initiatives in addition to substantial local responsibilities.

There are a number of specialist and non-government services provided by the mental health services.

Specialist integrated mental health services are delivered by the Top End and Central Australian Mental Health Services and include community-based adult, child, youth and forensic services, as well as inpatient services.

Inpatient and community-based services are provided in Darwin and Alice Springs. Rural and remote community mental health services are also located in Darwin Rural, Katherine, East Arnhem, Alice Springs Remote and the Barkly Regions.

Non-government services, on the other hand, are funded by the Mental Health Program to provide a range of services including:

- support services including sub-acute, outreach, rehabilitation and disability support services
- carer support services
- Aboriginal social and emotional wellbeing services
- mental health promotion.

Crisis helplines: mental health on call team; family counselling and support crisis helpline

The mental health on call team is a 24-hour service located in the Top End. The helpline provides support for anyone with a mental illness.

There are family counselling and support centres and crisis helplines in both Alice Springs and Darwin. The range of services includes parenting information and advice, counselling to youths, parents, children and Indigenous peoples.

Services for young mothers

There are a range of services and helplines for young mothers in both Alice Springs and Darwin. They include emergency housing, peer support groups and advice.

Alcohol and other drugs service

Each urban centre in the Northern Territory has either a government alcohol and other drug service or a community service or both. Central Australian Alcohol and Other Drugs Services in Alice Springs and the Alcohol and Other Drugs Services in Darwin are larger, government services that provide the following:

- community education through supporting activities for media campaigns and delivering targeted information and education sessions
- resources such as general and specialist articles, pamphlets, posters, videos and staff to provide information
- screening and intervention services and support
- clinical specialist services.

Tertiary prevention

Health

Sexual assault referral centres

Sexual assault referral centres (SARCs) operate in Darwin, Alice Springs and Tennant Creek. SARCs provides a counselling service to both adults and children who may have experienced (recently or many years ago) any form of sexual assault. Sexual assault can range from verbal harassment, unwanted touching or exhibitionism, to a violent attack.

For recent victims of sexual assault the SARCs provide the following services free of charge:

- 24-hour access to information regarding the medical, legal and counselling/support options available
- 24-hour medical assistance by female doctors including pregnancy prevention, screening and preventive treatment for sexually transmitted infections, collection of forensic evidence, and screening for drugs where drink spiking is suspected
- 24-hour confidential counselling, medical examination for children where child sexual assault is suspected.

By law, any suspected child sexual abuse must be reported to the police and/or Northern Territory FACs.

SARC also provides the following services:

- counselling for male and female adults who have been sexually assaulted either recently or as a child
- counselling for male and female children who have been sexually assaulted
- information, support and counselling for partners, family members and significant others
- information lending library regarding sexual assault

- community education
- support through the legal process
- an Aboriginal sexual assault counsellor is available.

Family support

Crimes Victims Services Unit

The Crimes Victims Services Unit is run by the Northern Territory Government Department of Justice. Its clients are victims of a violent act as well as relatives and close friends of a victim. The unit's aim is to assist and support victims of a violent crime to cope with a traumatic event. The services offered include free crisis counselling, support and referrals to appropriate resources for victims (and close family and friends) of a violent crime.

The unit operates from Darwin, Katherine, Alice Springs and Tennant Creek family services offices.

Education and care

No information available.

Child Safety

Statutory child protection

In the Northern Territory any person who believes that a child is being, or has been, abused or neglected is required by law to report their concerns. The *Community Welfare Act 1983* provides legal protection against civil or criminal liability for people who make reports in good faith. The Act also makes it clear that making a report does not breach any requirements of confidentiality or professional ethics.

In most cases where abuse or neglect has been substantiated, the child's family will be offered services to help them to improve the way they are caring for their child. In a minority of cases it may be found that a child's parents are unable or unwilling to protect their child from harm and alternative arrangements will need to be made for the care of that child.

Child protection

The Northern Territory Families and Children service provides a range of services that address issues such as the protection and care of children and the improvement of individual and family wellbeing. The services assist families to cope with normal parenting, social and economic pressure, family and individual crises, and protect and care for children who are no longer able to stay at home with their natural parents.

The program funds private, internal Department of Health and Families and non-government providers to deliver these services to the community.

Internal support and intervention services include child protection, out-of-home care and family counselling. These services are delivered through staff located in offices in the major Territory centres. Northern Territory FAC staff visit the larger rural and remote communities on a regular basis, and smaller communities are visited as needed.

Services funded and provided under the Northern Territory FAC program encompass:

- children's services
- family support services
- child protection
- substitute care
- adoption services
- domestic violence support services
- Aboriginal family violence services
- sexual assault services
- crisis support and accommodation services.

Mobile child protection team

The mobile child protection team (MCPT) is a Darwin-based child protection team that travels around the Northern Territory delivering statutory services for regional and remote FAC offices. The aim of the MCPT is to assist regional offices to provide a timely response to child protection matters, by working in consultation with local staff, particularly regarding the local communities, cultural issues, family relationships and history with FAC.

Specialist services for parental risk factors

Police Domestic Violence Unit

The Police Domestic Violence Unit covers a wide range of services included crisis help lines, emergency accommodation, counselling services for rape and drug and alcohol related offences, legal services, and speciality services for Aboriginal people. The services span across Darwin, Alice Springs, Tennant Creek, Katherine and Nhulunbuy.

4.9 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN THE NORTHERN TERRITORY

Service	2002–03 ($m)	2003–04 ($m)	2004–05 ($m)	2005–06 ($m)	2006–07 ($m)
Child protection and OOHC	13 948	18 640	22 240	26 530	27 794

Source: Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, the Northern Territory received 2992 notifications of alleged child abuse and neglect regarding 2580 children. In that same year, 852 substantiations of child abuse and neglect were made pertaining to 540 children. The rates of notifications, finalised investigations, substantiations and the number of children on care and protection orders have increased steadily each year since 2002–03.

NORTHERN TERRITORY CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	1333	24.6	1 670	29.6	1777	31.5	2312	40.7	2580	44.3
Finalised investigations	665	12.3	930	16.5	952	16.9	958	16.9	1173	20.2
Substantiations	311	5.7	491	8.7	447	7.9	462	8.1	540	9.3
Care and protection orders (0–17)	274	4.6	345	5.8	414	7.0	437	7.3	451	7.3

Source: ROGS 2008, Table 15A.153, using AIHW data.

NORTHERN TERRITORY CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	1554	1957	2101	2863	2992
Substantiations	327	527	473	480	621

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 5

Queensland

5.10 Verification status

This stocktake has been verified by the Queensland Department of Child Safety and Maternity Child Safety Branch.

5.11 Stocktake of service systems

The table below provides a summary of the service systems for protecting children in Queensland. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — QUEENSLAND

Sector	Primary	Secondary	Tertiary
Health	Antenatal and maternity care Community child health services Healthy Hearing Program Deadly Ears Deadly Kids Deadly Communities program School-based youth health services Child and adolescent oral health services Mental health services Universal postnatal contact services Primary Care Program	Early Intervention and Parenting Support Initiative (EIPSI) Children's developmental assessment services Child and youth mental health services (CYMHS)	Child witness counselling service EVOLVE mental health therapeutic teams
Family support	Playgroups QLD Child health line	Support for young parents Expanding parenting programs Neighbourhood centres Safe havens program Supported playgroups Early Years Health and Wellbeing Program Disability family and early childhood services Child Care and Family Support Hub Strategy	

Sector	Primary	Secondary	Tertiary
Education and care	Preparatory year Child care services Early Years centres Reading to Children Initiative Schooling Student wellbeing strategies	Remote area Aboriginal and Torres Strait Islander child care	
Child safety	Play a part programs — protecting children is everyone's business	Support for young parents Future Directions pilots Specialist counselling services Counselling for victims of abuse: Bravehearts Child advocacy service Youth and family support services (YFSS) Youth At Risk Alliance (YARA) Youth At Risk outreach services (YAROS)	Child protection Out-of-home care Children's Court Commission for Children and Young People and Child Guardian Community Visitor Program
Specialist services for parental risk factors: substance abuse mental health family violence homelessness (risk)	Community health services	Drug and alcohol services Mental health services Family violence services Healing services Referral for active intervention Public intoxication outreach support services Transitional accommodation for young people Domestic and family violence prevention Queensland Indigenous Alcohol Diversion Program	Redress Scheme

Primary prevention

Health

Antenatal and maternity care

Free and universal antenatal and maternity care is provided throughout Queensland, from both hospital and community settings, including public health and GP services.

Seventy per cent of Queensland Health birthing facilities provide post-birth discharge follow-up either by telephone contact to the woman, a drop-in service at the hospital, or home visiting, including early feeding support clinics. Of those facilities that offer a home visiting service, an average of 72 per cent of postnatal woman are seen at least 2.5 times within six weeks of the birth.

The Queensland Government has allocated $29.7 million over four years for the universal postnatal contact services initiative, which will provide flexible access to follow up and support for parents in the first six to eight weeks post birth. This will include universal antenatal psycho-social assessments for key risk factors, and the establishment of drop-in, open plan services within community child health clinics to provide a support and referral hub for new parents.

Community child health services

Queensland Health has 238 community child health services across the state. Primary health care services in rural and remote areas also offer maternal and child health services. These services provide a range of universal preventive and early intervention strategies and programs for parents/care givers of children aged newborn to 12 years. In particular, child health services provide:

- short consultations in child health clinics related to sleep and settling, behaviour management, postnatal support, breastfeeding management and support, development, injury prevention, immunisation and nutrition
- health surveillance and screening of growth and developmental assessments and hearing and vision assessment
- specialist home visiting support for families with complex needs, for example, FamilyCARE
- extended consultation at the Infant Feeding Support Program for infants under six months with feeding issues
- Triple P Positive Parenting Program® including seminars, groups and individual sessions.

Early intervention and prevention programs are offered in some primary schools including Royal Children Hospital, QEII, Redcliffe-Caboolture, Logan-Beaudesert, Gold Coast and Bayside Health Service Districts and provide services such as vision and hearing screening in preschools and year 1, parenting support and health promotion activity.

Healthy Hearing Program

The Healthy Hearing Program provides hearing screens to all newborn babies born in Queensland. The screening method is an automated auditory brainstem response which takes an electro-physical measure of the auditory systems response to sound.

Deadly Ears Deadly Kids Deadly Communities Program

This statewide Aboriginal and Torres Strait Islander hearing health program conducts hearing screening of children, training of staff in hearing assessments and provides ear nose and throat specialist services to remote communities.

School-based youth health services

The school-based youth health nurse (SBYHN) program provides the opportunity for young people (aged 12 to18) attending state secondary schools, their parents, and members of the school community to access a nurse in the school setting for matters relating to the health and wellbeing of young people. This includes the provision of health information, brief intervention and referral to appropriate health and other services. SBYHNs also support and work collaboratively with school communities to promote health and wellbeing through school policies and programs in order to help young people make a safe and healthy transition into adulthood.

Child and adolescent oral health services

Child and adolescent oral health services are for preschool and school age children until year 10 in secondary school. Public health services offer oral health care to all children from age four up to and including year 10 school students (totalling some 612 000 students in 2006).

Mental health services

Primary health care providers include GPs, community health workers, nurses, allied health professionals, school health nurses, counsellors and community support groups. Their roles include assisting individuals with mental health problems and facilitating access to specialist public and private mental health services when required.

Young people's mental health services see young people aged between 12 to 24 years and provide a range of services including sexual health.

Universal postnatal contact service

The universal postnatal contact services aim to ensure every new mother is coping with parenthood's early stresses. The Service is currently being upgraded with a hotline and six regional postnatal care clinics. The hotline will give parents immediate access to a one-stop-shop health hotline that they can call if their child is sick, their baby is difficult to feed or for general parenting advice about their child's development.

The clinics provide support to parents with babies aged up to 18 months old through breastfeeding and nutrition advice, child development support and parenting programs. The clinics have already proved very successful in Ipswich and Deception Bay which both see 20 to 30 children a day during half day sessions.

It is expected that by 2012 under the Universal Postnatal Contact Service, all mothers of newborns will have follow-up contact from a health professional after they leave hospital. The Service is provided by the Ministry of Health.

Primary Care Program

The Primary Care Program offers a number of services:

- the birth to 12 Service — provides a range of clinics for assessment, education and support for parents/care givers of children aged newborn to 12 years. This includes:
  - early feeding support clinics for the first 14 days after discharge from hospital following the birth of the child — located at Kallangur and Alderley (no appointment needed)
  - home visiting for families with complex needs and all first time parents
  - short consultation in child health clinics. Consultation includes sleep and settling, behaviour management, postnatal support, breastfeeding management and support, development, injury prevention, immunisation, nutrition
  - extended consultation at the Infant Feeding Support Program for infants under six months with feeding issues
  - Triple P Positive Parenting Program® including seminars, groups and individual sessions
  - hearing assessment and hearing referral clinic for children and young people aged four to 18 years
  - health surveillance and screening (hearing and vision assessments, growth and development assessments).
- the School-Based Youth Health Service — provides health consultations, assessment, support, health information, referral options and health promotion and education for parents/care givers and young persons aged 13 to 18 years who attend state secondary schools in the Royal Children's Hospital and Health Service District.
- child health resource centre — website access is available to obtain information on:
  - location of the nearest child health centre in Queensland
  - immunisation clinics across Queensland
  - child health care
  - common childhood conditions
  - emotion and behaviour
  - general nutrition and activity
  - growth and development
  - parenting
  - safety
  - young people
  - support organisations for carers.

- immunisation clinics — child health staff conduct a free vaccination clinic at the Zillmere Community Centre. Other vaccination clinics are conducted throughout the district by the Brisbane City and Pine Rivers Shire councils.
- child health clinics — there are approximately 13 clinics across the eastern, northern and western suburbs. These clinics have two separate schemes. One is focused on the parents/care givers for children aged newborn to 12 years. The second is a school-based youth health service, which is for young persons aged 13 to 18 years who attend a state secondary school, and their parents/care givers.
- child health line — this is a 24-hour telephone service staffed by child health nurses who can provide families from across Queensland with information about a range of child and youth health issues, describe strategies for intervention and support positive parenting practices. Nurses also provide information about local community services for families.
- child development program — a community-based service that provides assessment and treatment for children with developmental problems, aged newborn to 13 years. The program is accessible at the North West Community Health Centre in Keperra and the Pine Rivers Community Health Centre in Strathpine.
- child advocacy service — a child protection service that focuses on the prevention, assessment and early intervention of child abuse and neglect. The service is provided through a network of health professionals including paediatricians, social workers, nurses and therapists. These services are provided within hospital and community child health settings; they are targeted to children from birth to 18 years and their families.

Family support

Playgroups QLD

The Playgroups Association of Queensland provides playgroups for babies, community playgroups, teacher-led playgroups, supported playgroups and playgroups that target special needs groups. As a statewide service, programs and activities are held in metropolitan, regional, rural and isolated Queensland.

Playgroups Queensland is funded by both the Australian and Queensland Governments, however additional funds are raised locally through corporate giving, donations and fundraising activities. Families attending community playgroups also pay a small annual membership fee to offset costs.

Child health line

Queensland Health provides a 24-hour, seven-day telephone service (which was integrated with the 13 HEALTH telephone service from December 2008). It is staffed by child health nurses who can provide families throughout Queensland with information about a range of child and youth health issues, describe strategies for intervention and support positive parenting practices. Nurses also provide information about local community services for families.

Education and care

Preparatory year

Education Queensland provides a non-compulsory preparatory year before formal schooling. The preparatory year aims to assist children make a smooth transition to year 1. Prep is five days a week and children stay all day.

Child care services

In Queensland, child care services are licensed and monitored by the Department of Communities. Child care services available in Queensland include:

- long day care centres — usually open Monday to Friday between 7am and 6pm for at least 48 weeks of the year
- kindergartens — generally provide care and education for children from three and a half years to school age
- limited hours care services — operate for no longer than 20 hours in a week with a licensed capacity of no more than 30 children
- occasional care services — care for children on an occasional basis
- school age care services — offer care for school age children before and after school and during school vacations
- licensed home-based care — for a small group of children in one or more homes
- family day care is licensed care that is offered in private homes of carers under a family day care scheme.

Early Years centres

The Queensland Government is establishing Early Years centres at Nerang, Caboolture, Browns Plains and Cairns. The Early Years centres will be one-stop-shops where early childhood education and care, family support and health services are available for families expecting a child or with children aged up to eight years. The four Early Years centres will also provide services from sites in neighbouring communities to families who are unable to access the centres or who prefer to go to a site closer to their home.

Early Years centres will provide a range of services including:

- high quality early childhood education and care
- advice on child health and development
- health screening, immunisations and assessments
- antenatal and postnatal support and parenting information
- referrals to existing programs and specialist services
- personal and individual support
- playgroups
- toy libraries.

The aims of this program are to

- proactively support parents to take responsibility for the health and wellbeing of their children (in particular prep)
- build school community capacity to provide support and early intervention to vulnerable families to improve child health, development and learning outcomes
- facilitate access to existing child and family services (for example, child health clinics, GPs, child and youth mental health services) by vulnerable children and families.

Reading to Children Initiative

The Reading to Children Initiative is a pilot program. It aims to provide opportunities for volunteers — in particular, older people and grandparents — to contribute to the nurturing and wellbeing of young children and families in their local community by reading to children under school age.

The Carpentaria Shire Council delivers a reading to children program in the Normanton area. The Smith Family delivers the program in the Brisbane, Ipswich, Caboolture/Pine Rivers, Sunshine Coast, Darling Down, Gold Coast, Townsville/ Thuringowa, Mackay-Whitsunday, Wide Bay-Burnett and Fitzroy-Central West regions.

Schooling

The Department of Education, Training and the Arts supports primary and secondary schooling, which is a key universal service for protecting children. This includes supporting students with disabilities in state schools and special schools and providing them with the opportunities to achieve quality educational outcomes.

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

Student wellbeing strategies

Education Queensland is implementing a number of initiatives to promote health and wellbeing in schools. A range of support personnel are employed in schools to assist students experiencing personal and school difficulties, including guidance officers, chaplains, community education counsellors, as well as behaviour management support staff.

Child protection intervention services

Play a Part programs — protecting children is everyone's business

This program is a whole-of-community approach to child abuse prevention through community education seminars to promote an individual's responsibility to contribute to child abuse prevention. It provides selective prevention approaches, which work with local communities to develop and implement strategies to create child friendly communities.

The National Association for Prevention of Child Abuse and Neglect (NAPCAN) has been allocated funding to assist in the establishment of the Play a Part programs in five locations in South East Queensland: Inala to Goodna, Chermside, Toowoomba, Springfield Lakes and the Gold Coast. NAPCAN has been funded to deliver a minimum of five information and education sessions or workshops in five locations each year.

Specialist services for parental risk factors

Community health services

Queensland Health runs a number of community health services and projects. These services include population health activities (for example, cancer screening), sexual health clinics and mental health services. These services play a role in primary prevention and identification of parental risk factors for child abuse and neglect.

Secondary prevention

Health

Early Intervention and Parenting Support Initiative

The Early Intervention and Parenting Support Initiative (EIPSI) includes the Triple P Positive Parenting Program®, early intervention specialists (psychologists and social workers), Indigenous Triple P and the Young Parents Support Program:

- Level 3 — primary care Triple P is an early intervention program for children displaying 1–2 minor behavioural problems. This level involves individual consultations with parents and focuses on managing specific behaviour problems
- Level 4 — standard Triple P consists of 10 one-hour sessions focusing on causes of children's behavioural problems, strategies for encouraging children's development and ways to manage misbehaviour
- Level 5 — enhanced Triple P follows on from participation in a level 4 program. Families in need of further assistance are invited to participate, with a focus on skills training, including mood management and stress coping skills for parents, and marital communication skills as required.

The Early Intervention for Safe and Healthy Families Initiative (EISHFI) integrates the Family CARE Nurse Home Visiting Program and Queensland Health's Domestic Violence Initiative in seven health service districts. Its primary goal is to provide an acceptable and effective early intervention during the first year of a newborn's life for families exposed to key risk factors.

Children's developmental assessment services

The developmental assessment services are community-based multidisciplinary teams involved in the assessment and management of children from birth to primary school age with developmental and learning issues.

Child and youth mental health services

Child and youth mental health services (CYMHS) are specialised mental health services for children and young people (from birth to 18 years) and their families. CYMHS offers assessment and therapeutic services for children and young people who are experiencing psychiatric disorders or behavioural, emotional and developmental problems in all areas of their daily lives.

The service is located in Kirwan and can be accessed by referral. Referrals can only be made by GPs and senior guidance officers from the Department of Education. For children and young people who are living at home, a parent or guardian must be involved in the referral process. For any young person at risk, an identified adult carer/guardian will be required.

Family support

Support for young parents

There are a number of specialist support programs for young parents in Queensland. These include:

- Micah Projects Inc. — provides early childhood and family support to pregnant women and parents under 25 years, their preschool children and their partners in South Brisbane
- Young Parents Program — provides information and support to empower and assist young parents and pregnant young women to make informed decisions about their health and wellbeing, and to increase their resilience, skills and strategies to manage life events. The Young Parents Program provides services to disadvantaged, marginalised, at-risk and homeless young parents and pregnant young women aged 12–25 years
- the Aboriginal and Torres Strait Islander Young Parents Program — supports young Indigenous women and their partners through pregnancy, birthing and well into the postnatal period. Aboriginal health workers work with communities and families to increase access for young parents to health and other support services.

Expanding parenting programs

Expanding parenting programs involves providing recurrent and non-recurrent funds to expand the coverage of parenting programs in Queensland. In partnership with Queensland Health and Department of Education Training and the Arts, the capacity of existing funded services was strengthened to provide parenting education and support to key target groups, focusing on Indigenous families and families with a child with a disability.

Neighbourhood centres

Several neighbourhood centres in Queensland provide support services for at-risk families and children. These are:

- Deception Bay Outreach Families Project / Deception Bay Neighbourhood Centre — they provide support to at-risk families and children who have high needs and face multiple problems. The centres help to develop skills to ensure the safety and wellbeing of children and address accommodation and financial management issues. The project also provides universal drop-in services for all local parents in high-risk areas

- Atherton Neighbourhood Centre — supports vulnerable families with children under eight years of age, with a focus on Indigenous families
- George St Neighbourhood Centre — provides integrated outreach services responding to the needs of families, including the formation of a satellite hub at a preschool site.

Safe Havens Program

A joint state and Australian Government initiative which will provide short-term accommodation and support for children and young people escaping the effects of domestic and family violence in the Aboriginal and Torres Strait Islander communities of Cherbourg, Coen, Palm Island and Mornington Island.

Supported playgroups

Supported playgroups provide services for vulnerable families with children from birth to eight years. The services engage and support parents or care givers and their children by providing supported playgroups through the state that target culturally and linguistically diverse families or young parents. The program also aims to enhance opportunities for Aboriginal and Torres Strait Islander (ATSI) families to participate in playgroup activities and programs. This is achieved by providing culturally relevant supported playgroups and improving quality within existing ATSI community playgroups through integration, culturally sensitive training, improved information sharing and dissemination and support for workers/volunteers.

Early Years Health and Wellbeing Program

The program involves teams based in non-government organisations who work with clusters of school communities (teachers, parents, children, staff and others) to increase access by vulnerable and at-risk prep children to existing child health and family support services. The program operates in two sites, Ipswich and Mackay.

Disability family and early childhood services

Disability Services Queensland's family and early childhood services support families with a child aged up to six years who has, or is at risk of, a significant developmental delay. With the support and information provided through the service, families are able to strengthen their knowledge, skills and resources, giving them a better opportunity to help promote their child's developmental learning and inclusion in the local community.

Child Care and Family Support Hub Strategy

The Child Care and Family Support Hub Strategy is part of the Queensland Child Care Strategic Plan 2000–05 and responds to the expressed needs of parents for improved access to integrated child care and family support services especially in the early childhood years.

A child care and family support hub brings together a range of services that support families and children within a community. Child care forms the core of each hub with family support services provided in response to the needs of families and children using the child care service as well as families from the broader community.

There are currently 26 hubs across Queensland.

Education and care

Remote area Aboriginal and Torres Strait Islander child care

The remote area Aboriginal and Torres Strait Islander child care program provides a range of Indigenous child care and family support services to 35 Indigenous community organisations in North and Far North Queensland.

Child protection intervention services

Support for young parents

There are a number of specialist support programs for young parents in Queensland as described in the family support section.

Future Directions pilots 2002–09

The Future Directions pilots are 12 triennially funded prevention and early intervention pilots, under the *Queensland Families: Future Directions Strategy*, which is yet to be signed. Funding is allocated to trial new service models delivered through community-based agencies, which focused on strengthening individuals and families to:

- prevent or reduce the need for intensive and costly intervention
- divert children and young people from the statutory systems.

Specialist counselling services

Specialist counselling services are for families with vulnerable children under the age of 18 years. The program supports the development of nine specialist counselling services in targeted locations across Queensland. The purpose of the services is to address the needs of families with dependent children under the age of 18 years identified as at high-risk of child abuse and neglect, where a statutory child protection response is not appropriate, but where significant support is required for both the child and the family.

Counselling for victims of abuse: Bravehearts

Bravehearts supports and provides counselling services to children, adults, families and carers who have been impacted by sexual abuse.

Child advocacy service

The child advocacy service is a child protection service run by the Royal Children's Hospital that focuses on the prevention, assessment and early intervention of child abuse and neglect. The service is provided through a network of health professionals including paediatricians, social workers, nurses and therapists. These services are provided within the hospital and community child health settings. The service is targeted to children aged newborn to 18 years and their families, where there are child protection concerns within the Royal Children's Hospital catchment area.

Each of the 15 Queensland Health service districts has designated positions responsible for providing services to children and families identified as being at risk of abuse or neglect. These positions include child protection liaison officers and child protection advisers.

Youth and Family Support Service

The Department of Communities supports at-risk young people and families, in order to reduce their involvement in statutory child protection and youth justice systems, through the key services of the Youth and Family Support Service (YFSS).

The YFSS is an extended hours support and counselling service focusing on young people and families living within the greater Brisbane region boundaries. This service works closely with other government and community agencies to ensure coordinated and integrated support for young people and their families on a short- to medium-term basis.

The target group is young people between six and 17 years who are identified as at-risk and their families. Clients are referred to the service for a range of reasons such as police cautioning, being at risk of engaging in criminal activity, concern about prostitution or drug use, recent onset of self-injury behaviour, and running away from home, homelessness or risk of homelessness.

Youth At Risk Alliance (YARA)

The Gold Coast Youth At Risk Alliance (YARA) aims to assist the development of an integrated service delivery response to address the needs of young people with complex issues, and their families. The service comprises direct client service and a sector integration component.

The target group is 10 to 17 year olds who are considered to be at risk, and their families. Family support services are provided to families with children and young people from birth to 18 years who find themselves in vulnerable situations. Community and individual support is provided to community members, particularly those in vulnerable, at-risk populations.

Provision of the services is made by facilitating complex needs assessment plans to bring government and non-government representatives together to provide a coordinated approach when assessing and planning the needs of clients with complex issues.

YARA is funded by the Department of Communities and targets young people at risk of engagement with the youth justice and child protection systems.

Youth At Risk outreach services

Youth At Risk outreach services (YAROS) target young people aged 12 to 25 who are identified as being at risk through a range of factors including homelessness, involvement in survival sex, and illicit drug use. The service aims to divert young people from risk-taking behaviour and to prevent their entry into the formal sex industry.

The service conducts a range of prevention and early intervention activities that use a harm-minimisation approach, including information and referral, direct assistance, specialist counselling, support groups, health education (particularly for safe sex and drug use), and needle exchanges.

There are seven Youth At Risk outreach services located across the state, with two services located in regional areas. Each service conducts activities according to the specific needs of the young people in the local area.

Specialist services for parental risk factors

Drug and alcohol services

Drug and alcohol services in Queensland include a range of prevention, health promotion, assessment, counselling, early identification and intervention, treatment and educational services to minimise substance abuse. These services are funded through a range of programs or health services within the Queensland Health budget and Australian Government funds.

There are several programs or services specifically target families with children. These are:

- Cardwell Shire Community Support Association Inc. — provides support and assistance to Indigenous families, including children and young people affected by alcohol and substance abuse, family breakdown and general health and wellbeing
- Queensland Indigenous Alcohol Diversion Program (QIADP) — a trial supported accommodation program for three years administered jointly by the departments of the Premier and Cabinet, Communities, Child Safety, Justice and the Attorney-General, Corrective Services, Housing, Queensland Health and the Queensland Police Service. Under the program, eligible Indigenous people receive treatment and case management programs designed to reduce alcohol-related harm to the individuals, their families and the community. The program is also designed to reduce the number of Indigenous people in the criminal justice system. The alcohol diversion program targets participants through two referral streams
  - the criminal justice stream — Indigenous defendants charged with offences where alcohol is a factor
  - the Department of Child Safety families' stream (20 per cent of places) — Indigenous parents involved in the child protection system who also have an alcohol problem.
- Parents Under Pressure Program (PUP) — is a Queensland Health endorsed program. PUP was developed by Griffith University's Associate Professor Sharon Dawe and Dr Paul Harnett (University of Queensland). It is an intensive, multi-component, family-focused intervention designed to improve child behaviour, decrease parental stress and improve family functioning. It targets affect regulation, mood, views of self as a parent, drug use and parenting skills. The program has been evaluated in a large randomised controlled trial on families with maternal substance abuse, with women leaving prison, and in families with child neglect and abuse. Six Alcohol, Tobacco and Other Drug Services (ATODS) groups have received training for a number of their clinicians. The sites include Cairns, Townsville, Toowoomba, Logan, Peel Street and Biala. Of these six sites, only three sites continued on to see clients after training.

- Parents, Kids and Drugs Program (PKD) — a five-week, structured psycho-educational and support program designed for parents, or a person in a parenting role, concerned about their son's or daughter's actual or suspected use of alcohol or other drugs, where the son or daughter is under 25 years of age. PKD seeks to address the needs of parents who have a young person under 25 years of age, where the young person or their family is experiencing issues and/or harm in relation to the young person's illicit drug use. The program aims to increase parents' knowledge of alcohol and other drugs, improve their repertoire of behavioural and cognitive strategies for parenting adolescents with alcohol and drug issues, improve parent's self-efficacy and confidence in addressing their situations, to have a positive impact on various mental health indicators and provide a forum for discussion and support from fellow parents.
- Positive Parenting with Opioid Dependence — delivered at Logan-Beaudesert ATODS and West Moreton ATODS. An antenatal program for mother's registered on the Opioid Treatment Program. Developed by Catherine Brewster from Ipswich ATODS.

Mental health services

Public mental health services are provided in each of the 20 Queensland health districts. They deliver specialised assessment, clinical treatment and rehabilitation services to reduce symptoms of mental illness and facilitate recovery. These services are focused primarily on providing care to Queenslanders who experience the most severe forms of mental illness and behavioural disturbances, and those who may fall under the provisions of the *Mental Health Act 2000*.

A wide variety of other interventions, which support mental health and recovery, are provided by the broader government and non-government sectors. These may include services delivered by a housing or employment agency, or personal care from a non-government community support provider. Queensland Health has recently released the statewide Queensland Plan for Mental Health 2007–17, which outlines key initiatives to improve the quality, range and access to mental health services, with funding of over $201 million allocated from October 2005.

Family violence services

The Queensland regional domestic violence services provide primary, secondary and tertiary interventions. They provide:

- direct service to clients, including counselling and group work
- information and referral to other sources of assistance, community education, worker training
- development, coordination and participation in domestic and family violence networks to support integrated community responses to domestic and family violence.

Services are located in 12 regions across the state.

Healing services

Healing services for Aboriginal and/or Torres Strait Islander people affected by domestic and family violence, including traditional healing, counselling and support services are also provided in seven locations across the state.

In addition, 10 men's perpetrator services across Queensland deliver group sessions to men who perpetrate domestic and family violence. Limited counselling may also be provided through men's perpetrator services.

Referral for Active Intervention

Referral for Active Intervention (RAI) is a key secondary service program in Queensland implemented in 10 locations. Established in 2006, the purpose of RAI is to improve the safety and wellbeing of vulnerable children and their families. The target client group is vulnerable children from birth to 10 years and their families. The RAI services provide intensive child and family support, case management and improved access to specialist services. To access the program, a family must be referred by the Department of Child Safety, Department of Education, Training and the Arts or Queensland Health to an RAI service provider (which is a non-government organisation).

The four specific program objectives are:

- improved outcomes for vulnerable children and their families through the provision of intensive family support services
- reduce the number of (re)notifications and minimise progression through the statutory children protection system of vulnerable children
- reduce the number of statutory child protection investigations and assessments in Queensland and thereby increase the capacity of the Department of Child Safety to respond immediately to those children identified at high risk
- assist in reducing the over representation of Aboriginal and Torres Strait Islander children in the statutory child protection system.

The RAI initiative includes a network of supporting agencies and services through action network teams (ANTs). The teams operate as an advisory group overseeing the implementation of the RAI. They provide direction on expenditure of funding and guidance on re-configuring local service systems in regions.

Public intoxication outreach support services

Public intoxication outreach support services support people who are, or have been, intoxicated in public to divert them from harm and from the criminal justice system. The services provide a broad range of activities from 'front-end' responses for people who are intoxicated in public places through to community education and diversion activities for at-risk groups. The aim is to divert people from public intoxication and self-harming behaviours and help them to access places of safety and relevant services.

Funding for the public intoxication outreach support services has been delivered by the Queensland Government under the 2005–06 Responding to Homelessness budget initiative. Queensland Government funding has delivered:

- a new public intoxication outreach support service in North Brisbane
- a trial street-base outreach service in Cairns in 2005–06
- enhancements to existing public intoxication services in the Gold Coast, Brisbane, Sunshine Coast and Townsville.

Transitional accommodation for young people

Transitional supported accommodation will be provided for a period of up to 12 months for homeless young people who require a low to moderate level of support as they become ready to move into independent accommodation.

The service supports homeless young people who may have resolved any immediate crises, but need some ongoing support to stabilise and achieve independent living. This service is designed for young people over 16 years of age. Some of these young people may still be in senior school or in continuing education. This service, however, is not intended to become student accommodation for the duration of their studies.

Referrals are received from a variety of places including national reconnect services or youth support coordinator services, schools, shelters and other agencies. The Department of Housing is providing properties for these initiatives under the Crisis Accommodation Program. The funding for the program is provided through the Supported Accommodation Assistance Program.

Domestic and family violence prevention

The *Domestic and Family Violence Protection Act 1989* was amended in March 2003 to protect people in a broad range of intimate relationships from violence. As a result, the number of applications for domestic violence orders has increased as more people are made aware of their right to legal protection.

The Department of Communities implements prevention, early intervention and response services to support people affected by domestic and family violence. These services aim to reduce its incidence and the impact it has on children, families and communities.

The department monitors the effectiveness of the *Domestic and Family Violence Protection Act 1989* in protecting people in intimate relationships from violence. Promotional material is available on the Department of Communities website. It includes a perpetrator, victim and youth helpcard and other information booklets.

Queensland Indigenous Alcohol Diversion Program

The Queensland Indigenous Alcohol Diversion Program (QIADP) is a pilot alcohol diversion program that targets Indigenous defendants who are either charged with alcohol-related offences or Indigenous parents with an alcohol-related problem who are also involved in the child protection system.

Entry into the QIADP is restricted to Indigenous people who are alcohol-dependent or high-risk drinkers (such as regular binge drinkers) and who meet certain eligibility criteria. Participants must:

- agree to take part in the program
- normally reside in one of the three pilot locations
- be assessed by the QIADP assessment team as having a treatable alcohol problem.

Additional eligibility criteria have been developed for the Child Safety Stream, including that the participant:

- is an Aboriginal or Torres Strait Islander person

- is aged 18 or above (although entry into the program may be possible for 17-year-old parents in limited circumstances)
- has a child or children who the Department of Child Safety has assessed as being in need of protection and ongoing intervention
- uses alcohol in a way that negatively impacts on his or her ability to protect his or her child(ren) from harm – as per the threshold for intervention set out in the *Child Protection Act 1999*
- has not been charged with a serious criminal offence in any court.

The primary goal is to improve Indigenous health and to reduce the number of Indigenous people involved in the criminal justice and child protection systems.

The program is expected to offer a wide range of benefits including:

- reduction in the level of problematic alcohol use and alcohol dependency of program participants
- improved personal health of participants via reduction in the risks associated with the problematic use of alcohol and alcohol dependency leading to reduced demands on the health system
- addressing a participant's alcohol misuse which contributed to their offending or impacts negatively on their parenting through treatment
- improved family life, such as more stable relationships, enhanced parenting skills, and reunification of families
- improved social functioning of participants and their re-integration into the community
- ongoing support and assistance for participants in areas such as education, employment, accommodation and health
- cost savings and reduced pressure on resources for the criminal justice and child protection systems.

The QIADP treatment model is based on the flexible delivery of services across a range of treatment settings from hospital to home depending on the client's own unique needs.

Tertiary prevention

Tertiary prevention services are predominately child safety services although specialist health services providing counselling for victims of abuse support these services.

Child witness counselling services

These tertiary intervention services deliver counselling and support, including group work, to children affected by domestic and family violence through a range of interventions. Information, advice and referrals are also provided by child witness counselling services. There are 14 regional child witness counselling services in Queensland.

EVOLVE mental health therapeutic teams

The Evolve Interagency Services (EVOLVE) specifically caters for the therapeutic and behaviour support needs of children and young people in the care of the Department of Child Safety with severe and complex support needs.

A key focus of the EVOLVE program is to provide planned and coordinated clinical supports to children and young people in care, aimed at improving their emotional wellbeing and the development of skills to enhance their participation in school and community. This program has been established in seven locations across Queensland.

Child safety

Child protection services

The Department of Child Safety leads the provision of services designed to ensure the safety of children and young people who have been harmed or are at risk of harm. In delivering this output, the department receives and records reports of possible child abuse or neglect and investigates those assessed as presenting a risk to the safety of a child. In these matters, families are provided with support and intervention services ranging from initial advice to more intensive services such as short-term protective interventions. The department also provides a range of court services.

Out-of-home care

The Department of Child Safety has responsibility for foster and kinship care in Queensland. The department leads the provision of services designed to enhance the safety, education, health and other wellbeing needs of children in its care. Case plans are developed and reviewed on an individual case management basis, and placement and carer support services (such as advice to foster parents) are provided and the child's development is monitored.

Intensive residential therapeutic and behavioural support services are provided for those children most traumatised by abuse. Family contact is a critical element of case management and, where it is deemed appropriate, the department facilitates family contact and works with the child and family in preparation for reunification. Where reunification is not possible, the department endeavours to provide stable long-term permanent placements.

When a child or young person is about to leave care (for example, on turning 18 years) the department endeavours to provide them with the services and information they will require to live successful independent lives.

Children's Court

The Queensland Children's Court makes decisions about all care and protection matters.

Commission for Children and Young People and Child Guardian

The Commission for Children and Young People and Child Guardian promotes and protects the rights, interests and wellbeing of all Queenslanders under 18. It oversees services for, and decisions made about, children in the care of the Department of Child Safety.

The commission is an independent organisation that provides a variety of services. These include:

- monitoring and reviewing laws, policies and practices impacting on services provided to children and young people
- monitoring and reviewing laws, policies and practices that impact on the safety and wellbeing of vulnerable children and young people at risk
- administering a statewide Community Visitor Program for children and young people in alternative care, including foster care
- receiving and investigating complaints about services to children and young people known to the Department of Child Safety
- maintaining the Child Death Register, administering the Child Death Case Review Committee and conducting research into child deaths
- employee screening of certain types of child-related employment
- educating the community to comply with the *Commission for Children and Young People and Child Guardian Act 2000*
- conducting research into issues impacting on the safety and wellbeing of children and young people
- promoting laws, policies and practices that uphold the rights, interests and wellbeing of children and young people, particularly those at risk.

Community Visitor Program

The Community Visitor Program makes regular visits to children and young people in alternative care in order to provide help and support.

Community visitors may advise people with problems who live in:

- a youth detention centre
- out-of-home residential care, such as a youth shelter or a mental health facility
- supported accommodation
- respite care
- foster care.

The Community Visitor Program extends across Queensland and requests for a visit by a community visitor can be made at any time.

Specialist Services

Redress Scheme

The Redress Scheme completes the Queensland Government's response to the recommendations of the Forde Inquiry into the Abuse of Children in Queensland institutions. Under the scheme, eligible applicants receive an ex gratia payment, ranging from $7000 up to $40 000, to acknowledge the impact of the past and help them move forward with their lives.

Applications closed on 30 September 2008. Former residents who did not wish to participate in the Redress Scheme are free to choose instead to pursue their legal rights.

5.12 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN QUEENSLAND

Service	2002–03 ($m)	2003–04 ($m)	2004–05 ($m)	2005–06 ($m)	2006–07 ($m)
Child protection and OOHC	196 121	220 615	304 117	361 398	423 188

Source: Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, Queensland received 28 580 notifications of alleged child abuse and neglect regarding 24 048 children. In the same year, 8441 substantiations were made pertaining to 7341 children. The rates of notifications and substantiation of cases peaked in 2004–05 but in 2006–07 a decrease in rates was comparable to 2002–03 data. However, the rates of finalised investigations and number of care and protection orders have increased since 2002–03 despite some fluctuations.

QUEENSLAND CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	21 821	24.4	24 804	27.5	29 298	32.1	25 404	27.5	24 048	25.2
Finalised investigations	13 091	14.7	17 431	19.3	17 741	19.5	16 792	18.2	na	na
Substantiations	8 985	10.1	12 673	14.0	12 886	14.1	10 077	10.9	7 341	7.7
Care and protection orders (0–17)	4 107	4.3	4 950	5.2	5 857	6.0	6 446	6.5	6 156	6.0

Source: ROGS 2008, Table 15A.68, using AIHW data.

QUEENSLAND CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	31 068	35 023	40 829	33 612	28 580
Substantiations	12 203	17 473	17 307	13 184	8 441

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 6

South Australia

6.13 Verification status

This stocktake has not been verified by South Australian government agencies.

6.14 Stocktake of service systems

The table below provides a summary of the primary, secondary and tertiary child systems for protecting children in South Australia. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — SOUTH AUSTRALIA

Sector	Primary	Secondary	Tertiary
Health	Antenatal and maternity care in hospitals Parent Helpline Home visiting Child and family health services The Second Story (TSS)	Family and Baby Program Services for children with disability and developmental delay Child and adolescent mental health services (CAMHS)	
Family support	Parenting support Playgroups	Aboriginal Family Support Services	
Education and care	Children's services Preschools Learning Together Schooling	Early education for children with special needs Targeted early learning programs	
Child safety			Statutory child protection services Out-of-home care Children's Court
Specialist services for parental risk factors: substance abuse mental health family violence		Mental health services Drug and Alcohol Services South Australia Family violence services	

Primary prevention

Health

Antenatal and maternity care in hospitals

Comprehensive antenatal and maternity services are provided in South Australia's public hospitals.

Parent Helpline

The Parent Helpline is a free telephone information service for parents and young people from birth to 25 years of age in South Australia provided by the Children, Youth and Women's Health Service (CYWHS). The helpline provides information on health, behaviour and parenting issues and is staffed with qualified nurses, social workers, community health workers and selected volunteers.

Home visiting

The CYWHS provides two home visiting services for new parents — universal and targeted. The Universal Home Visiting Program is part of the Government's commitment to early intervention for a broad range of health issues of public health significance. Nurses offer a home visit to all new parents shortly after discharge from hospital. Nurses do the first recommended health check and determine those families requiring additional support.

Family home visiting has been funded by the government as part of the Every Chance for Every Child initiative and provides ongoing home visits and support to eligible families over a two year period. Nurses are supported by a multidisciplinary team including social workers, psychologists, family support coordinators and Aboriginal health staff.

Child and family health services

Child and family health services deliver a number of services at child and family health centres statewide, including:

- free health checks for children at key developmental ages between birth and six years
- immunisation is provided at many clinics sites in accordance with the National Immunisation Program
- comprehensive developmental assessment and counselling, and referral for infants and children who would benefit from early intervention.

Children can also be seen at any age when parents have concerns, questions or issues.

In addition, child and family health nurses visit all kindergartens and preschool centres across the state to provide vision, hearing, growth and developmental checks. This also provides opportunities for parents to discuss parenting or health concerns. Teachers, nurses and parents work in partnership to assess children's needs before school entry.

Child and family health nurses also provide referrals to the Hearing Assessment Centre, which offers a free statewide secondary hearing assessment service for children from birth to 12 years old.

The Second Story

The Second Story (TSS) is the youth section of Children, Youth and Women's Health Service. TSS is a free, confidential health service for young people aged 12 to 25 years.

TSS offers:

- 24-hour, seven-day health information (Youth Healthline — see below)
- clinical services
- counselling
- health education and promotion
- groups and programs.

The Youth Healthline is a 24-hour, seven-day telephone service for young people aged 12 to 25 years in South Australia.

The Youth Healthline is staffed by health professionals who are trained and experienced in working with young people. It is a confidential service for all young people, particularly those who may want to talk to someone about what is going on in their life but feel more at ease with a telephone conversation than with face-to-face contact.

The Youth Healthline staff are able to put young people in contact with health services in their area if ongoing support is needed. This service is also a resource for parents and service providers who may want information about health issues relating to young people or information about where to obtain support for young people and their families.

Family support

Parenting support

The Children, Youth and Women's Health Service provides parenting support through the Centre for Parenting, Parenting SA and parenting groups:

- Centre for Parenting — a multidisciplinary team, which supports parenting programs in the Children, Youth and Women's Health Service, provides information and training on parenting and parent-child relationships, especially attachment and early relationships. It produces resources for parents and professionals and runs some parenting groups about particular issues. These groups include behaviour management groups and family of origin groups for parents who would like to resolve issues about their own childhood experiences
- Parenting SA — provides information, resources, helpline services and parenting groups to give recognition to the important and demanding role of parenting and to promote the importance of effective parenting practices. Parenting SA is funded through the Community Development Fund from gambling revenue raised in South Australia
- parenting groups — the Children, Youth and Women's Health Service provides free parenting information and guidance, including groups where you can learn about different parenting topics and meet with other parents.

Playgroups

Playgroups are community-based, and members are involved in the planning, organisation and running of their playgroup. Many playgroups are members of Playgroup SA Inc. Playgroup SA is a non-profit, community-based organisation which is committed to providing quality services to families with young children throughout South Australia. Playgroup SA employs consultants to advise and support playgroups.

Education and care

Children's services

The Department of Education and Children's Services (DECS) is the government department that plans, administers, coordinates and supports children's services. Children's services include non-compulsory early education and child care services. These are:

- child care services — babysitting agencies, child care centres, emergency care, home and community care (respite care), family day care, occasional care and out of school hours care
- early learning programs — preschools (also known as kindergartens, child parent centres, children's services centres), play centres and playgroups.

Preschools

DECS is responsible for the provision of a statewide preschool program. The majority of preschools are operated by DECS and staffed by DECS employees. A few preschools are grant funded and in these centres staff are employed by the incorporated body.

South Australian Government policy is to provide preschool to all children in the year prior to their entry to school. Children aged no less than four years are entitled, where resources permit, to attend up to four preschool sessions per week for up to four consecutive terms prior to their entry to the reception class of primary school. Aboriginal children are able to start at three years of age. Fees for attending preschools are set by the centre's management committee and may vary from centre to centre. The state average fee is $50 per term. No child will be excluded from a government funded preschool on financial grounds.

There are also 13 rural integrated services throughout South Australia. These services combine a preschool and a child care centre in a purpose-built facility. The staff in the preschool are DECS employees and the staff in the child care centre are employed by the management committee. Parents using the service can access the Australian Government Child Care Benefit.

Learning Together

Learning Together is an early literacy and family support program for families with children under four years of age in five locations across South Australia provided by the Department of Education and Children's Services. Each program has developed a range of unique Learning Together activities for their families and communities. These activities include:

- facilitated playgroups
- the use of digital technology to make family books

- development of take home literacy packs
- home visits
- parent education groups.

Schooling

DECS sets the direction and manages the state's education system in South Australia and DECS delivers primary and secondary education to school students across the state. DECS is responsible for the education of children and students across all areas of the curriculum. Support staff including teachers, guidance officers, speech and language pathologists and social workers work in South Australian schools to resolve problems, and refer students to other professional help if they need it.

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

Secondary prevention

Health

Family and Baby Program

The Family and Baby Program is a free statewide service delivered by CYWHS that provides a day and residential program for parents that need extra assistance. The program aims to:

- ensure that all parents and care givers are supported to resolve feeding and settling issues for infants, from birth to one year of age
- increase the confidence and knowledge of parents in managing feeding and settling issues
- promote parent and infant relationships.

Services for children with disability or developmental delay

The CYWHS provides two key support services for children with disability or developmental delay and their families.

- The Early Childhood Intervention Program is for parents of children from birth to eight years of age, who are concerned about their child's development and may need special help. The program provides a range of support and advice to parents, including:
  - information about services and support groups in each area
  - assistance to help access services and benefits
  - support and assistance for dealing with agencies or organisations concerning services for children with special needs
  - promotion of links between agencies providing services for children to ensure hassle free transfer/attention.

- The Access Assistants Program supports students with a disability and who have complex health support needs, so that they can participate in a school curriculum in a government or non-government preschool or school. The program is available to children who satisfy the criteria for enrolment in special education programs or services provided by the government of the state in which the child resides.

Child and adolescent mental health services

Child and adolescent mental health services across South Australia provide a range of therapeutic counselling services for children and adolescents between birth and 18 years of age and their families.

In addition, the Behavioural Intervention Service is a statewide, intensive, specialist service for young people aged five to 18 years who have mental health issues and persistent, pervasive, challenging behaviours. The service offers a comprehensive assessment of the young person's issues in order to determine whether consultancy or day program intervention will be provided.

Family support

Aboriginal Family Support Services

Aboriginal Family Support Services is an NGO that provides a range of services along the continuum of care for Aboriginal families and their children. These include community wellbeing programs to build capacity in families to care for their children and break the cycle of abuse and neglect by ‘getting in early’. In addition Aboriginal Family Support Services provides tertiary child protection services including placements, carer recruitment and support and support for Aboriginal children in care.

Education and care

Early education for children with special needs

The Preschool Support Program provides extra staff to preschools to support the teaching and learning development of children with additional needs — developmental delay, disability and behavioural disorders. It is a free program from the Department of Education and Children's Services.

In addition, South Australia has one stand alone DECS preschool for young children with significant developmental delay and/or disability — the Briars Special Early Learning Centre. The preschool provides individualised educational programs for children to develop their potential in all learning areas.

Targeted early learning programs

Early learning programs provide support to parents of children from birth to four years of age who have:

- limited access to resources and other children’s services
- recently arrived in Australia and speak a language other than English
- cultural support needs.

Early learning programs help parents with their child's language and literacy development. To be eligible, children need to be less than four years of age and experiencing some delay or difficulty in the development of language and literacy skills. Fieldworkers visit families for approximately one hour a week and work directly with parents and children. They provide a hands-on program based on play, talking, stories and everyday activities around the home.

Early learning program fieldworkers are employees of the Department of Education and Children's Services.

Specialist services for parental risk factors

Mental health services

Mental health services in South Australia are provided through the public hospital system, and are made up of:

- emergency and crisis services
- treatment services for people with mental illness
- rehabilitation and recovery services
- services for people with severe and persistent needs.

Non-government organisations also provide information and support for people to live independently in the community. Services are provided for people of all ages, for Indigenous People, and people from culturally and linguistically diverse backgrounds.

In addition to services for adults with mental illness, the South Australian Children of Parents with a Mental Illness Partnership has been established to promote accessible, effective and comprehensive service provision for children of parents with a mental illness and their families in South Australia.

Drug and Alcohol Services South Australia

Drug and Alcohol Services South Australia (DASSA) offers a range of prevention, treatment, information, education and community-based services for all South Australians. DASSA's services are based throughout South Australia in community and hospital settings and include treatment and rehabilitation services for alcohol and other drug related problems. The services are targeted to people who have complex problems requiring specialist intervention. Services include telephone counselling, withdrawal management, a therapeutic community, pharmacotherapies, amphetamine treatment interventions, and statewide community-based counselling services.

DASSA is funded and provided by the South Australian Department of Health.

Family violence services

Family violence services across South Australia are provided by NGOs and include counselling, crisis services and housing.

Tertiary prevention

Tertiary prevention services are all child safety services although children in the child protection system continue to access a range of government services in other sectors.

Child safety

Statutory child protection services

Families SA provides statutory child protection services including intake, assessment and ongoing case management.

Out-of-home care

Out-of-home care is delivered by the Department of Families and Communities.

For children in care, the South Australian Government has introduced a whole-of-government strategy called *Rapid Response* to reduce waiting times, red tape and restrictive conditions, improve communication between key players, including service providers, carers and the children and young people, and eliminate gaps in services. Children in care are entitled to assessment, case management and an integrated service response suitable to their needs.

Children's Court

The South Australian Children's Court makes decisions on care and protection orders.

6.15 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN SOUTH AUSTRALIA

Service	2002–03 ($m)	2003–04 ($m)	2004–05 ($m)	2005–06 ($m)	2006–07 ($m)
Child protection and OOHC	49 706	52 161	67 767	72 803	103 628

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, South Australia received 18 434 notifications of alleged child abuse and neglect concerning 11 995 children. In the same year, 2242 substantiations were made pertaining to 1753 children. Since 2002–03, the rates of notifications and number of children on care and protection orders have increased steadily each year. The rates of finalised investigations and substantiations, however, have fluctuated since 2002–03 resulting in a general downward trend in 2006–07.

SOUTH AUSTRALIA CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	8911	27.0	9794	29.9	11 055	34.0	10 151	31.3	11 995	36.4
Finalised investigations	4537	13.8	4661	14.2	4 280	13.2	3 545	10.9	4 237	12.9
Substantiations	1896	5.8	1940	5.9	1 798	5.5	1 461	4.5	1 753	5.3
Care and protection orders (0 – 17)	1378	3.9	1455	4.2	1 553	4.5	1 671	4.8	1 881	5.4

Source: ROGS 2008, Table 15A.102, using AIHW data.

SOUTH AUSTRALIA CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	13 442	14 917	17 473	15 069	18 434
Substantiations	2 423	2 490	2 384	1 855	2 242

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 7

Tasmania

7.16 Verification status

This stocktake has been verified by the Tasmanian Department of Health and Human Services.

7.17 Stocktake of service systems.

The table below provides a summary of the primary, secondary and tertiary systems for protecting children in Tasmania. Further information about these services is outlined in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT IN TASMANIA

Sector	Primary	Secondary	Tertiary
Health	Child health and parenting services; parenting centres Child Development Unit Community health services/centres Family, Child and Youth Health Service Child and adolescent mental health services	Brighton Early Years Integrated Service Pilot Tasmanian Women's Health Program Youth health services C U @ Home Child and adolescent mental health services	
Family Support	Playgroups Tasmania Parenting Helpline Stronger Families and Communities Strategy, Tasmania		Sexual Assault Support Service Family violence counselling and support
Education and Care	Child Care Unit Family day care Kindergartens Schooling Long day care Strong Start programs Occasional care Out of school hours care Launching into Learning		
Child Safety		Youth ARC	Child protection services Kennerley Children's Home

Sector	Primary	Secondary	Tertiary
Specialist Services for Parental Risk factors: substance abuse mental health family violence		Kids in Mind Tasmania Tasmanian alcohol and drug services	Huon Domestic Violence Service Yemaya Women's Support Service Safe at Home

Primary prevention

Health

Child Health and Parenting Service; parenting centres

The Department of Health and Human Services is the main body that funds primary care for children and family services in Tasmania. Services are administered by the Child Health and Parenting Service and parenting centres.

While professional health staff address issues or situations that frequently arise in the normal process of parenting, the Child Health and Parenting Service provides counselling, support and health, practical parenting information for families, and growth/development assessments for children through more than 80 child health centres around Tasmania. They also offer screening for postnatal depression and provide counselling, support and referral as necessary. Issues covered include breastfeeding, sleeping and settling issues, balancing work and family life, postnatal depression, fathering, nutrition, child development, safety and the importance of play.

Child Development Unit

The Child Development Unit, funded through the Department of Health and Human Services, provides a comprehensive assessment and referral service for under school age children (birth to five years) who are suspected of having delays in one or more areas of their development.

As a team, the unit works from a family centred approach, which means parents are involved in the assessment and decision-making processes. Children's skills are observed and assessments are conducted and coordinated by the relevant professionals. The areas looked at are fine and gross motor abilities, coordination, perceptual development, speech and language skills, learning and cognitive ability, emotional and behavioural adjustment.

Referral to this service may come from parents, family doctors, paediatricians, child and family health nurses, health professionals and staff from creche and play centres. These services are available in the north and north-west regions of Tasmania.

Community health service centres

Community and health service centres offer a range of services for local residents depending on their individual health care needs provided by health professionals.

While there is some variation between centres, all provide home-based nursing, assistance with household tasks and personal care, home maintenance, health assessments and referrals to other health and community services. This service is a universal service available in both the north and south of Tasmania.

Family, Child and Youth Health Service

The Family, Child and Youth Health Service has a team of experienced and friendly professional staff who support families and young people. They check the growth and development of babies and children, and offer support groups, confidential counselling and home visits. Information is available on a wide range of child and family health issues, such as immunisation, toddler behaviour, sleeping and feeding problems, and bedwetting. For instance, if a child has been diagnosed with attention deficit disorder, the Family, Child and Youth Health Service can advise on strategies to help modify behaviour.

Child and adolescent mental health services

Child and adolescent mental health services are located in each region of Tasmania: Hobart, Launceston, Burnie and Devonport. They offer the following services to children and young people up to age 18:

- specialist assessment and treatment for children and young people with mental illness
- consultation, advice and support regarding many types of mental disorder, including depression, anxiety problems, disruptive behaviours, eating disorders, phobias, school refusal and attention deficit disorder
- child, adolescent and family therapy.

Family support

Playgroup Tasmania

Playgroup Tasmania is a member of Playgroup Australia Inc. Playgroup Tasmania services, supports and promotes playgroups in the community through regional zones. Its vision is to give every Tasmanian family the opportunity to experience community-based playgroups. It aims to give parents and carers of young children access to a stimulating, creative and secure environment in which they may interact together to foster the development of their mutual social, educational, emotional and physical needs through play.

Playgroup Tasmania offers access to over 153 affiliated playgroups and play centres. Currently over 1600 families attend playgroups in sessions operating from inner city localities, outer suburbs and small rural communities.

Parenting Helpline

The Parenting Helpline is available at any time to assist parents with stressful parenting issues or concerns.

Stronger Families and Communities Strategy

The Stronger Families and Communities Strategy is funded by FaHCSIA. The strategy is accessible in Launceston and Burnie. The strategy funds programs like the Responding Early Assisting Children (REACh) parenting program in Burnie, Child Care Links in Launceston, and other collaborative projects delivered through NGOs. Funding of $5 million has been allocated over the 2004–09 period for this strategy.

Education and care

The Child Care Unit

The Child Care Unit of the Department of Education is responsible for the administration of the *Child Care Act 2001* which commenced on 1 September 2003.

The unit supports the development of high quality child care programs and services in Tasmania by implementing an appropriate licensing process, including standards and supporting information; licensing and ongoing monitoring of child care services; providing advice and assistance in the planning, design and establishment of new services and renovation of older services; funding some services, particularly occasional care services in rural and isolated areas; and advising government, providers, parents and the community on child care matters.

Family day care

Family day care is a home-based child care service. Family day care caters for young babies through to pre-teens and can offer care during standard hours, before/after school, during school holidays and, in some circumstances, overnight and weekends. Although funding may come from different areas, family day care centres are provided by the local council.

Kindergartens

Funded by the Department of Education, the program is accessed from within school budgets. It is designed for young children in the year before formal schooling. In 2005, $21.34 million was dedicated to the program. This is a licensed service.

Schooling

Schooling is provided in each state and territory. Due to the size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system.

Long day care

Long day care provides centre-based quality child care, which generally operates for at least 40 hours per week, 48 weeks per year. Centre-based care usually caters for children aged from birth to five years and nurtures and encourages all aspects of the child's development. This is a licensed service.

Strong Start program

The Strong Start program focuses on families with children aged up to four years. The program aims to enhance each child's early personal growth and learning by coordinating and co-locating the delivery of services for young children. The two Strong Start pilot projects, the Integrated Services project in West Tamar and the Support for Young People project in the Derwent Valley are in their final year of operation. The projects strengthen relations between families and the providers of services to young children. Service providers adopt a coordinated early intervention approach to support families.

In the West Tamar region, the established structures, relationships and connections will assist support groups. In the Derwent Valley, the Early Years coordinator provides support to projects linked to the local and Australian Government Communities for Children program. Non-government organisations use the services. Partnerships are developed with isolated schools to facilitate the regular placement of the mobile play bus in these communities.

The program was given a once only payment of $200 000 by the Department of Education for use over three years.

Occasional care

Occasional care is a unique child care service that supports families by providing flexible care for children from birth to school age. Families can access occasional care regularly or irregularly. Occasional care allows the flexibility to leave children in an early childhood learning environment to socialise and interact with other children.

Out of school hours care

Out of school hours care is a program run by the Department of Education. It provides services to cater for the needs of primary school aged children and their families before school, after school, during non-teaching days and during school holidays.

Services need to be licensed and, where parents wish to receive the Child Care Benefit, the service must be accredited under the Australian Government's Child Care Quality Assurance system. Licensing and accreditation mean that services meet standards for providing quality child care in safe and secure surroundings. Some family day carers also offer out of school hours care — this can be arranged through a local family day care scheme. Out of school hours care programs are generally provided within school facilities.

Launching into Learning

Launching into Learning is a new initiative and commitment to the years prior to formal school. Forty-four schools are currently involved by taking on a greater role in engaging and forming relationships with families before children come to school.

All schools are implementing the Launching into Learning initiative in order to promote early literacy and school readiness. Schools are deliberately focusing on the needs of their community and making connections and forming partnerships with other groups, services and agencies in the area.

Secondary prevention

Health

Brighton Early Years Integrated Service Pilot

Brighton was selected as a pilot site for the Early Years Integrated Service project in Tasmania because of the economic disadvantage, high levels of need, the disproportionately high number of children with teen parents and the high proportion of Aboriginal families in the area. The program is delivered through schools and is funded by the Department of Health and Human Services and is largely targeted to children from birth to five years. A sum of $20 000 has been given to five schools with the aim of providing a variety of services for young people and their parents.

Each centre provides information, support and referrals regarding antenatal care, parenting, developmental milestones for children, and other needs relating to health and social development. Structures that encourage and welcome new parent groups are in place with the aim of attracting the vulnerable, more isolated parents. The centres collaborate with child health nurses and family support staff to initiate, develop and facilitate new parent groups.

In addition, a range of programs are provided including a supported playgroup. This promotes opportunities to model child-appropriate interactions and interactive activities that encourage child and family participation, and are built around fun, enjoyment, stimulation and learning through positive play.

Tasmanian Women's Health Program

The Tasmanian Women's Health Program provides information to women and service providers about health issues and services, and works within the health system to improve services to women. There is particular focus on the needs of low income women and women who have unequal access to the health system. Regional offices are located in Burnie, Launceston and Hobart, with staff providing outreach services to rural areas.

Youth health services

Youth health services are delivered by the Family, Child and Youth Health Service. Youth health services offer young people aged 12 to 24 years a flexible and confidential service including information, education, support, referral and counselling on issues such as drugs and alcohol (including needle availability program), sexual health, emergency health care, specialist counselling, pregnancy testing, referral services and any other aspects that affect the health and wellbeing of young people. There are three centres in Tasmania — in the north, north-west and south.

C U @ Home Program

C U @ Home is a program offered by nurses from the Child Health and Parenting Service to first-time mothers aged 15 to 19 years. If the young woman accepts the offer, nurses commence home visiting in the antenatal period with visits at regular intervals until the child's second birthday. The program ensures children born to young parents have equal opportunity for optimal development to become creative, competent, caring and resilient young people and adults.

The objectives of the program are to:

- improve birth weight, and reduce the incidence of pre-maturity and adverse neurological outcomes by helping young women improve their antenatal health
- improve children's health and development, by assisting young parents
- enhance parental lifestyle (which in turn, influences the child's health and wellbeing outcomes)
- supporting young mothers to set educational and/or employment goals.

The program is available in three areas of Tasmania — the northern region at Walker House Parenting Centre, the north-west region at the Burnie Parenting Centre and the south/south-east region at the Hobart Parenting Centre.

Child and adolescent mental health services

The child and adolescent mental health services provide a community-based service for children and adolescents with mental health disorders, and their families/carers. The service is available for children and adolescents under 18 years of age and is provided by qualified mental health professional. All referrals are made through the Mental Health Helpline.

There are three CAMHS services, one each in the north, north-west and southern regions.

Services offered include:

- specialist assessment and treatment of children and young people with more serious mental health problems
- treatment/management of many types of disorders including psychosis, bi-polar disorder, obsessive compulsive disorder, eating disorders, significant depression and/or anxiety disorders, suicidal thoughts and behaviour, post traumatic stress disorder and attachment disorder
- individual, family and group therapies
- education and training around mental health issues to other service providers.

Education and care

None.

Child safety

Youth ARC

Youth ARC responds to the needs of young people in the Hobart area and beyond. Youth ARC provides a safe, youth friendly environment for all young people between the ages of 12 and 25 regardless of their gender, social situation, sexual orientation or philosophical beliefs.

Youth ARC offers free internet access, job search facilities, recreational activities, alternative education schools (ALTed and Ed Zone), case management programs (Job Placement Education and Training, National Illicit Drugs Strategy and Transitions and Pathways Program), access to workers from outside services (Centrelink, sexual health, mental health), individual support from youth workers, skill development programs and opportunities to be involved in the arts.

Specialist services for parental risk factors

Kids In Mind Tasmania

The Tasmanian Government is funding a suite of initiatives focused on improving the services and supports available to children of parents with mental illness. The Kids in Mind Tasmania (KIMT) project has adopted a whole-of-government and a cross-sector approach, with consumer and carer involvement also. Programs include:

- Statewide Network Coordinator — aims to raise awareness of the needs of children of parents with mental illness, regionally and statewide
- Professional Development Project — aims to improve the provision of family-focused care for parents with mental illness by making available training for those workers who provide services to children and families where the parent(s) has a mental illness
- Family Sensitive Service Delivery Project — aims to encourage family sensitive practice within adult mental health teams
- Early Childhood Community Capacity Building Project — aims to initiate links and activities with community and consumer organisations to enhance community capacity and knowledge regarding child development and parenting issues, particularly with families that have children under five years.

Tasmanian alcohol and drug services

The Tasmanian alcohol and drug services provide information, alcohol and drug assessments, access to evidence-based treatment or referral to other services; professional counselling; group work programs; methadone and other pharmacotherapy programs; residential, outpatient and home withdrawal; outreach services to non metropolitan areas; professional consultations to other service providers; and specialist reports.

There are 16 regional service providers and centres across Tasmania.

Tertiary prevention

Family support

Sexual Assault Support Service Inc.

The Sexual Assault Support Service Inc. (SASS) provides counselling and support for men, women and children affected by sexual assault. The Sexual Assault Support Service provides three main services to the Tasmanian community. These are:

- Galileo House — provides counselling and support for children and young people who have been subjected to sexual abuse. SASS provides counselling and support to family members and other support people. This service also provides counselling and support to children under 13 years and their families for problem sexualised behaviour issues
- the Sexual Assault Crisis Service — provides crisis counselling for all survivors of sexual assault as well as parents and carers. The crisis service also offers support with police statements, and coordinates medical and/or forensic examinations if required

- the Adult Counselling and Support Service — provides individual counselling and group programs for any survivors of sexual assault 18 years and older, also family members and support people. This service is available nationally.

Family violence counselling and support service

DHHS' family violence counselling and support service offers professional and specialised services to assist children, young people and adults affected by family violence. This service is part of the 'Safe at Home' initiative: a Tasmanian whole-of-government response to family violence. The DHHS Family Violence Counselling and Support Service has offices in Burnie, Launceston and Hobart. Appointments can also be made to see clients in other locations.

Services include:

- information on family violence and its impact on adults, children and young people
- individual support and counselling for individuals affected by family violence
- group work programs for affected adults, children and young people.

For adults, services are available to anyone who needs support or information because their partner or ex-partner is or has been violent or abusive to them. People can self-refer, or be referred by another person or service. Services are offered to people in heterosexual or same-sex relationships.

Children and young people affected by family violence can be referred to the Family Violence Counselling and Support Service by 'Safe at Home' service providers. Most children and young people will be referred via the police, the Court Support and Liaison Service, the Child Witness Program or by a family violence worker who is already working with their parent or care giver. Other children and young people will be referred via DHHS Child and Family Services or DHHS Child Protection Advice and Referral Service (CPAARS) — which has been decentralised into regional intakes.

Child safety

Child protection services

Child protection services have the responsibility for intervening where children are at risk of abuse and neglect under the *Children, Young Persons and Their Families Act 1997*. Child protection activities are provided by the Department of Human Services and include intake, assessment, case management and out-of-home care services.

Notifications of abuse or neglect are directed to the statewide CPAARS. This service provides consultation, advice and referral about care and protection matters, and provides the entry point for statutory care and protection in the form of four regional intakes. If a judgement is made that a child is at risk, the notification may be referred to service centres in Hobart, Launceston, Devonport and Burnie for further assessment. Service activities include direct contact with the child and family, case management support (planning, monitoring and reviewing the needs of children), assistance with referrals to other agencies, and legal protective intervention.

Kennerley Children's Home

Kennerley Children's Home offers emergency support and care for children in Chigwell, Claremont and Lenah Valley.

The services offered by the Kennerley Children's Home include cottage/sibling care, foster care, and 'moving on' care — semi independent accommodation for young adults.

Referrals are necessary and can be obtained from a GP, hospital or the police.

Specialist services for parental risk factors

Huon Domestic Violence Service

Services offered by the Huon Domestic Violence Service (HDVS) include support, counselling, information, advocacy, court support and community education. It is a free service available to all victims of domestic violence. No referral is necessary and the service is free.

Clients can arrange a meeting time and place that suits them. Such places include the HDVS premises, another service's premises or home visits.

Yemaya Women's Support Service

The Yemaya Women's Support Service provides services for any woman who is or has been in an abusive relationship. The service primarily works with women experiencing concerns in an intimate relationship, but are flexible, e.g. mother–son abuse.

Safe at Home

Safe at Home is a major whole-of-government initiative developed in response to family violence within Tasmania. Government agencies, in consultation with other key stakeholder groups, have developed an integrated service delivery system built around the principle of primacy of safety of the victim.

Safe at Home is the Tasmanian Government's response to family violence accessed through the Department of Justice. The initiative is intended to achieve a reduction in the level of family violence in the medium- to long-term and, in the shorter term, to improve safety for adult and child victims as well as changing the offending behaviour of those responsible for the violence.

It involves a range of services working together to protect and support victims of family violence — including young people and children — while making offenders responsible for their behaviour.

Safe at Home has two key elements:

- managing the risk that the offender might repeat or escalate their violence
- implementing strategies to enhance the safety of victims of family violence.

Family violence services can be accessed through the Family Violence Response and Referral Line.

7.18 Cost and impact of child protection systems

Cost

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF SYSTEMS FOR PROTECTING CHILDREN IN TASMANIA

Service	2002–03 ($'000)	2003–04 ($'000)	2004–05 ($'000)	2005–06 ($'000)	2006-07 ($'000)
Child protection and OOHC	19 794	22 521	25 780	32 202	42 100

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, Tasmania received 14 498 notifications of alleged child abuse and neglect concerning 7326 children. In the same year 1252 substantiations were made pertaining to 799 children. There is an increase in rates of notification and substantiations across the child protection data since 2002–03. Final investigations have more than doubled over the last five years while the number of substantiated cases has more than tripled. Child and care protection orders have increased at a steadier rate since 2002–03.

TASMANIA CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	na	4.8	5215	47.0	5765	52.2	6585	59.7	7326	66.4
Finalised investigations	428	3.8	683	6.2	1054	9.5	1138	10.3	1165	10.6
Substantiations	205	1.8	329	3.0	636	5.8	650	5.9	799	7.2
Care and protection orders (0–17)	600	5.1	634	5.4	716	6.1	833	7.1	897	7.6

Source: ROGS 2008, Table 15A.119, using AIHW data.

TASMANIA CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	na	7248	10 788	13 029	14 498
Substantiations	213	427	782	793	1 252

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 8

Victoria

8.19 Verification Status

This stocktake has been verified by the Victorian Department of Human Services and the Victorian Department of Education and Early Childhood Development.

8.20 Stocktake of service systems

The table below provides a summary of the service systems for protecting children in Victoria. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — VICTORIA

Sector	Primary	Secondary	Tertiary
Health	Universal maternal and child health (MCH) services Antenatal and maternity care Koori maternity services Community health services School nursing	Early Childhood Intervention Service Enhanced maternal and child health services Child and adolescent mental health services	Intensive treatment services — Take Two Sexual abuse treatment service
Family support	Parenting services Parentline Best Start Children's centres Maternal and child health line	Early parenting centres Parenting assessment and skill development services Family intervention services In home support for Aboriginal families Supported parent groups and playgroups	
Education and care	Kindergarten Child care Student support services Schooling	Inclusion support	Educational support: children in residential care
Child safety		Family services Family support innovation projects Placement prevention programs Community-based intake Home Based Care — Adolescent Community Placement Program Secure welfare service	Statutory child protection services Out-of-home care placements and support services

Sector	Primary	Secondary	Tertiary
Specialist services for parental risk factors substance abuse mental health family violence		Drug and alcohol treatment and rehabilitation services Mental health services Family violence services Sexual assault services	

Primary prevention

Health

Universal maternal and child health (MCH) services

The universal maternal and child health (MCH) services are free for all Victorian families with children aged from birth to six years provided through MCH centres in each local government area.

The services offer support, information and advice regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning. Parents can also join groups that provide health information, and an opportunity to meet other parents in the local area. All MCH centres are staffed by registered nurses with qualifications in midwifery and family and child health.

Local governments use the service to offer additional activities that respond to local needs and priorities, for example immunisation sessions. MCH services are also supported by a 24-hour telephone service.

The universal MCH services are jointly funded by the Department of Education and Early Childhood Development (DEECD) and local government, and both the universal service and enhanced service are managed and delivered by local government in community settings or by other locally-based community services.

Antenatal and maternity care

Free, universal maternity care is provided at Victorian public hospitals. The services provided are:

- primary maternity services — for women who experience an uncomplicated pregnancy and birth, and do not require ongoing specialist supervision or intervention. The service providers in this level are usually GPs and midwives, although obstetricians may also participate in providing primary care in some locations
- secondary maternity services — for women who have or develop complications and require secondary level medical input during pregnancy or birth. Women are referred for medical care, provided at the same hospital or through transfer to another hospital during pregnancy or labour. Midwives are still involved, both during the antenatal period and in providing continued clinical care in labour and the postnatal period
- tertiary maternity services — for women and babies with complex and/or rare medical conditions, who require multidisciplinary specialist care. Obstetricians are particularly essential in providing tertiary level care, with midwives still involved in providing continued clinical care, during labour and the postnatal period. Victoria has three hospitals that provide tertiary maternity services. Women are referred or transferred to a tertiary hospital during pregnancy or labour.

Koori maternity services

Koori maternity services provide culturally appropriate maternity care to Aboriginal and Torres Strait Islander women throughout pregnancy. The services work with hospitals for birth and through Aboriginal community-controlled cooperatives in ten sites throughout Victoria during the postnatal period. There are two key ways in which care is provided. The first involves an Aboriginal maternity health worker and a midwife, who are both employed by the Aboriginal health service. They combine their skills to offer a comprehensive service to women in the local community, including a clinical component. The second employs an Aboriginal health worker who supports women during pregnancy and after birth and is responsible for linking Aboriginal women with appropriate clinical service providers.

School nursing

Two school nursing programs are provided by DEECD to schools:

- primary school nursing — 75.8 effective full-time nurses deliver a universal vision screening and targeted hearing screening service to all prep students in primary schools across the state. Primary school nurses conduct a health assessment of all students in participating schools in their first year of school, provide follow up contact with parents, respond to referrals from school staff regarding identified health issues for students at any year level, and provide referrals to relevant health practitioners
- secondary school nursing — 100 registered division 1 nurses operate in 199 of Victoria's most disadvantaged secondary schools. Approximately half of the nurses have been allocated to schools in rural Victoria resulting in 75 per cent of rural students having access to a nurse. Secondary school nurses are members of the school welfare team and are able to facilitate support to all students, as well as those assessed as a risk, to improve their health and wellbeing and to maximise their learning opportunities.

Family support

Parenting services

Parenting services are provided through a statewide Victorian parenting centre and the nine regional parenting services, and are funded by the DEECD and delivered by community service organisations.

Victorian parenting centres are statewide services that provide a leadership role in the parenting field through the provision of research, evaluation, training and parent information resources. Regional parenting services provide information, education and support on a group and individual basis to parents, carers and professionals who work with children (maternal and child health nurses, teachers and child care workers).

Parenting services also develop service networks and coordinate local services concerned with parenting. Most provide group programs to parents and refer individual parent support issues to relevant family support services. Where possible, the parenting programs are designed to be accessible to all parents of children aged from birth to 18 and are provided through universal service platforms. However, the parenting services particularly target parents with children with disability or developmental delay, and families with risk factors.

Parentline

Parentline is a confidential and anonymous statewide telephone counselling, information and referral service for all Victorian families with children aged from birth to 18 years, whose focus is prevention and early intervention rather than crisis support. Parentline assists with the development of strategies and skills that promote the confidence, resilience and wellbeing of families and links families with community resources. Parentline is available statewide and is provided by the DEECD.

Best Start

Best Start projects bring together children and family support services, education services, health services, community organisations, local government, parents and the community in new partnerships that have a concentrated focus on meeting the needs of all young children aged from birth to eight years. Best Start is funded by DEECD in 24 mainstream sites in disadvantaged areas with six targeted Aboriginal Best Start sites.

Children's centres

DEECD provided capital grants for 38 children's centres in metropolitan and (predominately) rural areas in 2007–08. These centres will provide a one-stop-shop for families offering a range of integrated services — integrated community-based early childhood education and care (long day care with integrated kindergarten), maternal and child health, early intervention services, and family services. It is expected that many children's centres will be co-located with schools.

Maternal and child health line

This Victorian Government service is staffed by qualified maternal and child health nurses who provide callers with information, support and advice regarding child health, maternal and family health and parenting issues.

Education and care

Child care

Centres that provide care or education for five or more children under the age of six years in the absence of their parents or guardians are required to be licensed in Victoria. This includes long day care centres, occasional care centres and kindergartens.

The Australian Government has responsibility for the national child care policy. The Australian Government funds long day care child care places and provides subsidies for family day care schemes and outside school hours care in the form of the Child Care Benefit. In addition, the Victorian Government funds a number of specialist care programs:

- the adult, community and further education program provides occasional child care for children under six years for parents participating in adult, community and further education courses

- Take a Break child care program — occasional child care for children under six years of age to allow parents of young children to participate in a range of activities including study, recreational classes, shopping, social events and voluntary community activities. The Take a Break child care program is jointly funded by the Victorian Government (30 per cent) and the Australian Government (70 per cent).

Child care in Victoria is provided by a range of private, local government and non-government providers.

Kindergarten

In Victoria, the kindergarten program is a one-year program in the year prior to school entry. The government's commitment is to ensure that all children aged four years in the year prior to school entry have the opportunity to access one year of quality kindergarten education. A fee subsidy is available for eligible children and families, as well as grant funding per capita to kindergartens.

DEECD-funded kindergarten programs operate in a range of settings including purpose-built stand-alone kindergartens, community-based and private child care centres, community halls, and state and independent schools.

Schooling

Schooling is provided in each state and territory. Due to size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system below.

Student support services

Schools in Victoria are funded to provide student support services, the focus for schools is the development of individuals through:

- a range of broad-based programs focusing on primary prevention
- early intervention services for students at risk of depression, self-harm, substance abuse and suicide
- establishing integrated models of service delivery with the Department of Education working in collaboration with the Department of Human Services to connect schools with community-based services.

Student support services provide student welfare, visiting teacher, curriculum and speech pathology services and assessment services.

Child safety

None.

Secondary prevention

Health

Early childhood intervention services

Early childhood intervention services (ECIS) support children with a disability or developmental delay from birth to school entry and their families. ECIS provides special education, therapy, counselling, service planning and coordination, and assistance and support to access services such as kindergarten and child care.

Services are tailored to meet the individual needs of the child and focused on supporting the child in their natural environments, in their everyday experiences and activities. These services are funded through the Department Human Services (DHS) and provided by DHS managed specialist children's services teams and early childhood intervention community service organisations.

In addition, the ECIS program provides supports for families of children with a disability or developmental delay through two initiatives:

- Signposts for Building Better Behaviour — an early intervention parenting skills development program that provides parents or carers of children aged three to 15 years with an intellectual disability or developmental delay with strategies to manage difficult behaviours before such behaviours escalate to the point where intensive behavioural intervention is required
- The Strengthening Parents Support Program — assists parents and carers who have a child with a disability or developmental delay aged birth to 18 to connect with other families and the community. The program operates from a self-help group model and provides opportunities for parents in similar situations to meet on a regular basis for mutual support, networking opportunities, information sharing and training.

Both initiatives are funded by DEECD and delivered through community service organisations.

Enhanced Maternal and Child Health Service

The Enhanced Maternal and Child Health Service responds to the needs of children and families at risk of poor outcomes. In particular it focuses on children for whom there are multiple risk factors or indications of a significant level of risk.

This service is provided in addition to the suite of services offered through the universal MCH services. It provides a more intensive level of support, including short-term case management in some circumstances.

This may be provided in a variety of settings such as the family's home, the maternal and child health centre or other location within the community.

The primary focus of the Enhanced Maternal and Child Health Service are families with one or more risk factors, including:

- drug and alcohol issues
- mental health issues
- family violence issues
- families known to child protection
- homelessness
- unsupported parent(s) under 24 years of age
- low income, socially isolated, single parent families
- significant parent–baby bonding and attachment issues
- parent with an intellectual disability
- children with a physical or intellectual disability

- infants at increased medical risk due to prematurity, low birth weight, drug dependency and failure to thrive.

Indigenous families who require additional support to access the universal MCH services are included in the target group.

Child and adolescent mental health services

Specialist child and adolescent mental health services are provided by DHS for children and adolescents up to the age of 18 years with serious emotional disturbances. This includes young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development and/or where there are substantial difficulties in the person's social or family environment. Service components include:

- intensive mobile youth outreach services
- clinical care
- acute inpatient services
- day services
- conduct disorder programs.

Family support

Early parenting centres

Early parenting centres provide a range of more intensive interventions to assist parents with children from birth to age three who are experiencing early parenting difficulties. Early parenting centres develop parenting skills associated with positive, protective parent–child relationships and enhanced family functioning. This is achieved through the provision of residential, day stay, in-home services and group education/seminars. The three early parenting centres in Victoria are all in metropolitan Melbourne and are public hospitals within the meaning defined in the *Health Services Act 1988.*

Parenting assessment and skill development services

Parenting assessment and skill development services (PASDS) are regional services that provide both a parenting needs assessment and intensive parenting skills development, education and support service. PASDS are provided on a flexible basis: in-home, day stay and residential family settings. The service targets infants known to Child Protection Services and judged to be at high risk of harm, and their parents. The service seeks to address risk areas in a safe, monitored setting thereby reducing the need to separate the infant from the family during the assessment period. Families are referred to PASDS by Child Protection Services and the service is delivered by community service organisations including early parenting centres.

Family intervention services

The family intervention services program is a statewide population-based prevention and early intervention initiative based on the Triple P Positive Parenting Program®. It assists families of children less than 10 years who are experiencing significant parenting difficulties or whose children exhibit disruptive, defiant or aggressive behaviour to acquire skills and behaviour associated with the development of positive, protective parent–child relationships and social competencies in children. Family intervention services aim to reduce parental depression, anxiety and stress, and to reduce conflict in relationships between parents.

Family intervention services are funded by the DHS and delivered by community service organisations.

Supported parent groups and playgroups

Supported parent groups and playgroups for families from disadvantaged backgrounds or who live in isolated areas including in particular Indigenous families, recent or high need immigrant (including refugee) families, families affected by disability, and families affected by chronic disadvantage and with complex needs. They aim to provide quality play opportunities at a critical time in a child's development (birth to four years of age). They also provide families with opportunities to establish friendships and social support structures.

Supported parent groups and playgroups are funded by DEECD and the Australian Government and are provided by local government and community service organisations in each municipality.

In-home support for Aboriginal families

The program aims to strengthen support for, and improve parenting capacity of, Aboriginal women with new babies and their families. The support is available from birth through to three years for those wishing to participate and who live within one of the five designated catchment areas — Mildura Aboriginal Cooperative, Rumbalara Aboriginal Cooperative, Gippsland and East Gippsland Aboriginal Cooperative, Victorian Aboriginal Health Service, and Wathaurong.

The components that are offered to each family will vary depending on their needs and other services involved. All parents can participate in group and community activities. Families identified as requiring more intensive parenting support will be provided with individual support from an in-home support worker who will adopt a coaching/modelling approach to increase parental knowledge in health, wellbeing, safety and childhood development. In home support for Aboriginal Families is funded by DEECD and delivered by the community services organisations.

Education and care

Inclusion support

DEECD funds specialist programs for Indigenous kindergartens. Koorie early childhood field officers work with kindergarten programs and other Early Years services to encourage culturally appropriate programs for Koorie children and their families. In addition, DEECD funds Koorie preschool assistants to work with kindergartens to increase and enhance the participation of Indigenous children.

The Australian Government also funds inclusion support for children with disabilities and Indigenous children in child care.

Child safety

Family services

Family services represent the foundation of Victoria's prevention and early intervention strategy. Family services are delivered by community agencies and are designed to improve the safety and wellbeing of children and the strength, resilience and capacity of their families.

Family services are provided to families with children from birth to 18 years, or parents expecting a child, who are finding it difficult to ensure the wellbeing of their children. Priority access will be given to families with complex needs where risk indicators or indicators of neglect/cumulative harm relating to the child are present, and where families are currently or likely to be prematurely reported to child protection services. These families are able to access a range of services as part of the family services suite, including assessment, intake, case work and case management, counselling, in-home support, and group support.

The services are provided on the basis of a child's need, and families may undertake an initial assessment to determine the kinds and intensity of services required. This is particularly significant, since many families receiving family services may require a combination of supports to maintain their family's stability and ensure their children's wellbeing.

Family support innovation projects

The family support innovation projects (FSIPs) are a key element in Victoria's recent reforms. They are intended to complement the family services accessed by families who have repeated contact with the child protection system. The FSIPs provide local and subregional focal points for child and family services and allow earlier and more informal engagement with families who are likely to need support to ensure their child's wellbeing.

The FSIPs are convenient hubs that provide information on and referral to local support services — including child and family services as well as health and community services such as education, drug and alcohol, disability, mental health and housing services. They allow families to learn about the services available to them and, if appropriate, seek out supports before they reach crisis.

The FSIPs also provide the local presence for community-based intake. The Child FIRST sites are intended to align with the FSIPs. Together, these provide a visible social infrastructure presence in local areas.

The rollout of the FSIPs has been targeted at areas with high rates of child protection notifications. The initial implementation of the FSIPs was targeted at 44 LGAs in areas that accounted for 62 per cent of the state's child protection notifications. FSIPs are intended to be rolled out across the state by 2008–09.

Placement prevention programs

Placement prevention programs provide specialist case management and support services to children and young people who are either at risk of requiring child protection intervention or are statutory clients in need of additional case support (DHS 2006, p. 125). Thus, this program provides a mix of secondary and tertiary services. Three services are included within the placement prevention suite:

- intensive case management services — which provide multidisciplinary, intensive case management and youth outreach services to young people aged 12 to 18 who have come into contact with the child protection system, but who are not currently in out-of-home care
- family preservation services — which provide an intensive, short-term service to families of children who are at risk of requiring child protection services. This service is intended to improve families' capacity to protect and care for their children, preventing the need for protective intervention
- innovative support services — which are region-specific services developed to meet the specific needs of children and families in an area.

Placement prevention services are provided directly by both the DHS and by community service organisations.

Community-based intake

Community-based intake (Child FIRST) provides a central community referral pathway for concerns relating to a child's wellbeing. Through Child FIRST, the Victorian Government has established community-operated centres in subregional catchments.

Child FIRST allows families to access prevention and support services without having to be the subject of a notification to child protection. As a result, families can access services and supports before they reach a crisis, creating fewer notifications and enabling child protection workers to focus on meeting the needs of the most vulnerable children and families.

Home Based Care — Adolescent Community Placement program

The Home Based Care Adolescent Community Placement program provides accommodation and care to young people aged 12 to 18 years who are unable to live with their families for a range of reasons, such as family violence, they are on bail or subject to other courts orders, or are homeless. Adolescent community placement enables young people to reside in a home-like environment with the support and supervision of approved carers. Approved carers receive reimbursement for the costs associated with caring for the young person. Community service organisations are responsible for recruiting, training and supporting carers and case management.

Adolescent Community Placement services are provided by community service organisations.

Secure welfare services

Secure welfare services provide secure accommodation and care for young people aged 10 to 17 who are at substantial and immediate risk of significant harm. Following admission of a child or young person to secure welfare services a comprehensive plan is developed to reduce risk issues and enable the young person to be placed safely back into the community. A statewide service is currently provided by the DHS through two gender specific units in metropolitan Melbourne.

Specialist services for parental risk factors

Mental health services

The specialist public mental health system consists of clinical services and psychiatric disability rehabilitation and support services (PDRSS) and is the responsibility of the DHS. Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. PDRSS are provided by non-government community organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness.

Specialist clinical mental health services in Victoria are provided on an area basis, and are often referred to as area mental health services (AMHS). They include adult mental health services, child and adolescent mental health services, and aged persons mental health services. Each of these service categories provides inpatient psychiatric services in addition to a range of residential and other community-based services.

In addition, specialist mother and baby services provide for the admission of mothers with a mental illness with their baby, in addition to associated community and multidisciplinary services. Services are available in three locations: Heidelberg, Clayton and Werribee.

Drug and alcohol treatment and rehabilitation services

The Victorian Government provides the community with drug treatment services through a purchaser–provider model. This means that, rather than providing services itself, the government purchases these services from independent agencies on behalf of the community. The major service streams purchased by the DHS are:

- counselling, consultancy and continuing care
- outpatient withdrawal
- home-based withdrawal
- residential withdrawal
- rural withdrawal
- residential rehabilitation
- peer support
- youth outreach
- specialist methadone service
- Koori community alcohol and drug worker and resource services.

In addition to the mainstream drug and alcohol services, there are two programs that directly target parents, or pregnant women. These are:

- family residential rehabilitation program provided by Odyssey House — directed to drug-addicted parents and unique in alcohol and drug rehabilitation in that it features qualified preschool teachers and a fully operational child care/preschool centre. Both custodial and non-custodial parents are assisted, as part of their programs, in parenting and family skills. Although the children are not regarded as clients, they play an integral role in their parents' rehabilitation program
- women's alcohol and drug service — provides antenatal and postnatal support for pregnant women with ongoing drug and alcohol issues, inpatient methadone program, training and education. The multidisciplinary staff team includes a dietician, pharmacist, obstetrician, paediatrician, midwives, social workers and education and research staff.

Family violence services

DHS funds a number of family violence support services that are delivered by community organisations throughout Victoria. The three types of services are below:

- family violence support services — counselling and support services to women and children throughout Victoria who have experienced family violence or are at risk of being unsafe in the family environment. Services provided may include assessment, information and referral, education, individual and group counselling, and support and case coordination. The program may also provide assistance to women seeking intervention orders through court support, advocacy and referral services
- Indigenous family violence services — preventive and support services to Indigenous women, children and men. Services may include individual and group counselling, information and referral, service coordination and court support as well as family mediation and spiritual and cultural healing activities. Services are provided for people who have experienced family violence, respond to the needs of those who use violence towards family members, and support the recovery and healing of the local community
- men's family violence services — services for men with a history of violent and abusive behaviour towards family members to develop non-abusive behaviours and new relationship and parenting skills. Services provided to men may include individual or group counselling, telephone counselling and referral.

Sexual assault services

Victoria's sexual assault services provide direct services to adults and children who have been sexually assaulted and their non-offending family members. Services include crisis care responses, counselling, casework, advocacy and group work. An after hours telephone service providing counselling, information and coordination of crisis care support is also available.

Crisis care is provided to sexual assault victims requiring immediate assistance, with priority being given to victims of recent sexual assault, which occurred within the last 72 hours or up to two weeks, or to a recently disclosed child sexual assault. Crisis care services include crisis intervention, counselling, advocacy, and liaison with forensic medical officers, police and other medical staff, in addition to a range of other support functions such as practical assistance.

Crisis care services for children and young people subject to child protection intervention are provided by the Victorian Forensic Paediatric Medical Service. Sexual assault support services are provided by hospitals and community service organisations.

Tertiary prevention

Tertiary prevention services are predominately child protection services although these services are supported by several specialist health programs that provide intensive counselling and support, and an education program to support children and young people in out-of-home care with high needs.

Health

Intensive treatment services — Take Two

These specialist intensive therapeutic counselling and multiple treatment methods are aimed at addressing trauma and attachment disorders involving children, their families and carers. Take Two is targeted to children or young people who have been seriously abused or neglected, who are exhibiting or at risk of developing severe emotional or behavioural disturbance. Take Two is centrally coordinated and delivered by eight regional and two central teams that provide a statewide service. Take Two is funded by the DHS and delivered by a consortium of four community service organisations.

Sexual abuse treatment services

Counselling and support services for children and young people who are victims of intra-familial child sexual abuse and who are subject to a child protection intervention. This group of children and young people are referred on the basis of being a victim of sexual abuse or where there are significant indicators suggestive of sexual abuse. Services may also be provided to non-offending and supportive family members or care givers, where appropriate in the context of service delivery to a particular child or young person.

Education

Educational support for children in residential care

Education-related support services are provided for children and young people residing in residential care services who have special and additional education needs. The program funds specialist educational support workers and other educational support staff to undertake comprehensive assessments, develop education plans and provide support to children and young people in residential care services to improve their educational outcomes.

Children in residential care services are provided by funded community service organisations and the Department of Human Services, and are partly funded by the Australian Government.

Sexual abuse treatment services are provided by hospitals and community service organisations.

Child safety

Statutory child protection services

Child protection services are provided by the DHS and cover intake, investigation and assessment of notifications of child abuse and neglect, and the case managed activities associated with protective intervention and preparing and making a protection application through the courts, following the investigation and substantiation of child abuse.

Child protection services cover children and young people from birth to 18 years at risk of significant harm as a result of abuse or neglect within the family unit.

Child protection services undertake the supervision and management of children and young people on protective orders living at home, the statutory supervision of children and young people who are unable to live at home, and work towards the return home of children and young people on statutory orders, where separation has been necessary.

The After Hours Child Protection Emergency Service (AHCPES) is a crisis service that responds to urgent matters that cannot wait until the next working day. The AHCPES receives calls from both the public and professionals. The AHCPES will plan a response that may include direct intervention from the AHCPES, coordination of a response from other welfare organisations or consultation over the telephone.

Where it is determined by AHCPES that the child or young person is at significant and immediate protective risk, child protection will attend as soon as practicable and assume responsibility for the protective aspects of the situation. If the AHCPES decides that an urgent response is not required, the AHCPES is responsible for forwarding information to the appropriate regional office on the next working day.

The metropolitan AHCPES is managed by the Eastern Metropolitan Region; an after-hours outreach service is also located in each of the rural regions.

Out-of-home care

The range of services associated with OOHC are funded by the DHS but delivered in the community sector (unless noted). These services include a number of out of home placement types:

- general home-based care — foster care placements for children and young people from birth to 18 years, who are unable to live with their families due to issues of abuse and neglect and require a placement with a foster care family
- intensive home-based care — foster care placements for children and young people from birth to 18 years, who demonstrate a significant level of challenging behaviour or have high dependency needs
- complex home-based care — foster care placements for young people from 12 to 18 years who are, or have been, registered on the High Risk Adolescent Schedule, or demonstrate a high level of risk behaviours
- kinship care — supported placements with a family member of children and young people from birth to 17 years
- therapeutic care — home-based care service provided by voluntary carers specifically recruited, trained and supported to provide a therapeutic model of care. The target groups for therapeutic care are

  - children from birth to 10 years who are entering care for the first time or who have been in care for no longer than six months who have been subjected to significant levels of abuse or neglect
  - children from birth to 12 years who have been in care for up to two years and who have experienced at least two placement breakdowns due to behavioural issues or are assessed as requiring additional support, for example based on a trauma assessment

- permanent care — placements appropriate to the needs of children when a decision has been made that they cannot live with their family of origin on a permanent basis. Permanent care placements are provided by volunteer care givers, who receive reimbursement for the costs of care
- lead tenant — semi-independent accommodation and support for young people aged 15 to 18 years who are unable to live with their family due to issues of abuse or neglect and are in transition to independent living. A volunteer lead tenant lives in a residential unit with a small group of young people and provides them with support and guidance in developing their independent living skills
- residential care — accommodation in residential facilities for children and young people aged seven to 18 years who are unable to be placed in home-based care
- RICE education and youth services — therapeutic care, including residential care and education services, provided to children and young people aged nine to 15 with high and complex needs who are unable to be accommodated in other home-based or residential services and mainstream schools. There are two subgroups
  - children and adolescents who are unable to be placed in home-based or other form of residential care due to high and complex needs
  - children and adolescents who are placed elsewhere in out-of-home care and are unable to attend alternative educational provision (including mainstream schools) as a result of high and complex needs.

In addition, the DHS funds a number of targeted support programs for children and young people in OOHC:

- client placement support services — intensive case management and support services for young people aged 12 to 18 years in out-of-home care, who demonstrate a high level of risk behaviours (provided by both DHS and the community sector)
- residential care case management — case management for children and young people in residential accommodation
- leaving care support services — targeted support services for young people up to the age of 21 years, who are subject to a custody or guardianship order that is expired or soon to expire, to assist in transition from statutory care to independent living. Leaving care services includes leaving care mentoring, which is targeted at young people aged 16 to 18 years preparing to leave care for independent living.

8.21 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF CHILD PROTECTION SYSTEMS IN VICTORIA

Service	2002–03 ($'000)	2003–04 ($'000)	2004–05 ($'000)	2005–06 ($'000)	2006–07 ($'000)
Child protection and OOHC	250 325	255 595	290 983	295 755	306 718

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, Victoria received 38 675 notifications of alleged child abuse and neglect concerning 30 241 children. In the same year, 6828 substantiations were made pertaining to 6588 children. The rate of notifications, investigations and substantiations has remained fairly stable over the last five years. There was a reduction in finalised investigations and substantiations from 2005–06 to 2006-07 of 0.7 and 0.8 per cent, respectively.

VICTORIAN CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	28 379	26.0	27 934	25.6	28 506	26.1	29 630	27.1	30 241	27.1
Finalised investigations	11 075	10.2	10 760	9.9	10 553	9.7	10 554	9.6	9 939	8.9
Substantiations	6 844	6.3	7 023	6.4	7 014	6.4	7 287	6.7	6 588	5.9
Care and protection orders	5 038	4.3	5 251	4.5	5 658	4.9	5 984	5.1	6 179	5.2

Source: ROGS 2008, Table 15A.51, using AIHW data.

VICTORIA CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004-–05	2005–06	2006–07
Notifications	37 635	36 956	37 523	37 987	38 675
Substantiations	7 287	7 412	7 398	7 563	6 828

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 9

Western Australia

9.22 Verification status

This stocktake has been verified by the Western Australian Child Protection Unit of the Department for Child Protection and the Department of Health.

9.23 Stocktake of service systems

The table below provides a summary of the service systems for protecting children in Western Australia. Further information about the services is provided in the following sections.

SYSTEMS FOR PROTECTING CHILDREN — WESTERN AUSTRALIA

Sector	Primary	Secondary	Tertiary
Health	Child health services Antenatal and maternity care School health services	Adolescent clinic State Child Development Centre (SCDC) Individual and Family Support Program Early years and consultancy service Family Pathways Child and adolescent mental health services	The Child Protection Unit — medical, forensic and social work assessment The Specialist Child Interview Unit
Family support	Parenting services Parent Link home visiting services Ngala Grandcare Parent Help Centre	Support for families of children with special needs — the Kalparrin Centre Parenting programs Best Start for Aboriginal families Best Beginnings	
Education and care	Child care Kindergarten and pre-primary Schooling		
Child safety			Statutory child protection services Out-of-home care
Specialist services for parental risk factors substance abuse mental health family violence		Mental health services Drug and alcohol treatment and rehabilitation services Family violence services	

Primary prevention

Health

Child health services

Child health services aim to promote improved health outcomes for babies, young children and their families across Western Australia through the provision of universal and targeted prevention, early identification and intervention community health services. The universal community child health service begins with child health nurse contact with all mothers with new babies and additional contacts at the critical points in the child's development throughout the first four years. It is a vital entry point for families with young children into health and social services and a unique opportunity to improve outcomes for families experiencing difficulty in caring for their children.

There are 310 child health centres across Western Australia that provide a free service.

The metropolitan Child Development Service provides a range of assessment, early intervention and treatment services to children with or at risk of developmental disorders and delay. Child development services also play a key role in health prevention and promotion through the delivery of community education, professional development and the delivery of universal prevention programs. Child development services in Western Australia are important referral points from universal and specialist health service providers.

Antenatal and maternity care

Free, universal maternity care is provided at Western Australian public hospitals.

School health services

Western Australian school health services aim to promote improved health outcomes for school aged children and young people through universal and targeted prevention, health promotion, early identification and intervention. Services are provided on site and in collaboration with public and private schools. The Department of Education and Training and the Department of Health jointly fund the program. Universal health assessments at school entry, support to children in school with particular health needs, access to health care for adolescents and health promotion for all students are key elements of the program.

Family support

Parenting services

The Western Australian Department for Communities provides parenting services in 14 locations across the state. Parenting services have videos, brochures, books, audiotapes and other information to help make life easier for those caring for children. Parenting services in country areas use vans stocked with library resources to serve wide geographic areas.

Parent Link home visiting services

Parent Link services are offered to parents on a voluntary basis to help them provide a more supportive environment for their children. Volunteers who are themselves parents and experienced in the issues which concern families with young children visit parents in their own homes. Volunteers are supervised by a professional coordinator.

The service is available to parents with at least one child under the age of five. Parents work with the coordinator to plan the parenting skills and support they need. Volunteers then develop activities to help parents build on these skills. They also provide links to local community services and supports.

Parent Link services are offered in a number of locations across the state.

Ngala

Ngala is an early parenting centre that delivers a range of primary and secondary services to increase and enhance parenting skills. Ngala services include:

- coffee mornings — an informal face to face way for families to make their first or follow up connection with Ngala that is offered in five metropolitan locations
- consultations — telephone, centre or home consultations can be scheduled at a time and place to suit the needs of families to enable them to explore options regarding their parenting. Centre consultations are provided in three locations, telephone consultations are statewide, and video-conferencing and home visits are also provided via a link through the Department of Health's telehealth facilities
- family programs — including overnight stay and day stay services at one metropolitan location. Families attending these services are supported by Ngala's interdisciplinary team including child health, midwives and mothercraft nurses, lactation consultants, social workers and Hey Dad WA staff. A GP, paediatrician and psychiatric registrar are also available for consultation with families attending an overnight stay. Admissions require a letter of admission from a GP or a specialist who is registered with the Medical Board of Western Australia
- helpline — provides brief guidelines and reassurance for parents and seek to encourage confidence by outlining options for parents
- Hey Dad WA — through Hey Dad WA, Ngala aims to engage men in early parenting by providing a 'male friendly' environment across all Ngala services. It assists men to gain skills to allow them to be fully involved in all aspects of parenting and fatherhood
- parent education — Ngala provides several two-hour education sessions for parents, grandparents and carers of children birth to five years in a range of visiting locations
- local activities and centres in Norranda, the Pilbara and Kwinana.

Ngala is jointly funded by the Australian and Western Australian governments.

Grandcare

The Grandparents Caring for Grandchildren Support Service (Grandcare) was established in September 2002. Funded by the State Government, the Grandcare program is delivered by Wanslea Family Services Inc.

Grandcare includes an 1800-telephone information line which offers practical assistance, informal counselling and advice on child management and education, financial support and links to other community resources, and country and metropolitan support group networks, some with creche facilities. The service also has a visiting assessment and support service, and ongoing grandparenting skills and personal development training.

Parent Help Centre

The Parent Help Centre focuses on the parenting needs of families with children up to 18 years of age. Highly trained staff work with parents and carers to help them understand the stages of child development, increase their knowledge of community resources and develop social networks in their local community. They also advise on how parenting styles can impact positively on children's behaviour.

Programs run by the centre include group and individual sessions in which parents can support and learn from each other by sharing ideas which work. The Parent Help Centre also organises workshops, public talks and presentations. It runs programs in suburban Perth and by arrangement in country centres.

The Parent Help Centre also operates the Parenting Line which offers 24-hour telephone information and advice about caring for children up to 18 years of age.

Education and care

Child care

The Western Australian Department of Communities regulates and licences child care facilities in Western Australia.

Kindergarten and pre-primary

The Western Australian Department of Education and Training provides two years of pre-primary education — kindergarten and pre-primary for children aged five and six years respectively. Kindergarten and pre-primary are delivered in public primary schools and although not compulsory are attended by around 90 per cent and 95 per cent of children, respectively.

Schooling

Schooling is provided in each state and territory. Due to size of the budget for schooling, and the assumed delivery of this service in all states, it has not been included in the estimated cost of the primary system below.

Secondary prevention

Health

Adolescent clinic

The adolescent clinic at King Edward Hospital for Women provides a holistic health service to adolescents in Western Australia who are under 18 years old and in their first ongoing pregnancy. Services offered to adolescents include support and care during pregnancy, a home visiting midwife service, counselling and support services, postnatal follow-up visit, opportunities to meet other young mothers, and advice and practical support in other areas such as accommodation and employment.

State Child Development Centre

The State Child Development Centre (SCDC) is delivered from the Princess Margaret Hospital for Children and provides professional care for children with developmental concerns and their families.

Children are assessed and treated for a wide range of developmental or behavioural concerns and associated difficulties by a multidisciplinary team. Referrals to SCDC are accepted from other professionals (e.g. GPs, community nurses, teachers, school psychologists) and services are provided free of charge.

Individual and Family Support program

The Individual and Family Support (IFS) Program is available to people who have an intellectual disability and provides:

- early childhood development services for preschool children vulnerable to intellectual disability
- an autism early intervention program
- school-age family support
- development support to adults living in the community.

IFS teams include psychologists, occupational therapists, physiotherapists, speech pathologists, social trainers and social workers. IFS is provided by the Disability Service Commission.

Early Years and Consultancy Service

The Early Years and Consultancy Service is provided by the Disability Services Commission and comprises a team of clinical and developmental psychologists who provide services and consultancy support to people in regional areas of Western Australia. The services they provide can be broken down into four main areas:

- consultancy services to people needing assistance with behaviour management
- training programs for families and communities dealing with behavioural and developmental problems
- early intervention services for children with autism
- assessment and diagnosis of intellectual disability and autistic spectrum disorders.

Family Pathways

Family Pathways is a statewide service which provides assessment and intervention for children with longstanding mental health problems. It is not an emergency service and is not able to respond to an urgent crisis. Family Pathways provides services for children from four to 12 years. Services for rural families can include teleconferencing and day attendance at a Family Pathways unit, usually for two weeks.

Referrals for Family Pathways are considered from mental health providers including:

- secondary metropolitan and rural child and adolescent mental health services
- private psychologists and private psychiatrists
- the state Child Development Centre (team referrals only)
- the Psychological Medicine Clinical Care Unit of Women
- children's health service.

Child and adolescent mental health services

Specialist child and adolescent mental health services are provided by the Western Australian Department of Health. Various services are available for children and adolescents with emotional, behavioural and learning problems and their families. Services include assessment, diagnosis, consultation and therapy.

Family support

Support for families of children with special needs — the Kalparrin Centre

The Kalparrin Centre is a drop-in centre for families of children with special needs. It is situated in the Princess Margaret Hospital and is a place where families can get information and support related to their child's condition. The Kalparrin Centre is operated by Parents of Children with Disabilities Inc. and the service is open to any family member of a child with a special need regardless of the degree of severity or type of impairment.

Parenting programs

The Department of Health delivers a range of parenting support programs across Western Australia. Three main ones are outlined below:

- Triple P Positive Parenting Program® — a program for parents of young children aged 3 to 5 years where the parent has concerns about the child's behaviour or development at some time and want practical suggestions on how they can support their children and prepare them for the transition from home to school. Triple P gives parents information and advice about how to promote the development of social skills in their child. Triple P aims to help children learn social skills they can use in their dealings with others
- HUS-S-H Baby — for families with babies four weeks to six months, the course assists parents to develop skills at settling their babies
- Sleepworks — a program to help parents understand their baby's needs for wakefulness and sleep. It is recommended for babies from six months to toddlers aged three years.

Best Start for Aboriginal families

Best Start is a service for Aboriginal children from birth to five years. It aims to improve their health, education, social and cultural development. The services are located in rural, remote and metropolitan areas. Best Start is jointly run by the Department for Child Protection, the Department of Health and the Department of Education and Training. The Department of Indigenous Affairs provides a support role.

A range of Best Start projects have been developed across Western Australia. These are flexible and take into account the cultural differences between communities. They include:

- playgroups for young children which carers can attend
- nutritional and health education programs
- immunisation and mobile health clinics
- cultural camps and activities for children, parents and grandparents
- women's support groups
- family tracing services
- assisting with reading and language skills
- workshops on safety in the home, behaviour management, nutrition, hygiene and motor skills development in young children.

Best Beginnings

Best Beginnings is a service for families of new infants. Experienced home visitors provide support, advice, information, connections and practical help. The program is structured according to the families' needs. The aim is to improve child health and wellbeing, parent and family functioning, and social support networks.

The program is jointly administered by the Department for Child Protection and the Department of Health. Families need to be referred to the program before birth or before the baby is three months old. Visits can continue until the child is two years old. Best Beginnings is offered across the state.

Child safety

None.

Specialist services for parental risk factors

Mental health services

Mental health services in Western Australia are provided by a mix of public, private and NGO providers. Community-based mental health services offer assessment, diagnosis, treatment, rehabilitation and ongoing coordinated care, delivered by a range of health professionals. Mental health in hospitals involves hospital admission for the treatment of mental illness. Health professionals provide assessment, treatment, counselling, support, education and rehabilitation.

In addition, a range of support services are also available including accommodation, advocacy, counselling and self-help and support groups.

Drug and alcohol treatment and rehabilitation services

The Western Australian Department of Health funds dedicated drug and alcohol community-based services that provide counselling to users and their families, support groups and education. They can either be generic (responding to anyone with a drug or alcohol issue) or targeted (responding to a particular age group, gender or specific challenge such as parenting). These services are also supplemented by residential treatment services and withdrawal services.

In addition to the mainstream drug and alcohol services, there are three programs that directly target parents or pregnant women. These are:

- Women's and Newborn Drug and Alcohol Service — offers obstetric and neonatal services for women and families in Perth. Antenatal care, in liaison with drug rehabilitation programs, is offered to women who are using alcohol or other drugs during pregnancy or who are on drug treatment programs. Experienced medical, nursing and social work staff are available for consultation throughout pregnancy. The purpose is to encourage effective antenatal care for women. There are no conditions of rehabilitation and the focus is on healthy parenting
- Holyoake — commenced operations in 1975 and provides a specific range of non-residential, family-focused services to people of all ages experiencing problems related to their own, or someone else's, alcohol or other drug use. Holyoake offers a psycho-social model of supportive, skills-based and educational programs for all family members and concerned others. Two community drug service teams are located in the Northern Metro area and the Wheatbelt area of Western Australia are providing Holyoake alcohol and drug outreach programs to families in these communities
- Pregnancy, Early Parenting and Illicit Substance Use (PEPISU) pregnancy and parenting substance use program — a non residential treatment service that provides counselling, support and outreach services to women who are pregnant and/or parenting and have problematic alcohol and/or other drug use in Perth. PEPISU also provides a children's program for children whose lives are affected by their parent/s alcohol and/or drug use. The children's program includes art therapy, peer support, school holiday programs and social/recreational activities.

Family violence services

The Western Australian Department for Communities funds a range of services to assist people living with family and domestic violence in Western Australia. These include crisis and emergency, safe accommodation, counselling and support, legal services and services for children.

Tertiary prevention

Tertiary prevention services are predominately child protection services although these services are supported by counselling and treatment services.

The Child Protection Unit — medical, forensic and social work assessment

The Child Protection Unit provides a medical, forensic and social work assessment of children up to 16 years old who have experienced some form of child abuse or are at risk of experiencing child abuse. Both inpatients and outpatients are seen at the unit. The Child Protection Unit also has a therapy service that provides therapy for children and their families where a child had been abused or there is a belief that the child's behaviour is a result of some form of abuse. Sexual assault services, family abuse and intervention services and domestic violence advocacy services are sources of support.

All services are funded by the Department of Health.

The Specialist Child Interview Unit

The Specialist Child Interview Unit (SCIU) has been established in recognition of the need to ensure that children who have been abused do not experience additional unintentional stress during assessment and investigation of the allegation. The unit became fully operational on 5 July 2004, and is co-located with the Child Protection Unit Therapy Service (Department of Health). It is a family friendly facility where Department of Child Protection staff conduct joint interviews with police. The unit's model of service provision and recording of evidence has been based on best practice examples from around the world.

Four of the community child protection worker positions were allocated to the SCIU in September 2003. These workers have attended specialist training.

Child Safety

Statutory child protection services

The Department for Child Protection has a statutory responsibility to:

- promote and safeguard the wellbeing of children, young people, families and communities
- assess and respond to concerns for the wellbeing of children and young people and families
- develop frameworks and responses and the provision of services that strengthen families and build the capacity of communities to care well for children and young people.

Through the *Children and Community Services Act 2004*, the Department for Child Protection in Western Australia has powers to act where a child is in need of protection. The Act enables the department to receive and assess concerns for a child's wellbeing and allegations of child abuse and neglect and to take actions to protect children and young people.

The reporting of children and young people who have been or who are likely to be harmed through abuse or neglect is supported through reciprocal protocols that have been negotiated with key government and non-government agencies. These arrangements are supported by legislative provisions that protect people who make reports and strengthen information sharing.

Out-of-home care

The Department for Child Protection has statutory responsibility to contribute to the protection and care of those children and young people who are unable to be cared for by their families. The department is the major agency coordinating foster care in Western Australia. The department acts as a central coordination point for all children and young people who need to be placed with foster carers.

The department also provides funding and resources to other organisations for a variety of foster care and family support services.

9.24 Cost and impact of child protection systems

Costs

The costs for the tertiary system below are from the 2008 ROGS (Table 15.A.1).

COST OF SYSTEMS FOR PROTECTING CHILDREN IN WESTERN AUSTRALIA

Service	2002–03 ($'000)	2003–04 ($'000)	2004–05 ($'000)	2005–06 ($'000)	2006–07 ($'000)
Child protection and OOHC	80 973	100 749	102 266	106 417	120 087

Notes: comprises out-of-home care and child protection expenditure reported in ROGS.

Impact

In 2006–07, Western Australia received 7700 notifications of alleged child abuse and neglect on 6916 children. In the same year, 1233 substantiations were made pertaining to 1154 children. The rates of finalised investigations, substantiation of cases and number of care and protection orders have increased steadily since 2002–03. Notifications jumped sharply from 2005–06 to 2006–07.

WESTERN AUSTRALIA CHILD PROTECTION STATISTICS (CHILDREN AGED 0 TO 16)

	2002–03		2003–04		2004–05		2005–06		2006–07	
	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000	no. of children	rate / 1000
Notifications	2138	4.7	2238	4.9	2928	6.4	3049	6.6	6916	14.6
Finalised investigations	1794	3.9	1906	4.2	2214	4.8	2413	5.3	2917	6.2
Substantiations	846	1.9	921	2.0	1035	2.3	919	2.0	1154	2.4
Care and protection orders	1470	3.0	1639	3.4	1783	3.7	2046	4.2	2629	5.2

Source: ROGS 2008, Table 15A.85, using AIHW data.

WESTERN AUSTRALIAN CHILD PROTECTION NOTIFICATIONS AND SUBSTANTIATIONS — TOTAL NUMBER

Total number	2002–03	2003–04	2004–05	2005–06	2006–07
Notifications	2293	2417	3206	3315	7700
Substantiations	888	968	1104	960	1233

Source: AIHW Child Protection Australia 2006–07 Tables 2.3 and 2.4.

Chapter 10

Australian Government

10.25 Verification status

This stocktake has been verified by the Department of Families, Housing, Community Services and Indigenous Affairs.

10.26 Stocktake of service systems

The table below provides a summary of the service systems for protecting children that are funded or delivered as national programs across Australia. All the services described below are funded by the Australian Government unless otherwise noted. Further information about the services is provided in the following sections.

SYSTEMS FOR PREVENTING CHILD ABUSE AND NEGLECT — NATIONAL

Sector	Primary	Secondary	Tertiary
Health	Breastfeeding initiatives Prenatal health promotion Maternal Medicare arrangements Primary care through Medicare Programs to support the health of Indigenous children and families	Innovative Health Services for Homeless Youth (IHSHY) program Hearing services Helping children with autism	
Family support	Stronger Families and Communities Strategy Indigenous Children Programme Playgroups Family Relationships Services Program (FRSP) Financial assistance for families with children Raising Children Network		
Education and care	Child care Schooling KidsMatter Mind Matters	Autism specific early learning and care centres Extra support for children with disability program	
Child safety		Responding Early Assisting Children Program Child Abuse Prevention Program (CAPS)	Transition to Independent Living Allowances

Sector	Primary	Secondary	Tertiary
Specialist services for parental risk factors: substance abuse mental health family violence		Mental health services Drug and alcohol services Family violence services	

Primary prevention

Health

Prenatal health promotion

The Australian Government funds several prenatal health promotion activities including:

- smoking and pregnancy — funding was allocated to lead a national program aimed at helping women — particularly Indigenous women — to stop smoking during and after pregnancy. The purpose of this initiative is to encourage doctors, midwives and Indigenous health workers to give advice to pregnant women about the damage caused by smoking
- National Alcohol Strategy — as part of the strategy there are projects that aim to reduce the incidence of damage to unborn babies (foetal alcohol spectrum disorders), to reduce the secondary supply of alcohol, and to provide education about proper alcohol use.

Breastfeeding initiatives

The Australian Breastfeeding Association (ABA) delivers a range of services to encourage breastfeeding including support groups, a 24-hour national breastfeeding helpline, workplace accreditation and information, and advocacy. The ABA is supported by the Australian Government, as well as through fundraising and sales from products.

The Baby Friendly Hospital Initiative (BFHI) is a hospital accreditation scheme that involves compliance with 10 key steps. BFHI is a World Health Organisation initiative, administered nationally in Australia by the Australian College of Midwives.

Initiatives of the Breastfeeding Education and Support Program include research into reasons some mothers give up breastfeeding, improved data collection, an information and community education campaign, and activities to support families such as access to advice and innovative programs for disadvantaged and young mothers.

Maternal Medicare arrangements

The Australian Government offers management of the Medicare arrangements in relation to women's reproductive health, paediatric and neonatal services. Relevant areas of the Medicare Benefits Schedule (MBS) include:

- antenatal services by allied health practitioners, including midwives
- assisted reproductive technology
- obstetrics
- gynaecology
- sterilisation
- paediatric and neonatal services.

Primary care through Medicare

Services provided by GPs and other primary care professionals and funded under Medicare are a key element to the health care of children and families. This includes general consultation items used by children and families, as well as specific child health MBS items:

- Healthy Kids Checks — commencing in 2008–09, the new Medicare items will be delivered by a GP or a practice nurse, and will include health indicators such as height, weight, eyesight and hearing assessments, and will be claimable at the same time as the four-year-old immunisation. Funding will be provided to state and territory governments to ensure that state-funded, or other immunisation providers (such as community health centres and local councils) are able to provide checks to patients
- health checks for Aboriginal and Torres Strait Islander children — comprehensive annual health assessments of children from birth to 14 years. The health checks enable prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

In addition, GP Super Clinics are a key element in building a stronger primary care system that will benefit children and families. They will provide a greater focus on health promotion and illness prevention, and better coordination between privately provided GP and allied health services, community health and other state and territory government funded services. There are currently 31 designated GP Super Clinic locations and implementation is underway.

Programs to support the health of Indigenous children and families

The Australian Government through the Department of Health and Ageing (DoHA) provides primary health care funding for Aboriginal medical services nationally. In addition, DoHA delivers a number of programs to improve the care available to Indigenous children and their families. These are:

- New Directions: An equal start in life for Indigenous children — this program in five sites addresses the health needs of Indigenous children and their mothers comprising the following measures
  - comprehensive mothers and babies services and wider access to home visiting services provides health care and access to early learning support for Indigenous mothers, babies and children
  - Rheumatic Fever Strategy
  - the Indigenous Mother's Accommodation Fund (managed by the Department of Families, Housing, Community Services and Indigenous Affairs) to support women who need to leave their communities temporarily to have their babies.

- Health@Home Plus — under Health@Home Plus, Indigenous children aged from birth to eight and their mothers have access to a comprehensive, nurse-led home visiting program based on the 'Olds model'.[10] This will improve pregnancy outcomes by helping women engage in good preventive health practices and support parents to improve child health and development.
- Healthy for Life — enhancing the capacity of over 80 Aboriginal and Torres Strait Islander primary health care services by improving the quality of child and maternal health services and chronic disease care, and to improve the capacity of the Indigenous health workforce.

Family support

Stronger Families and Communities Strategy

The Stronger Families and Communities Strategy is an Australian Government initiative managed by FaHCSIA providing funding in three streams:

- Communities for Children
- Early Childhood — Invest to Grow
- Local Answers.

Stronger Families and Communities projects deliver both primary and secondary services and intersect education and care, child safety, family support and health service systems.

Communities for Children (CfC) is place-based early intervention and prevention approach to child protection and development. NGOs (called facilitating partners) are funded in 45 disadvantaged sites throughout Australia to work with local stakeholders. They jointly develop and deliver tailored approaches to deliver positive and sustainable outcomes for children and families across four key action areas: early learning and care, child-friendly communities, supporting families and parents, and family and children's services working effectively as a system. All service delivery is grounded in the principles of community development, partnerships and evidence-based practice.

The facilitating partners act as brokers in engaging smaller local organisations to deliver a range of activities in their communities. Examples of activities being implemented under CfC are:

- home visiting
- early learning and literacy programs
- early development of social and communication skills
- parenting and family support programs
- child nutrition
- community events to celebrate the importance of children, families and the early years.

[10] [10] See 'The story of David Olds and the Nurse Home Visiting Program', Goodman, A. 2006 <http://www.rwjf.org/pr/product.jsp?id=15872>.

Invest to Grow funds a range of successful established early childhood prevention and early intervention programs delivered by NGOs. Since 2006, Invest to Grow has also provided funding for the Child Care Links Initiative. This initiative uses child care centres in disadvantaged areas as community hubs to link families with young children to local support services and to strengthen community networks. It aims to build the evidence base for using this model as an early intervention strategy to improve outcomes for young children and their families.

Local Answers funds local grassroots projects that address a particular community issue or problem affecting children and families.

Indigenous Children Programme

The Indigenous Children Programme (ICP) aims to strengthen Aboriginal and Torres Strait Islander children, families and communities and build their resilience and support networks. Under the ICP, FaHCSIA provides grant funding to NGOs across Australia for prevention and early intervention programs that support the wellbeing of Indigenous children and build culturally strong parenting skills and support for Indigenous families.

Playgroups

The Playgroup program provides quality playgroups for families and their young children, regardless of where they live or their circumstances. There are currently four playgroup models funded by FaHCSIA:

- community playgroups — delivered in each state by playgroup associations represented by Playgroups Australia
- supported playgroups — also delivered by playgroup associations
- locational supported playgroups — initiated and facilitated by a paid coordinator and early childhood worker and managed at the local level by NGOs
- intensive support playgroups — skilled early childhood and family support workers delivering mobile playgroup services, managed at the local level by NGOs.

The families and children who are assisted by supported, intensive support and locational supported playgroups can have multiple needs and face a range of social, economic and other challenges — these are targeted secondary prevention services. They are often harder to reach and require support for a longer time.

Family Relationship Services Program

The Family Relationships Services Program (FRSP) aims to:

- enable children, young people and adults in all their diversity to develop and sustain safe, supportive and nurturing family relationships
- minimise the emotional, social and economic costs associated with disruption to family relationships.

FRSP is funded in partnership between FaHCSIA and the Attorney General's Department and delivers a wide range of services, including:

- family counselling
- family relationship centres

- mediation and dispute resolution
- specialised family violence services
- family relationship services for special needs groups (carers of people with disability, humanitarian entrants, families affected by drought).

These services are primary and secondary prevention services for protecting children.

Financial assistance for families with children

The Australian Government provides a number of benefits and payments for families with children. These are:

- Family Tax Benefit Part A
- Family Tax Benefit Part B
- Baby Bonus
- Maternity Immunisation Allowance
- Double Orphan Pension.

Raising Children Network

The Raising Children Network website helps parents fulfil their roles by providing centralised, Australian focused, evidence-based information for parents with children from birth to eight years of age. It also provides information for people who work with parents. The objectives of the website are to provide assistance in caring for children, information on being a parent, assistance to professionals, and to facilitate:

- parents in the use of professional services
- community connectedness
- community and professional partnerships.

The Raising Children Network is funded by FaHCSIA.

Education and care

Child care

The Department of Education, Employment and Workplace Relations (DEEWR) helps families to participate in the social and economic life of the community through the provision of support for child care services, including:

- helping families with the cost of child care through the child care benefit scheme
- policy advice, research and service management related to providing children's services
- helping services provide quality care under the Child Care Services Support Program
  - quality assurance, training and support services to improve the quality of children's care

- funding, training and support products and services to promote equity of access
- funded child care places and operational support for child care services (Community Support Payments)
- Family Day Care Start Up Payment.

Schooling

The Australian Government provides funding for schools through payments to the states and territories as well as providing assistance to identified individuals in schooling including those with special needs.

KidsMatter

KidsMatter is the first national mental health promotion, prevention and early intervention initiative specifically developed for primary schools. It involves the people who have a significant influence on children's lives — parents, families, care givers, teachers and community groups — in making a positive difference for children's mental health during this important developmental period.

The KidsMatter initiative aims to:

- improve the mental health and wellbeing of primary school students
- reduce mental health problems among students (for example, anxiety, depression and behavioural problems)
- achieve greater support and assistance for students experiencing mental health problems.

The initiative is currently being piloted in over 100 schools across Australia and is funded by the Australian Government and the Australian Rotary Health Research Fund.

Mind Matters

Mind Matters is a resource and professional development program to support Australian secondary schools in promoting and protecting the social and emotional wellbeing of members of school communities. Funded by DoHA, Mind Matters is targeted at children aged 12 to 17 to prevent and address adolescent depression and anxiety in secondary schools as part of the curriculum.

Child safety

None.

Secondary prevention

Health

Innovative Health Services for Homeless Youth program

The Australian Government funds the Innovative Health Services for Homeless Youth (IHSHY) program through the states and territories to improve health outcomes for homeless youth and youth at risk of becoming homeless. A number of IHSHY services provide young parent education programs, and antenatal and postnatal home visiting services for young mothers.

Hearing services

Provision of free hearing services for eligible clients is available through the Australian Government Hearing Services Program. Free services include hearing assessment, the fitting of hearing devices and associated rehabilitation services to eligible clients including children and young adults under the age of 21 years.

Helping children with autism

The Australian Government is implementing a package to better assist children with autism and their families through early intervention. This package includes:

- individual assistance for children aged six and under diagnosed with an autism spectrum disorders (ASD) and who are not yet at school to support the provision of structured and intensive early intervention services such as one-on-one intensive activities and tailored group and individual programs
- autism advisors to assist families and carers of children diagnosed with an ASD to access advice and information about appropriate early intervention services
- workshops and a website to support parents, carers and professionals in their roles
- playgroups for children with ASD or ASD-like symptoms and their families and carers across Australia. These playgroups will offer play-based learning opportunities for children and social support networks for their families and carers
- new Medicare items for diagnosis and early intervention treatment for children with autism or any other less prevalent pervasive developmental disorders, such as Rett's disorder, Asperger's syndrome and childhood disintegrative disorder. This will also increase access to early intervention therapy immediately after diagnosis. The Medicare items were available from 1 July 2008.

Family support

See services described under primary prevention.

Education and care

Autism specific early learning and care centres

The autism specific early learning and care centres will provide early learning programs and specific support for children with ASDs. The centres will be accredited long day child care centres and will provide services based on best practice principles for working with children with ASDs. Centres will be established in six sites, mostly in metropolitan locations.

Extra support for children with disability program outside school hours care

This FaHCSIA program assists children with disability and their families by funding services to deliver appropriate and flexible outside school hours and vacation care. A particular focus of this program is to increase access for children and teenagers with disability aged 12 to 18 years. The program will be delivered at over 40 sites located across Australia by a range of disability and child care service providers.

Child safety

Responding Early Assisting Children Program

FaHCSIA provides grant funding to NGOs in each state who are delivering programs, projects and/or measures that directly or indirectly assist in the prevention of child abuse.

The Responding Early Assisting Children program is intended to improve the capacity of families and care givers to respond appropriately to children's needs for care, development and safety through timely access to community resources that can support them in their parenting role. It aims to improve access to support services and encourage families to engage with their community through partnership approaches. REACh has an emphasis on ensuring the best possible start and promoting successful transitions for children in vulnerable families. The program is about child-centred, family focused and community connected responses.

Child Abuse Prevention Service

Child Abuse Prevention Service (CAPS) is an NGO that aims to support parents and alleviate family stress, to make sure that children can grow up in an environment of security, happiness and self worth. CAPS offers 24-hour crisis support through a national free-call crisis helpline.

Specialist services for parental risk factors

Mental health services

The Australian Government has a range of mental health programs that provide funding for mental health treatment, workforce support, and financial support for people with a mental illness.

Specific programs that target parents with a mental illness or their children are:

- children of parents with mental illness — aims to promote better mental health outcomes for children (from birth to 18 years) of parents with a mental health problem or disorder through a range of activities and programs. There are COPMI programs in every state that are partly funded by state governments.
- national plan for perinatal depression — better support and treatment for expectant and new mothers experiencing depression including
  - routine screening for depression — once during pregnancy and a follow-up check at around the time the baby is two months old
  - follow-up support and care for women who have been assessed as at risk of or experiencing antenatal or postnatal depression
  - training for health professionals to help them screen expectant and new mothers and identify those at risk of or experiencing depression.

Drug and alcohol services

Under the National Illicit Drug Strategy (NIDS), the Australian Government provides funding for drug treatment services delivered by NGOs.

In addition, the *Strengthening and Supporting Families Coping with Illicit Drug Use* (Strengthening Families) program is an early intervention, family focused component of NIDS funded by FaHCSIA. Education, counselling support services, advice and referral services are targeted at families of people who use illicit drugs including children of drug-using parents. Eighteen NGO providers are funded until 30 June 2009 to deliver a range of Strengthening Families projects that support children of drug-using parents by giving them the opportunity to participate in normal childhood activities like playgroup, music lessons and sporting activities.

Family violence services

FaHCSIA funds services to tackle family violence and child abuse. Specialist family violence services are funded under the Family Relationships Services Program as well as Indigenous family violence services.

Indigenous family violence services comprise two programs:

- Family Violence Partnership Program — funding for projects and initiatives that aim to develop a sustainable reduction in, and prevention of, Indigenous family violence and child abuse through the enhancement of existing, or establishment of new, services and initiatives, in partnership with states and territories throughout Australia
- Family Violence Regional Activities Program — provides practical and flexible support for grassroots projects that have been identified by Indigenous communities as a local priority to address family violence, sexual assault and child abuse.

Tertiary prevention

The Transition to Independent Living Allowance

The Transition to Independent Living Allowance (TILA) aims to ensure that young people exiting formal/informal care are assisted to transition to independent living through enhanced access to accommodation, employment or education and the development of life skills and knowledge. The one-off payment of up to $1000 is available to young people aged between 15 to 25 years who are about to, or have exited, state-based care and/or informal care including out-of-home care and Aboriginal and Torres Strait Islander Kinship care arrangements. TILA is provided by the Australian Government and administered by DEEWR.